

# Caring

Headlines

July 25, 2013

## A special wedding on Lunder 9



*See story on page 4*

Members of the Trang-Phan wedding party gather at the bedside of patient, Thuy Pham, after wedding on Lunder 9.

# A visit from the Studer Group

*reinforcing our commitment to a culture  
of service excellence*

The underlying message throughout Karen's presentation was that to truly embrace a culture of service excellence, organizations must practice a policy of 'zero tolerance' for anything less than exceptional care and service.

**O**n June 26, 2013, leadership throughout Patient Care Services had an opportunity to attend the half-day session, "Hardwiring a Culture of Excellence," presented by the Studer Group. You may have heard of the Studer Group—the internationally renowned company that coaches healthcare organizations in achieving exceptional clinical and operational outcomes, especially during times of great change. Our presenter, Karen Cook, RN, who co-authored *The HCAHPS Handbook*, has more than 20 years of healthcare experience and an impressive record of helping organizations cultivate workplace environments that value excellence in care and service. Needless to say, it was a powerful and compelling session.

The underlying message throughout Karen's presentation was that to truly embrace a culture of excellence, organizations must have zero tolerance for anything less than exceptional care and service. She cited two examples that illustrate how, 'What you permit, you promote.' The first example simply had to do with seeing a piece of trash on the floor. What would you do—pick it up or walk on by? What you permit, you promote. The second example had to do with retaining employees who aren't committed to our mission and values. We've come to view a low turnover rate as a sign of staff-satisfaction. But does that low turnover rate come at the cost of retaining



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

staff who don't strive for excellence in their daily practice? If it does, that's not a formula for success. What we permit, we promote.

Another point Karen stressed was the connection between excellence and consistency. It's not enough to just *have* great systems, great communication, or great documentation, unless you use them effectively *every single time*. Think about the HCAHPS (the Hospital Consumer Assessment of Healthcare Providers and Systems), the standardized survey that measures patients' perceptions of care. HCAHPS only publicly report the frequency of 'top-box' or 'always' responses. Because when patients are choosing a hospital, they want to know which hospitals provide excellent care and service *all the time*.

This is what the Studer Group means by hardwiring excellence into your culture. Extraordinary care and service should be the baseline customer-service expectation and only spike *up* as situations demand.

*continued on next page*

Communication is how we convey courtesy, respect, empathy, and assurance; it's often the basis of first impressions; the barometer of your attitude at the bedside; and nothing else in health care has a greater impact on patients' perceptions of care.

Karen shared an example from one hospital she worked with that implemented a policy whereby no employee passes a call light without responding. No one says, "That's not my job." If it has to do with meeting the needs of a patient or family member, it's everyone's job. I love that.

Communication is one of the most important components of a culture of service excellence—it affects every interaction with patients and families. Communication is how we convey courtesy, respect, empathy, and assurance; it's often the basis of first impressions; the barometer of your attitude at the bedside; and nothing else in health care has a greater impact on patients' perceptions of care. When we talk about consistency, reliability, and hardwiring a culture of excellence, we're talking about a workforce that has the desire, the tools, and the ability to communicate effectively.

Karen shared an evidence-based communication model called, AIDET<sup>®</sup>, that provides a framework for communicating with patients, families, and colleagues. When used consistently, this method leads to better clinical outcomes and an upswing in patients' perceptions of care. AIDET<sup>®</sup> stands for:

- **Acknowledge**—greet people with a smile; call them by name if you know it. This helps create a positive, welcoming impression

- **Introduce**—introduce yourself politely. Explain who you are and why you're there. Let them know you're knowledgeable and experienced. This helps allay anxiety
- **Duration**—let patients (and colleagues) know if there's going to be a delay. Do what you can to minimize the delay, and apologize or employ service-recovery methods when appropriate. This helps set realistic expectations
- **Explanation**—let patients know what you're doing, how procedures work, and whom to contact if they need assistance. Talk, listen, learn, and respond.
- **Thank-you**—Thank patients and/or colleagues for their patronage, help, or assistance. Ask if there's anything else you can do for them. This helps foster an attitude of gratitude

I want to thank Karen for her very enlightening presentation. It's clear that the goals and values of the Studer Group are closely aligned with our own. Before leaving, Karen made a point of acknowledging the work we're doing on Innovation Units, including quiet times, hourly rounding, cleanliness, nurse communication, and responsiveness. She reinforced that this is, 'the right work.' I assured her that we're hardwiring excellence into our culture through the commitment of our extraordinary staff to provide extraordinary care and service to every patient, every day. And I thank *you* for that.

## In this Issue

A Wedding on Lunder 9.....	1	Clinical Narrative.....	8
Jeanette Ives Erickson.....	2	● Meghan Bertone, RN	
● A Visit from the Studer Group		Carol A. Ghiloni Oncology Nursing Fellowship.....	10
A Wedding on Lunder 9.....	4	Fielding the Issues I.....	11
Patient Education.....	5	● Restraint Solutions	
● Optimal Care through Accessibility		Professional Achievements.....	12
Critical-Care Nurse Residency.....	6	Fielding the Issues II.....	14
A Letter of Appreciation.....	7	● New Criteria for Identifying MDROs	
		Announcements.....	15
		Notification: EFIC Study.....	16

(Cover photo by Paul Batista)



# Staff come together to grant special wish for family of cancer patient

—by Rebecca Loh, RN, Lunder 9 staff nurse

It started with a simple wish uttered to a night nurse on the Lunder 9 Oncology Unit. Patient, Thuy Pham, was dying of lung cancer. Her son, Hue Trang, was engaged to be married. Knowing his mother's time was short, he wanted to get married at her bedside. From the beginning, it seemed an impossible task. Pham needed oxygen to breathe comfortably; her passing was imminent. Bride-to-be, Jennifer Phan, was still at home in California. This Buddhist family had expected to enter a three-year mourning period upon Pham's passing, during which it would be inappropriate to get married. They

weren't looking for a mock ceremony; they wanted a full-fledged, legally recognized wedding.

