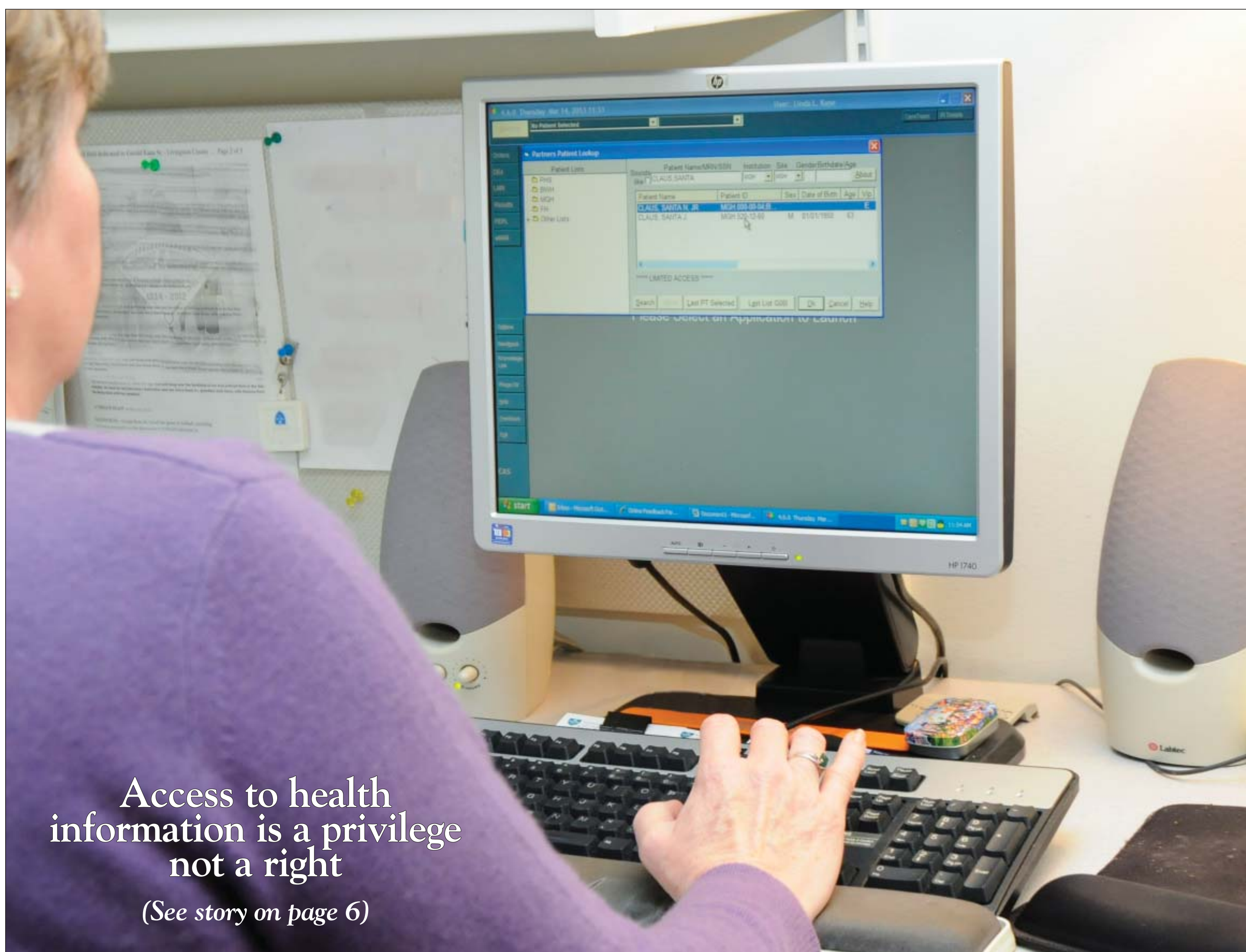
Caring Headlines
March 21, 2013

Are you authorized to access that information?



Access to health information is a privilege not a right

(See story on page 6)

The newsletter for Patient Care Services
Massachusetts General Hospital

Magnet visit exceeds already high expectations

It gives me great pleasure to report that our Magnet site visit, March 4–7, 2013, was an altogether memorable and rewarding experience. Our appraisers (Mary G. Nash, RN, team leader; Linda C. Lewis, RN; Carol 'Sue' Johnson, RN; and Linda B. Lawson, RN) from the American Nurses Credentialing Center (ANCC) could not have been more professional, clinically knowledgeable, engaging, and personable. The team will submit its findings to the ANCC, and within the next 90 days the Commission on Magnet Recognition will vote on our re-designation status. Based on what I saw and heard during their four-day visit, I'm confident the appraisal team left MGH with the same impression I get every time I walk through these doors—that MGH is home to the finest clinicians, support staff, and administrators in the world.

Not only did Magnet appraisers find no deficiencies at MGH (*zero!*), they're recommending us for exemplars in four areas. Truly, this exceeded even my high expectations.

Not only did Magnet appraisers find no deficiencies at MGH (*zero!*), they're recommending us for exemplars in the areas of nurse satisfaction (where we exceeded the benchmark in all five criteria); nursing research and the development of nursing science; innovation; and rewards and recognition. Truly, this exceeded even my high expectations.

I had planned to use this column to share my observations of the visit, but in reflecting on the comments I heard during and since the visit, I think you'd rather hear what *other people* are saying. For instance, in our very first session with the appraisers, they told us, "You should be proud that you went directly from submission of evidence to a site visit. Most organizations' evidence is returned for clarification. Mass General's evidence was extremely well prepared."

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

An ED staff nurse wrote, "Thank-you for the opportunity to represent ED nursing at the Magnet meeting yesterday. I loved it. They encouraged everyone to talk about their practice. I learned so much and felt renewed about my own practice and my twenty-five-year tenure as a member of 'Team MGH.'"

Our colleagues at MGH West made a lasting impression. Their appraiser was delighted to learn that staff had improved patient-satisfaction scores by listening to patients and crafting solutions based on their feedback. She told the team she could, "sense the camaraderie, enthusiasm, and professionalism" as soon as she walked through the door.

From Revere we heard, "I just want to thank you for the chance to showcase our practice. It was a wonderful visit—so positive—it made me proud to be an MGH Revere Health Center nurse."

From the Lunder 8 Neuroscience Unit, "One of the appraisers spent time reviewing our quality data and asking questions. She told us, "You've really created a Magnet culture here. Your team is wonderful."

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It goes without saying (but I'm going to say it anyway) that the success of this visit, the success of our hospital, is because of you—your commitment, your enthusiasm, your leadership, and your ability to think *way* outside the box. Thank-you for your exceptional service.

A Speech-Language Pathology colleague shared, "In an impromptu interview, one of the Magnet appraisers asked how nurses collaborate with speech pathologists. I explained that nurses often ask physicians to consult us and that we rely on nurses to clarify the reason for the consult. The appraisers seemed eager to speak with clinicians from other disciplines."

From the MGH Back Bay Health Center, "It was awesome to be in the room with so many wonderful nurses. Sometimes we can feel dis-connected from the acute-care team. But having the Magnet appraisers visit our practice was so important to me and my colleagues. It gave us a chance to appreciate the broader impact we have."

On the Obstetrics Unit, the appraiser was impressed that so many staff members were present for the interview, where topics ranged from safe hand-offs, to safety reports, quality, research, new-grad orientation and quiet time. Said one nurse, "She loved our units, loved the set-up, and especially loved the lack of noise."

When staff in the Cox 1 Infusion Unit were asked why they were using a travel nurse, the travel nurse spoke right up: "I only go to Magnet hospitals, and MGH is by far the best Magnet hospital I've ever been to."

Other noteworthy observations from the Magnet visit:

"When an organization invests in you, you can't help but invest yourself in the organization. It's a culture of caring."

"As Magnet nurses, we have a responsibility to our patients, our hospital, and our profession."

"Working in a Magnet hospital means teamwork, collaboration, and caring.

"Our health center cares for the most vulnerable patients—it's a privilege to work here."

"I feel respected, so I give respect."

"As a unit service associate, I'm part of our infection-control program."

"I've been a physician a long time, and I've worked with the best people in health care. But I owe my success to one nurse. When I was a resident, a very forceful attending physician asked me a question, and I froze. The nurse leaned over and whispered the answer to me. I'll never forget her."

"Everyone here has your back. You can call anyone for help."

"People are working their butts off here. And loving it!"

It goes without saying (but I'm going to say it anyway) that the success of this visit, the success

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Celebrating Social Work Month with NASW social worker of the year

An interview with Karon Konner, LICSW

March is Social Work Month, and we're proud to be able to celebrate it with news that MGH clinical social worker, Karon Konner, LICSW, was named social worker of the year by the National Association of Social Workers (NASW). The award honors NASW members who exemplify the best of the profession's values and achievements, demonstrate outstanding leadership, contribute to a positive image for social work, and take risks to achieve outstanding results. Recently, Konner sat down with colleagues, Marilyn Wise, LICSW, and Ellen Forman, LICSW, to reflect on her accomplishments, her practice, and the skill and compassion she and her colleagues exemplify every day at MGH.