Pham's oncologist drafted a letter urgently asking the Massachusetts Registry to waive the three-day waiting period for a marriage license. Chaplaincy and Social Service found a suitable clergy member to officiate. Palliative Care and Lunder-9 staff worked to ensure Pham's medication would allow her to be comfortable but aware throughout the ceremony.

The future bride arrived in the middle of the night, wedding gown in hand. Early in the morning, she and Trang rushed to City Hall with the oncologist's letter in hand. They were able to find a judge and pull him out of a hearing to sign the paperwork.

Nursing, the MGH Flower Shop, Catering, the Photography Department, and so many other disciplines worked together to make this wedding the special event everyone wanted it to be.

The ceremony was lovely, albeit bittersweet. A small group of friends and family, chaplains, and

unit staff attended. The couple was married at Pham's bedside, holding her hand. Though stoic by nature, Pham seemed truly thankful to be able to be part of her son's wedding.

Pham died peacefully two days later, surrounded

by loved ones. Her family expressed gratitude for the care she received and the incredible effort made by staff to arrange the wedding. They were touched that so many 'strangers' had come together and worked so hard on their behalf. Less than 48 hours after a simple wish was made in the quiet hours on Lunder 9, Hue Trang and Jennifer Phan were married.



(Photos by Paul Banatao)



Scenes from the wedding, including bride, Jennifer Phan, 'walking down the aisle,' (aka the Lunder 9 hallway) lined with unit staff and well-wishers.

# Promoting optimal care *ensuring optimal accessibility*

—by Mallory A. Hillard, Christine Marmen, RN, and Anna Pandolfo, CMI,  
for the PCS Patient Education Committee

Among those resources are the Disability Program housed within the Office of Patient Advocacy, the on-line Excellence Every Day (EED) portal, and numerous assistive technologies available throughout the hospital to assist with communication, transportation, and other factors affecting access to care.

**A**s a community, MGH strives to provide all patients with equitable, quality care, including patients with special needs that may affect their ability to navigate the complex physical environment of a large, academic medical center. MGH has developed a number of resources to ensure patients with disabilities enjoy the same level of access to our care and services as all other patients and family members. Among those resources are the Disability Program housed within the Office of Patient Advocacy, the on-line Excellence Every Day portal, and numerous assistive technologies available throughout the hospital to assist with communication, transportation, and other factors affecting access to care. These resources support our mission to provide high-quality care to all patients.

The MGH Disability Program provides assistance to patients and caregivers around planning visits to MGH, accessing accommodations, and responding to concerns and recommendations related to accessibility. For more information about the program, call 617-726-3370.

The Excellence Every Day portal is a great source of information for patients with disabilities. The portal provides a link to the Accessibility MGH website, which describes adaptive equipment, communication devices, and services available to assist patients in navigating around MGH. Also available here is the Patient Education Committee's *Teachable Moments* flyer, highlighting resources about inclu-

siveness, patient-centered care, and adaptive equipment. The Etiquette link in the Disabilities Toolkit guides staff in appropriate etiquette and 'person-first' language. The Disabilities page also provides information about upcoming educational offerings, including meetings of the Council on Disabilities Awareness, the Employees with Disabilities Resource Group, and links to internal and external resources including staff contacts at MGH.

American Sign Language, multiple language interpreters, and remote CART Services (Communication Access Real-Time Translation) are among the communication aids available at MGH. To request any of these services, contact Medical Interpreter Services at 617-726-6966. Public videophones are located in the White Lobby and in the Maxwell & Eleanor Blum Patient and Family Learning Center. These phones are available for patients who are Deaf to make calls directly (or through a video relay service) to other videophone users. Portable videophones for inpatient units are available through Materials Management at 617-726-9144.

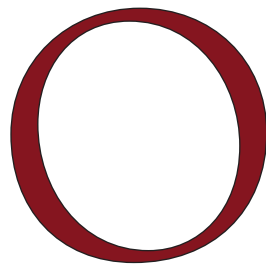
The Blum Patient and Family Learning Center also offers assistive devices such as an ergonomically designed computer mouse, wheelchair-accessible tables, ZoomText, and Telesensory Vertex and Duxbury Braille translation software.

For information about how to integrate these resources into your practice, please visit the EED portal ([http://www.mghpcs.org/EED\\_Portal/index.asp](http://www.mghpcs.org/EED_Portal/index.asp)), contact the Blum Patient and Family Learning Center (617-724-7352), or call Zary Amirhosseini, disability program manager, at 617-643-7148.

# Critical Care Nurse Residency

— by Gail Alexander, RN, professional development manager

Back row (l-r): Nicholas DiGiovine, RN, (Surgical ICU); Kayla Paschal, RN, (Medical ICU); David De La Hoz, RN, (Medical ICU); Gerald Finerty, III, RN, (Cardiac ICU); Emily Stout, RN, (Neuroscience ICU); Christina Lawrence, RN, (Neuroscience ICU).  
Front row: Meghan Esposito, RN, (Medical ICU); Elizabeth Sivertsen, RN, (Surgical ICU); Meghan Bertone, RN, (Surgical ICU); and Margaret Flynn, RN, (Cardiac Surgical ICU).



On June 25, 2013, Gino Chisari, RN, director of the Norman Knight Nursing Center for Clinical & Professional Development, welcomed family, friends, and colleagues of the most recent graduating class of the Critical Care Nurse Residency Program (formerly the New Graduate in Critical Care Nursing Program) to a celebration of achievement. Ten new critical-care nurse residents joined the ranks of the 194 alumni of these important critical care transition programs.

Chisari noted that the program has been extended to 12 months, citing evidence that bringing independently

practicing nurses together for advanced professional development during the second half of their residency represents best practice.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, congratulated the nurse residents on meeting the rigorous demands of the program. She acknowledged the crucial guidance of critical-care leadership, the generosity of the many professionals who served as instructors, and the invaluable support and skill of the preceptors.

Nurse residents, Meghan Bertone, RN, (see narrative on page 8) and Christina Lawrence, RN, shared clinical narratives describing situations they had encountered while caring for critically ill patients. In follow-up discussions with Gail Alexander, RN, Critical Care Nurse Residency coordinator, Bertone and Lawrence spoke about the rewards and challenges of learning to manage multiple demands, support family members, and keep patients safe from harm.

Certificates of completion went to:

- Meghan Bertone, RN, Surgical ICU
- David De La Hoz, RN, Medical ICU
- Nicholas DiGiovine, RN, Surgical ICU
- Meghan Esposito, RN, Medical ICU
- Gerald Finerty, III, RN, Cardiac ICU
- Margaret Flynn, RN, Cardiac Surgical ICU
- Christina Lawrence, RN, Neuroscience ICU
- Kayla Paschal, RN, Medical ICU
- Elizabeth Sivertsen, RN, Surgical ICU
- Emily Stout, RN, Neuroscience ICU

For more information about the Critical Care Nurse Residency Program, contact Gail Alexander at 6-0359.



# A letter of appreciation

*from the 2012-2013 class of critical-care nurse residents*

January, 2013

To Ms. Jeanette Ives Erickson (senior vice president for Patient Care and chief nurse):

We're writing to express our appreciation for one of MGH's finest, Gail Alexander, RN. As members of this year's Critical Care Nurse Residency, we feel her expertise in the field guided us from day one. Not only was Gail welcoming from the very beginning, she helped coach us through our initial fears, anxieties, and uncertainties. She was more than an educator, she was a mentor.

Gail has an innate ability to teach, a talent for breaking down complicated material and building a foundation for future understanding. From comprehending the effects of positive-pressure ventilation on hemodynamics to assessing and treating pain, Gail's presentations were filled with teachable moments.

She began every class by asking if we had any concerns or worries, encouraging us to verbalize our fears as we became immersed in our practice. She understands that critical-care nursing is more than mastering pharmacology and physiology, it encompasses emotions, ethics, values, and so much more.

In short, our success would not have been possible without, not just our preceptors, but Gail, who worked tirelessly to support us throughout the program.

Gail and the Critical Care Nurse Residency are essential components of excellence in nursing at MGH. We know what an incredible opportunity we were given, and what a tremendous difference the program made in terms of our preparation to practice in the critical-care setting. We're honored to be nurses at MGH.

We would also like to acknowledge the contributions of: Lillian Ananian, RN; Mary Guanci, RN; and Jenn Albert, RN, for their informative lectures, hours of effort, and expertise in numerous topics. We strongly encourage you, the Knight Nursing Center, and the ICUs to continue to support this phenomenal program. This hospital needs more new graduates influenced by Gail Alexander.

Respectfully,

The 2012-2013 class of critical-care nurse residents



# Challenging situation proves valuable learning experience for new critical-care nurse

Mrs. M was a 60-year-old woman who'd had an aorto-bifemoral bypass graft. Her course was complicated by a clot that had developed in her thigh requiring a stent, and compartment syndrome that required a fasciotomy.

**M**y name is Meghan Bertone, and I recently completed the Critical Care Nurse Residency Program (see article on page 6).  
“What’s going on here?” Mrs. M asked for what felt like the hundredth time that day. I patiently reminded her, “We’re in the ICU at Mass General. You had surgery a few days ago. You’ll be here a bit longer while you recover.”

Mrs. M was a 60-year-old woman who'd had an aorto-bifemoral bypass graft. Her course was complicated by a clot that had developed in her thigh requiring a stent, and compartment syndrome that required a fasciotomy (a surgical procedure to relieve tension or pressure). Further complicating her condition, she had developed rhabdomyolysis (a condition where damaged skeletal-muscle tissue breaks down) after surgery.

Medically, Mrs. M was a complex patient—my day was non-stop between nursing interventions, titrating drips, checking labs, keeping up with documentation, and updating the team about all her changes. Pain was also an issue, and much of my effort was spent trying to control it. I frequently re-positioned her, waited while she decided if it was better, then re-positioned her again. Mrs. M had baseline anxiety that was exacerbated by her hospital stay. She needed me to be at the bedside to comfort and reassure her. Her forgetfulness scared her, and her confusion was increasing.



Meghan Bertone, RN, critical-care nurse resident

Throughout my shift, when I reminded Mrs. M where we were, she would respond with, “Oh, yes. That’s right,” or, “I know I’m confused. I remember now.”

But this time was different. She didn’t say, “Where are we?” She said, “What’s going on here?” Then, to my usual response, she said “I’m not sure that’s what’s really going on.”

No matter how many times I explained, she didn’t believe me and started to become argumentative. At one point, she even accused me of trying to kill her! She didn’t believe I was a nurse or that we were in a hospital. She was convinced she’d been kidnapped and demanded a phone to call 911. My sweet, mildly confused patient had turned into an extremely agitated, upset patient in an instant.

At this point, I started to panic. I had only ever encountered situations like this as a nursing student. My no-fail solution to situations like this had always

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Though I wish my patient hadn't experienced such a distressing situation, it was rewarding for me to have made the decision independently about how to handle it, and that it worked... I realize how important it is to develop relationships with my patients. I try to focus on providing comfort and support to each patient and not get wrapped up in a checklist of tasks.

been: Get the nurse—stat! But in that moment I realized I *was* the nurse; this was *my* responsibility.

Mrs. M was escalating. I had to do something, fast. Clearly, telling her repeatedly that we were in the hospital wasn't working. I went to the resident and told him my patient was agitated and combative. I suggested a dose of PRN Haldol might be helpful. He agreed and wrote the order. Still, I knew Mrs. M would need more than just medication to calm her down.

I remembered that Mrs. M's chart contained the phone numbers of two friends and her two children. One friend had already visited that day, and two others had called to check on her. I asked Mrs. M if I could call her family so they could speak to her and confirm that I was telling the truth. She was receptive to the idea.

For some reason, speaking with family members had proven to be an unexpected challenge for me. With the patient population in the ICU being so ill, I was always nervous I'd say the wrong thing. I didn't want to give false hope, but at the same time, I didn't want to sound *hopeless*. Normally, I didn't like hearing my name paged to field a call from a family member, but in this case I felt the family could potentially provide a positive intervention.

I picked up the phone. For the first time, I was calling a patient's family instead of them calling me. When Mrs. M's daughter didn't answer, I left a message, choosing my words carefully. I wanted the daughter to call back as soon as possible, but I didn't want to alarm her thinking her mother had taken a turn for the worse.