Karon Konner, LICSW, MGH clinical social worker and NASW social worker of the year.

Question: What brought you to MGH?

Konner: I completed my second field placement here as a graduate student at Simmons School of Social Work, and I loved it. I liked the fast-paced environment, multi-disciplinary collaboration, and the philosophy of social work that was practiced here. In most hospital settings, the primary responsibility of social workers is discharge-planning. At MGH, we're fortunate to be able to use our clinical expertise to help patients and families better cope with illness and disability. And we offer interns a professional practice environment in which to learn. It's a vital contribution to the profession.

Question: Can you describe 'Team 5' and your pioneering role as social worker for that team?

Konner: It became clear that there was a population of patients who required a higher level of inter-disciplinary care and collaboration to fully meet their medical and psychosocial needs. These patients are more likely to have long hospitalizations due to the complexity of their conditions—it may be patients with mental illness and extensive medical needs, or isolated elders with dementia.

In 2006, I was asked to join the team in the early stages of its development. I felt these patients needed a dedicated team of providers to optimize their care, and I have great respect for the other team members.

Team 5 developed expertise working with this population, and it enabled staff to cultivate relationships with community providers. Many of these patients are socially isolated, but have many providers

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I'm very proud to be a member of the Social Service Department at MGH. The intra-departmental collegiality and inter-disciplinary collaboration allow us to have a good balance of autonomy and consultation. Our department prioritizes self-care and resilience, which helps us do our best work day after day.

involved in what is often fragmented care. The role of the social worker is to develop a cohesive picture of the patient's life so the team can develop effective treatment plans and ensure continuity of care.

Question: What do you do as Social Service's guardianship and conservatorship consultant?

Konner: As the consultant and as part of the guardianship team (along with colleagues from the Office of General Counsel and Psychiatry), I oversee all guardianships and monitor case progress. I educate social workers and colleagues from other disciplines about mental-capacity issues from both a clinical and legal perspective. Careful and thorough assessment is crucial in determining mental capacity and deciding on the best plan of care for patients.

Question: Tell us about your work with disaster mental-health efforts.

Konner: In 2005, social-work colleagues, Natascha Gundersen and Kristen Prendiville, and I had the opportunity to join the MGH team with Project HOPE to provide mental-health support to survivors of the tsunami in southeast Asia. The framework for mental-health services for the mission hadn't been established, so we had to be creative and respond to what we were seeing without speaking the native language. With our mental-health colleagues, we developed a three-pronged mission to provide support to staff, survivors aboard the ship, and land-based services. We set up a prayer room and an art-therapy room on the ship, where survivors of all ages could gather to draw and paint the horrors they'd experienced.

Through this experience I was asked to join a Disaster Medical Assistance Team (MA-1 DMAT), a part of the National Disaster Medical System as one of their first mental health specialists. I've been deployed in the aftermath of a number of disasters, including: Hurricane Katrina, in 2005; Hurricane Gustav in Baton Rouge, in 2008; Hurricane Ike in Galveston, Texas, in 2008; the Red River Floods in North Dakota, in 2009; and the Haiti earthquake, in 2010. As a mental-health specialist, team safety is always my first priority. In the field, usually an austere environment, team members have to take care of one another. Relationship-building, checking-in with one another, and debriefing after difficult days is a big part of the job. Responders are far from home and may be witnessing difficult scenes with limited resources. And re-entry can be a challenge. It takes time to re-adjust.

As with our hospital patient population, a lot of what we do is help survivors understand that what they're feeling is a normal response to an abnormal situation. Drawing on the tsunami art-therapy experience, and with the help of Kathy Clair-Hayes, LICSW (now with the HomeBase program), we created Mental Health Clinical Bags that we now take on every deployment. They contain comfort items such as small stuffed animals and expressive tools like journals that can help restore a sense of normalcy for disaster survivors.

Being able to help in times of disaster, like the work MGH social workers do every day, is a privilege. As social workers, we're well-prepared for this work. Meeting people 'where they are,' often at vulnerable times, to provide crisis intervention is what we do as clinicians every day. We use the same values and principles in a disaster. Social workers understand in a holistic way the interplay between people and their environment.

Question: Any additional thoughts?