I also called Mrs. M's friend who had visited earlier. Luckily, she answered, and I quickly explained the situation. I asked if she could try to reorient Mrs. M, and she was great. She spoke to Mrs. M and assured her that she was indeed in the hospital. But unfortunately, Mrs. M remained paranoid and skeptical. She told her friend she was afraid to drink anything I gave her because I might have poisoned it. She said she couldn't believe her friend because someone could be there forcing her to play along with all the 'lies.' It was upsetting to hear my patient say these things about me and the hospital.

After a while, perhaps because the Haldol kicked in, Mrs. M calmed down and realized she was confused. I was able to reach her son and another friend to further reorient and reassure her. Her daughter also called back and spoke with her.

Speaking with her loved ones helped bring Mrs. M back from her agitated state to the sweet patient I knew she was. Now she was more embarrassed than upset and repeatedly apologized to me. I knew she hadn't known what she was saying, nor had she meant any of it. I assured her she didn't have to apologize. It's common, I told her, for patients to become confused in the hospital after receiving anesthesia and other medications. I was glad I was able to find a way to comfort her and remedy the situation.

A senior nurse who'd been across the hall popped her head in afterward and said, "That was a smart idea," to call the family. Hearing that was extremely validating for me as I particularly admired this nurse.

Though I wish my patient hadn't experienced such a distressing situation, it was rewarding for me to have made the decision independently about how to handle it, and that it worked. I overcame my aversion to speaking with family members and actually sought their help instead of resorting solely to medication. I realize how important it is to develop relationships with my patients. I try to focus on providing comfort and support to each patient and not get wrapped up in a checklist of tasks. Speaking with family members is less nerve-racking now, and I find I do it more confidently each time.

This initially difficult experience proved to be a great learning opportunity and helped me improve my nursing practice.

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

This is a wonderful example of relationship-based care delivered by a new-graduate nurse. Even in the short time Meghan had been caring for Mrs. M, she got to know her. That knowledge allowed her to pick up subtle changes in Mrs. M's voice and behavior. Meghan appropriately consulted the resident to request medication and sought out Mrs. M's family and friends as a strategy to re-orient her. Meghan's interventions helped calm Mrs. M and guide her safely through her delirium.

This narrative also touches on the impact delirium has on the caregiver. Especially with new clinicians, there can be a heightened sense of anxiety. Confidence comes with experience, and Meghan just added a valuable chapter to hers.

Thank-you, Meghan.

# The Carol A. Ghiloni Oncology Nursing Fellowship

—by Mandi Coakley, RN, staff specialist

The 13th Carol A. Ghiloni Oncology Nursing Fellowship recently welcomed two student-nurse fellows for a 10-week experience in the Oncology Nursing Service. The fellowship provides student nurses with an opportunity to learn about and observe the many roles nurses play in caring for oncology patients and the numerous career opportunities available to them upon graduation. The Ghiloni Oncology Nursing Fellowship was developed in 2001 to help student nurses learn about oncology nursing as a specialty with the hope of recruiting them into oncology nursing positions upon graduation.

This year's fellows, Francesca Miceli, a nursing student at the University of Massachusetts, Amherst, and Francisco Portella, III, a student at Purdue Uni-



versity, began their learning experience on inpatient units with assigned preceptors. For the first four weeks, Miceli worked with, Jessica Auclair, RN, on Phillips 21, and Portella worked with Colleen O'Connell, RN, on Lunder 9. After five weeks they switched.



In addition to hands-on clinical experience on the units, fellows had an opportunity to observe practice in Radiation Oncology, the Infusion Unit, and the Yawkey outpatient disease centers. They attended Schwartz Center rounds and HOPES programs; they spent time in the Blood Transfusion Service, Interventional Radiology, and took advantage of other learning opportunities within the Cancer Center.

The Ghiloni Oncology Fellowship receives partial funding from the Hahnemann Hospital Foundation. For more information, call Mandi Coakley, RN, staff specialist, at 617-726-5334.

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At left (l-r): Mandi Coakley, RN, staff specialist and coordinator of the Ghiloni Fellowship; Carol Ghiloni, RN; and fellows, Francesca Miceli and Francisco Portella, III. Above: Miceli and Portella on Lunder 9

# Innovative solutions reducing the need for restraints

In the past few years, collaborative work among nurses and occupational therapists on the Blake 11 Psychiatric Unit has resulted in an effective, reliable approach that reduces the use of physical restraints for patients with behavioral issues.

*Question:* Minimizing the need for restraints has long been a patient-safety concern; what innovations are occurring at MGH in this area?

*Jeanette:* In the past few years, collaborative work among nurses and occupational therapists on the Blake 11 Psychiatric Unit has resulted in an effective, reliable approach that reduces the use of physical restraints for patients with behavioral issues.

*Question:* Can you describe the approach?

*Jeanette:* It's based on the theory that stimulating patients' senses (vision, hearing, taste, or proprioception) evokes compensatory responses that mitigate escalating behaviors. Initially, these sensory interventions were provided by occupational therapists based on their assessment of and collaboration with patients. Certain interventions were identified as calming, which led to incorporating those interventions into the patient's plan of care. Today, those interventions have become standard practice on the unit and are employed by all disciplines, including nurses, patient care associates, psychologists, and physicians.

*Question:* How has that approach impacted the use of restraints?

*Jeanette:* On Blake 11, patients are given an opportunity to self-select sensory activities that they find calming. Incorporating interventions that patients themselves have identified as helpful increases their effectiveness and has led to reduced use of restraints.

*Question:* Is this approach being used in other units or settings in the hospital?

*Jeanette:* Yes. This work has become a central focus of the PCS Restraint Solutions in Clinical Practice Committee. Committee champions were instrumental in introducing these interventions to the Emergency Department's Acute Psychiatric Service (APS). When we were constructing the new APS office in the Lunder Building, we took care to include certain sensory qualities in the environment, such as dimmer lighting, televisions that can access the care channel, and paint colors with calming, soothing tones. APS nurses collaborated with occupational therapists to create a sensory cart stocked with a number of sensory-based items.

*Question:* How can I begin to incorporate this approach into my practice?

*Jeanette:* Occupational Therapy has developed a Sensory Task Force to collaborate with clinical nurse specialists and nursing directors on units whose patient populations are at higher risk for restraint use. The goal of this inter-disciplinary work is to develop an effective sensory-based alternative to restraints.

Other restraint alternatives used by front-line staff can be found on the EED portal page under Collaborative Governance Restraint Solutions in Clinical Practice (at [http://www.mghpcs.org/eed\\_portal/EED\\_restraints.asp](http://www.mghpcs.org/eed_portal/EED_restraints.asp)).

For more information, call 4-6104.

# Professional Achievements

## Healy appointed

Caitlin Healy, RN, staff nurse, Emergency Department, was appointed a member of the National Committee on Clinical Practice for the Emergency Nurse Association, in Chicago, in May, 2013.

## Harris appointed

Cathie Harris, RN, clinical nurse specialist, Emergency Department, was appointed a member of the National Committee on Clinical Practice for the Emergency Nurse Association, in Chicago, in May, 2013.

## Robbins appointed

Christopher Robbins, RN, staff nurse, Endoscopy Unit, was appointed vice speaker of the House of Delegates for the Society of Gastroenterology Nurses and Associates Board of Directors, in Austin, Texas, on May 17, 2013

## Washington appointed

Deborah Washington, RN, director of PCS Diversity, was appointed a member of the Executive Council of the Massachusetts branch of the American Association of Retired People in May, 2013.

## Adams honored

Ryan Adams, RN, staff nurse, Medical ICU, received the Nursing Appreciation Award from the department of Medicine residents, in May, 2013.

## Fern receives scholarship

Ellen Fern, RN, staff nurse, Endoscopy Unit, was awarded the Annual Course Scholarship by the Society of Gastroenterology Nurses and Associates, at their annual meeting in Austin, Texas, May 21, 2013

## Pomerleau honored

Mimi Pomerleau, RN, Obstetrics, received the Rita P. Kelleher Award, at the William F. Connell School of Nursing, June 1, 2013.

## Faoro certified

Nicholas Faoro, RN, staff nurse, Burn, Plastic & Reconstructive Surgery Unit, became a certified plastic surgical nurse by the Plastic Surgical Nursing Certification Board, in collaboration with the center for Nursing Education and Testing, in May, 2013.

## Blakeney presents

Barbara Blakeney, RN, innovation specialist, presented, "Unlocking the Power of Innovation," at a national webinar, sponsored by API Health Care, April 10, 2013.

Blakeney also presented, "Innovation in Nursing Practice," at the same venue, May 9, 2013.

## Coakley and Barron present

Amanda Bulette Coakley, RN, staff specialist, and Anne-Marie Barron, RN, clinical nurse specialist, presented, "Therapeutic Touch: the Intervention and the Research," at the third annual Integrative Nursing: the Art of Healing Conference, at Boston Medical Center, April 30, 2013.

## Chambers presents

Jeff Chambers, RN, staff nurse, Emergency Department, co-presented with representatives from the Boston Fire Department and Boston Emergency Medical Services at St. Luke's Warren Hospital, in Phillipsburg, New Jersey, May 22, 2013.

## Chang presents

Lin-Ti Chang, RN, staff specialist, presented, "Closing the Gap of Health Disparity by Improving Access to Health Education and Wellness for elder Chinese Residents Living in the Boston Community," at the 25th quadrennial congress of the International Council of Nurses, in Melbourne, Australia, May 19, 2013.

## Amatangelo presents

Mary Amatangelo, RN, nurse practitioner, Neurology/Stroke Service, presented, "Women and Stroke," at the 30th annual Brain Injury and Stroke Conference in Concord, New Hampshire, May 16, 2013.

Amatangelo also presented, "Post-Stroke Paradigm," and "Women and Stroke," at the National Primary Care Conference, in Chicago, May 17th.

## Lally and Blue present

Patricia Lally, RN, staff nurse, Gastrointestinal Unit, and Timothy Blue, MD, presented, "Recognizing Gastrointestinal Problems in Children and Adults with Autism: Strategies to Create a Positive Environment within the Endoscopy Suite," at the National Meeting of the Society of Gastroenterology Nurses and Associates, in Austin, Texas, May 21, 2013.

## Scott presents

Katrina Scott, chaplain, presented, "The Rise of the Religiously Unaffiliated," at the annual meeting of the Funeral Consumers Alliance of Eastern Massachusetts, in Newton, in March, 2013.

## Pomerleau presents

Mimi Pomerleau, RN, Obstetrics, presented, "Front-Line Healthcare Workers Panel," at the advocacy summit of Save the Children, in Washington, DC, April 10, 2013.

## Drapek presents

Lorraine Drapek, RN, nurse practitioner, Radiation Oncology, presented, "Snapping Out Liver Metastases," at the annual congress of the Oncology Nursing Society in Washington, DC, April 26, 2013.

## Staff nurses present

Staff nurses, Ellen Fern, RN, and Janet King, RN, of the Endoscopy Unit, presented, "Aiming Higher... Creating a Brighter Tomorrow with pH Best Practices," and, "Ignite your Potential to Understand Normal Esophageal Motility and Abnormal Manometry Findings," at the national meeting of the Society of Gastroenterology Nurses and Associates, in Austin, Texas, May 17, 2013.

## Staff nurses present

Staff nurses, Lynn Collier, RN, and Marjorie Voltero, RN, of the Gastrointestinal Unit, presented, "How to 'Fire Up' an Inter-Generational GI Workforce to Transition to an Electronic Record," at the national meeting of the Society of Gastroenterology Nurses and Associates in Austin, Texas, May 20, 2013.

## Inter-disciplinary team publishes

Jeffrey Adams, RN, director, The Center for Innovations in Care Delivery; Nikolay Nikolaev, Human Resources; Jeanette Ives Erickson, RN, senior vice president, Patient Care; Marianne Ditomassi, RN, executive director, PCS Operations; and, Dorothy Jones, RN, director, The Yvonne L. Munn Center for Nursing Research, authored the article, "Identification of the Psychometric Properties of the Leadership Influence over Professional Practice Environments Scale," in the *Journal of Nursing Administration*, in May, 2013.

## Lux publishes

Laura Lux, RN, staff nurse, ICU, authored the article, "Put a Stop to Bullying New Nurses," in the June issue of *Nursing* 2013.

## Arnstein appointed

Paul Arnstein, RN, pain clinical nurse specialist, was appointed a member of the Clinical Practice Guideline Committee of the American Pain Society, May 9, 2013.

## Pomerleau publishes

Mimi Pomerleau, RN, authored the article, "Cultivate Passion in your Practice with the 4 Rs," in *Nursing for Women's Health*, in the April/May, 2013, issue.

## Campbell presents poster; wins first prize

Elizabeth Campbell, RN, IV Therapy, presented her poster, "Mentoring Graduate Nurses to the Intravenous Therapy Nursing Specialty," at the annual seminar of the League of Intravenous Educators, in Farmington, Pennsylvania, April 16-17, 2013. The poster won first prize.

## Nurses present poster

Marion Freehan, RN, nursing director; Jason Gendreau-Visco, RN, staff nurse; June Guarente, RN, clinical nurse specialist; Lisa Henderson, RN, staff nurse; Denise Lozowski, RN, quality nurse coordinator; Lisa McDonald, RN, staff nurse; Ellen Silvius, RN, ambulatory nurse manager; Lorraine Walsh, RN, staff nurse; Pamela Wrigley, RN, clinical nurse specialist; Patricia Lally, RN, staff nurse; Tanya Medvedoff, RN, staff nurse; and, Kathy Sherbourne, RN, nurse practitioner, presented their poster, "A Standardized Nursing Curriculum to Ensure Competency of Nurses for Pediatric Patients in Procedural Areas," at the national meeting of the Society of Gastroenterology Nurses and Associates, in Austin, Texas, May 18, 2013.

## Nurses present poster

Marian Jeffries, RN, clinical nurse specialist; Christine Gryglik, RN, clinical nurse specialist; Diane Davies, RN, research nurse; and, Sheila Knoll, RN, surgical database manager, presented their poster, "Chest-Tube Dressings: Outcomes of Taking Petroleum-Based Dressings Out of the Equation on Air Leak and Infection Rates," at the National Teaching Institute Conference of the American Association of Critical Care Nurses, in Boston, in May, 2013.



## Professional Achievements (continued)

### Sannella honored

Susan Sannella, PT, physical therapist, received the MGH Chelsea Shining Star Award at the MGH Chelsea HealthCare Center, June 14, 2013.

### Inter-disciplinary team publishes

Denise Richards, RN; Mary Larkin, RN; Elaine Javier; Terri Casey, RN; and Margaret Grey, RN, authored the article, "Learning Needs of Youth with Type 2 Diabetes," in *The Diabetes Educator Journal*, in the May/June, 2013, issue.

### Adams spotlighted

Jeffrey Adams, RN, director, The Center for Innovations in Care Delivery, was profiled in "Emerging Nurse Scientists: an Interview with Jeffrey M. Adams, PhD, RN," by Karen Hill, RN, in the *Journal of Nursing Administration*, in May, 2013.

### MacDonald presents

Abigail MacDonald, LICSW, social worker, presented, "Emotional Considerations in Donor Conception and Surrogacy Arrangements," at the Donor Conception/Surrogacy Connect & Learn Seminar, at Children's Hospital in Waltham, May 4, 2013.

### Inter-disciplinary team publishes

David Nathan, MD; John Buse, MD; Steven Kah, MD; Heidi Krause-Steinrauf; Mary Larkin, RN; Myrlene Staten, MD; Deborah Wexler, MD; John Lachin; and the GRADE Study Research Group authored the article, "Rationale and Design of the Glycemia-Reduction Approaches in Diabetes: a Comparative Effectiveness Study," in *Diabetes Care*, in May, 2013.

### Arnstein presents

Paul Arnstein, RN, pain clinical nurse specialist, presented, "Detecting and Treating Neuropathic Pain," at the Neuropathic Pain: Diagnosis & Treatments Conference of the Massachusetts Pain Initiative, in Marlborough, May 17, 2013. Arnstein also presented, "Physiology and Pathophysiology of Pain," and, "What is Causing, Prolonging, and Amplifying Chronic Pain?" at the national conference of the American Association of Nurse Practitioners, in Las Vegas, June 19, 2013.

### Rainie honored

Blake Rainie, CNM, nurse midwife, received the Excellence in Teaching Award, from the American College of Nurse-Midwives, June 6, 2013.

### Folger appointed

Abby Folger, PT, physical therapist, was appointed chair of the Cardiovascular and Pulmonary Special Interest Group of the American Physical Therapy Association of Massachusetts, on June 27, 2013

### Mulligan appointed

Janet Mulligan, RN, nursing director, IV Therapy, was appointed a member of the Gamma Epsilon Chapter of Sigma Theta Tau, in June, 2013.

### Vega-Barachowitz appointed

Carmen Vega-Barachowitz, CCC-SLP, director, Speech, Language & Swallowing Disorders, and Reading Disabilities, was appointed a member of the Board of Trustees for Bunker Hill Community College, in June, 2013.

### Wilson appointed

Jessica Wilson, PT, physical therapist, was appointed treasurer of the Cardiovascular and Pulmonary Special Interest Group of the American Physical Therapy Association of Massachusetts, on June 27, 2013.

### Rowin certified

Tessa Rowin, PT, physical therapist, became a certified orthopaedic clinical specialist by the American Board of Physical Therapy Specialists and American Physical Therapy Association, in June, 2013.

### Inter-disciplinary team presents

Paul Arnstein, RN; Antje Barreveld, MD; Michele Matthews, RPh; and, Jeffrey Shaefer, DDS, presented, "Interprofessional Pain Education for Healthcare Professionals," at the international conference on Opioids: Basic Science, Clinical Applications and Compliance," in Boston, June 9, 2013.

### Capasso presents

Virginia Capasso, RN, clinical nurse specialist, presented, "Care of the Patient with Venous Disease," at the Primary Care Conference of Nurse Practitioners for Continuing Education, in Falmouth, June 24–25, 2013.

### Inter-disciplinary team presents

Maureen Hemingway, RN; Roy Phitayakorn, MD; and Emil Petrusa presented, "Integrating Technical and Team Training Skills in an In-Situ OR," at the Society in Europe for Simulation Applied to Medicine, in Paris, in June, 2013.

### Larkin presents

Mary Larkin, RN, clinical research manager, Diabetes Research Center, presented, "Musculoskeletal Complications in Type 1 Diabetes," at the 73rd scientific sessions of the American Diabetes Association, in Chicago, June 22, 2013.

### Freehan presents

Marion Freehan, RN, nursing director, Endoscopy Unit; and Ellen Silvius, RN, nurse manager, Pediatric Medical Services, presented, "Aiming High with a Vision for a State-of-the-Art Pediatric-Focused Endoscopy Suite," at the national meeting of the Society of Gastroenterology Nurses and Associates, in Austin, Texas, May 20, 2013.

### Nurses present

Paul Arnstein, RN, and Barbara St. Marie, RN, presented, "Understanding the Pharmacology of Addiction and Prescription Drug Abuse as Part of the ER/LA Opioid REMS: Achieving Safe Use While Improving Patient Care," at the regional conference of the Kentucky Coalition of Nurse Practitioners and Nurse Midwives, in Lexington, Kentucky, April 17, 2013.

### Inter-disciplinary team presents

David Thomas; Paul Arnstein, RN; Chris Herndon, RPh; and, Beth Murinson, MD, presented, "Improving Pain Education in Medical, Pharmacy, Nursing, and Dental Schools in the United States," at the 32nd annual scientific meeting of the American Pain Society, in New Orleans, May 9, 2013.

### Lowe presents

Colleen Lowe, OTR/L, occupational therapist, presented, "Musculoskeletal Work-Related Upper-Extremity Disorders/RSI," at Tufts University, in Medford, May 29, 2013.

### Arnstein publishes on-line

Paul Arnstein, RN, pain clinical nurse specialist, authored the (electronic) chapter, "Analgesics," in the advanced practice nursing continuing education course, *Advanced Practice Nurse Pharmacology*, accessible on-line at: <http://ce.nurse.com/60185/advanced-practice-nurse-pharmacology/>.

### Nurses publish

Maureen Hemingway, RN, and Lisa Morrissey, RN, authored the article, "Development of a Complex Multidisciplinary Orientation Program," in the *AORN Journal*, June, 2013.

### Nurses publish

Amy Israeli, RN, and Laura Long, RN, authored the article, "Care of Patients with Deep Inferior Epigastric Perforator Reconstruction," in *Plastic Surgical Nursing*, April–June, 2013.

### Bourgeois a panelist

Mary Bourgeois, PT, physical therapist, participated in the panel discussion, "Exercise for Patients with Pulmonary Hypertension," at the Education Forum for Patients and Caregivers Conference of the Pulmonary Hypertension Association, in Cambridge, June 8, 2013.

### Nurses present poster

Virginia Capasso, RN, clinical nurse specialist; Sheila DeCastro, RN, staff nurse; Christine Pontuso, RN, staff nurse; Alicia Wierenga, RN, staff nurse; Barbara Blakeney, RN, innovation specialist; Donna Hudson-Bryant, RN, nurse practitioner; and Patricia Kelly, RN, nurse practitioner; created the poster, "Keratin Products in the Treatment of an Unusual Acute Surgical Wound with Tendon Exposure." Hudson-Bryant presented the poster at the New Nurse Practitioner Conference, in Newton, May 1–3, 2013, and Capasso presented it at the Symposium on Advanced Wound Care, in Denver, May 2–4, 2013.

# New criteria for identifying MDROs

**Question:** I heard there's been a change in what organisms are flagged with a red P for precautions.

**Jeanette:** Yes. On July 1, 2013, the criteria used to identify and flag multi-drug-resistant, gram-negative organisms (MDROs) changed at MGH.

Patients with MDROs have always required Contact Precautions, but the criteria for identifying those patients wasn't consistent throughout the Partners system. In preparation for implementation of Partners eCare, that process has now been standardized across all Partners entities. Standardization decisions were made by Infection Control and Microbiology experts and based on published guidelines, institutional antibiograms, and expert opinion.

**Question:** How are MDRO gram-negatives different from MRSA and VRE?

**Jeanette:** MRSA and VRE are singular, gram-positive bacteria. While they may be resistant to more than one antibiotic, they're defined by their resistance to a single drug: methicillin (or oxacillin) and vancomycin, respectively.

MDRO gram-negatives include a total of 11 bacteria, and resistance is defined differently for the sub-groups within that list.

**Question:** I've also heard about Carbapenem-Resistant Enterobacteriaceae (CREs) and Extended Spectrum Beta-Lactamases (ESBLs). Do MDRO criteria require Contact Precautions for these bacteria, as well?

**Jeanette:** Yes. CREs are a recognized cause of difficult-to-treat infections associated with high mortality. Enterobacteriaceae (enterics) are a large family of gram-negative bacteria that live in the human gastrointestinal tract. Carbapenem-resistance can be easily transmitted among these bacteria, which makes placing CRE patients on Contact Precautions important. Contact Precautions have been required for CRE patients at MGH since 2005.

ESBLs refer to enteric bacteria that produce an enzyme that induces resistance to extended-spectrum (third generation) cephalosporin antibiotics but doesn't induce resistance to carbapenems. Prior to July 1, 2013, MGH isolated a subset of patients with ESBL bacteria and only in ICUs. These patients were not flagged and didn't remain on precautions after being

transferred to general care units. Now, all patients with an enteric organism, identified as resistant to ceftriaxone (a marker of ESBL production), require Contact Precautions and are flagged for MDRO. This is new.

**Question:** What should I do if I see a culture result that meets the new criteria but the patient doesn't have a red P?

**Jeanette:** Place the patient on Contact Precautions

in a single room or a double room with a blocked bed. Unlike MRSA and VRE patients, MDRO patients may not share rooms.

Culture results are reviewed regularly and flags are manually activated in electronic systems by Infection Control. A culture result may be known by bedside clinicians before the flag has had a chance to be activated. It's not necessary to wait to see the red P to place a patient on Contact Precautions.

For more information, call your unit-based infection-control practitioner or the Infection Control Unit (6-2036). Evenings, weekends, or holidays, contact the infectious disease resident on call.

Organism	Definition
Enterobacteriaceae (enterics) <ul style="list-style-type: none"><li>• Enterobacter spp.</li><li>• Citrobacter spp.</li><li>• Klebsiella spp.</li><li>• Serratia spp.</li><li>• Proteus spp.</li><li>• Escherichia coli</li><li>• Morganella morganii</li></ul>	Isolates that test <b>resistant</b> to ceftriaxone and/or meropenem.
Pseudomonas and Burkholderia spp.	Isolates that test <b>resistant</b> to cefepime.
Acinetobacter spp.	Isolates that test <b>intermediate</b> or <b>resistant</b> to meropenem
Stenotrophomonas spp.	Isolates that test <b>resistant</b> to trimethoprim-sulfamethoxazole (Bactrim)

# Announcements

## SAFER Fair

Join collaborative governance champions (representing the Diversity, Ethics in Clinical Practice, Fall Prevention, Informatics, Pain Management, Patient Education, Policy, Procedure and Products, Research and Evidence-Based Practice, Restraint Solutions, and Skin Care committees) to see how they're working to make a SAFER environment for patients, families, and the entire MGH community.

September 24, 2013  
11:00am–2:00pm  
under the Bulfinch tent

Food, games, and prizes!

For more information, call Mary Ellin Smith, RN, at 4-5801.

## Senior HealthWISE events

All events are free for seniors 60 and older

### Lecture Series

"The Experience of a Chaplain; Finding Comfort and Strength,"

Thursday, August 15, 2013  
11:00am–12:00pm

Haber Conference Room  
Speaker: Reverend John Polk, director, MGH Chaplaincy

"Minimally Invasive Hip Replacement,"

Thursday, August 29th  
11:00am–12:00pm

Haber Conference Room  
Speaker: Young-Min Kwon, MD, director of the MGH Joint-Replacement Fellowship Program

Hypertension Screenings:  
Monday, August 26th  
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.

## Mind Body Spirit Nursing on-line certificate programs

The MGH Institute of Health Professions is offering on-line Mind Body Spirit Nursing certificate programs:

- 9-credit certificate of completion in Mind Body Spirit Nursing
- 15-credit post-master's certificate of advanced study

Classes begin September 9, 2013. Full-time employees of Partners HealthCare may take one 3-credit course at half-price.

Vouchers may be used to cover the cost of tuition.

For more information, call 617- 643-6432, or visit: [www.mghihp.edu/mbs](http://www.mghihp.edu/mbs).

## ACLS Classes

Certification:

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

Day one:  
September 9, 2013  
8:00am–3:00pm  
O'Keefe Auditorium

Day two:  
September 23rd  
8:00am–1:00pm  
Their Conference Room

Re-certification (one-day class):  
August 14th  
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).

## New Global Health certificates from the IHP

The MGH Institute of Health Professions School of Nursing, in conjunction with Partners In Health, is offering two certificate programs in Global Health Nursing beginning in the fall. A 9-credit, on-line certificate of completion is available for nurses with a baccalaureate degree or higher; a 15-credit certificate of advanced study is available for master's-prepared students.

Flexible schedules available to accommodate working professionals.

For more information go to: [www.mghihp.edu/globalhealth](http://www.mghihp.edu/globalhealth).

## Master's in Health Professions Education

The IHP's Master of Science in Health Professions Education (MSHPEd) program is designed for expert clinicians who also teach. This unique program provides an opportunity to study educational best practices in an inter-professional setting. Participants attend two intensive, weekend seminars each year and complete the remainder of the course on-line, (full- and part-time options available).

Applications are reviewed on a rolling basis; next cohort starting in September. For more information or to apply, go to: <http://www.mghihp.edu/academics/center-for-interprofessional-studies-and-innovation>, and click on Academics. Full-time Partners employees receive a tuition discount; contact your Human Resources representative.

For more information, call 617-726-0968.

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For more information, call: 617-724-1746

### Next Publication

August 22, 2013

# EFIC (Exception from Informed Consent) study approved by Partners IRB

The Phase III study examines progesterone versus a placebo in a 1:1 randomized fashion as an acute therapy for adults with moderate or severe non-penetrating traumatic brain injury.

**M**GH staff should be aware that a study utilizing EFIC (Exception from Informed Consent) has been approved by the Partners Institutional Review Board (IRB) and will soon begin enrolling subjects at MGH.

The Phase III study examines progesterone versus a placebo in a 1:1 randomized fashion as an acute therapy for adults with moderate or severe non-penetrating traumatic brain injury (administered within two hours of entry to the ED and infused intravenously for 96 hours).

Progesterone has been linked to significant benefits in multiple animal-model studies of neurological trauma. A pilot study in 100 adult humans demonstrated safety for both men and women. Patients enrolled in the study will be managed under a clinical standardization guideline based on the guidelines of the Brain Trauma Foundation. Numerous sites around the country are participating in this NIH-funded study, which has enrolled more than 800 subjects.

MGH is joining the study along with Boston Medical Center.

The study has received FDA approval and has undergone a process of local, community consultation and public disclosure. Every effort will be made to obtain surrogate consent from family members, but if none can be reached, subjects will be enrolled. Individuals can be removed from the study by a legally authorized representative who arrives later, or individuals may opt out in advance by putting their names on a national list at the study website: <http://sitemaker.umich.edu/protect/home>.

For more information about the study, contact Eric Rosenthal, MD (857-238-5654), MGH principal investigator and associate director of the MGH Neurosciences ICU, or Melissa Howell (617-726-4597), MGH Neurological Emergency Treatment Trial program manager.

For information about the IRB or the EFIC process, contact Elizabeth Hohmann, MD, physician director, Partners IRBs.



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