Konner: I'm very proud to be a member of the Social Service Department at MGH. The intra-departmental collegiality and inter-disciplinary collaboration allow us to have a good balance of autonomy and consultation. Our department prioritizes self-care and resilience, which helps us do our best work day after day.

I want to mention the Clinical Recognition Program. I found it a valuable opportunity to reflect on my growth and development in a way we rarely do with the demands of our daily work. It reinforces that we are, 'constant learners.'

Overall, I feel challenged every day. Expectations are high, and we rise to meet them, providing the best possible care to patients and families. I look forward to investing my energy and using the experience I've gained to support staff and optimize our practice in my new position as a clinical director in Social Service with oversight of the medical and surgical services.

Congratulations to Konner on her personal and professional successes and for embodying the best of what social work has to offer.

For more information about the Social Service Department and the array of services they provide, call 6-2643.

Access is a privilege not a right

As employees, we may feel pressure to access their health information, or there may be expectations from others that we can because we're 'insiders.' Our first question should always be: "Am I authorized to access this record?"

When a family member, friend, or co-worker is admitted to the hospital, it can be an emotionally charged time. Our instinct is to try to help. As employees, we may feel pressure to access their health information, or there may be expectations from others that we can because we're 'insiders.' Our first question should always be: "Am I authorized to access this record?"

Recently, the Medical Policy Committee approved the *Accessing Protected Health Information by Workforce Members* policy that states: "If an adult MGH patient wants to authorize an MGH/MGPO employee or professional staff member to directly access his or her Electronic Health Record, the individual must submit a written request to Health Information Services using the Authorization to Access Electronic Health Record Form." The policy specifically requires written consent; verbal consent is not sufficient.

Patients may not understand that accessing their records electronically means their entire medical record or history can be viewed. This new policy was enacted to address that point.

Under the new policy, when an employee seeks electronic access to a medical record, staff in Health Information Services on Founders 8 will verify the employee's status, ensure collection of a valid signature, review the authorization in its entirety, send a copy of the form back to the patient, and issue approval for the request. If the patient wishes to restrict any part of his/her record, electronic access will *not* be granted, and a paper copy of the record will be provided.

Accessibility parameters are as follows:

- Parents or guardians may view their child's record if the child is under age 11
- Written authorization is required for patients 18 years old and older
- No electronic access is allowed for children age 11 through 17
- Must be an employee or part of the professional staff that already has access to the electronic health record to perform his/her job

MGH employees may *not* access the records of family members, co-workers, or friends whose care is outside of MGH, including other Partners' facilities.

The MGH Privacy Office uses a system called Monitoring Access Patterns (MAP) to identify potentially inappropriate access each day. An employee may receive an e-mail from the Privacy Office requesting clarification as to why he/she accessed a certain record. Staff of the Privacy Office verify that there is a work-related need or look for written authorization in the record, if applicable.

Alternatively, Patient Gateway may meet the needs of patients wanting someone to review their medical information. Patients can delegate individuals to access information electronically. As always, a patient's provider is the best resource for interpretation of medical information.

The entire *Accessing Protected Health Information by Workforce Members* policy can be found on-line in the Trove Library.

For more information, contact the MGH Privacy team at MGHPrivacyOffice@partners.org. To schedule a presentation of the access policy and guidelines on your unit, or to speak to a member of the Privacy Office, call 6-1098.

To submit an authorization form, contact Ellen Gonick at 6-2469.

Prayer trees

I wonder if Johnny Appleseed started this way

—by Kate Gerne, pediatric chaplain

In the Blake 10 Neonatal ICU, pediatric chaplain, Kate, Gerne (left), and members of the Carpi and Bohlin families add prayers to the tree in support of their 2-week-old daughter and grand-daughter, Lily.

When I became pediatric chaplain in September, 2012, I wanted to do something to distinguish pediatric units from other units in the hospital. As a chaplain, I'm all too familiar with, 'in the meantime.' That's what I call the periods of time when someone is anticipating the birth of a child, sitting in the Emergency Department waiting room, or waiting to hear a diagnosis. It can be a raw and vulnerable time. Pediatric waiting rooms are rife with 'in the meantime' moments, so I wanted to do something to make those times more bearable.

I remembered how popular the prayer tree was during Spiritual Care week. I thought prayer trees would be a great addition to waiting rooms—a non-intrusive way for people to convey prayers—writing them on ribbons and tying them to branches of the tree. And once the tree fills up, it's a beautiful, creative expression of love and hope. At the end of each week, prayers are collected and read at a service in the MGH Chapel.

With the approval of the nursing directors, I placed prayer trees in the staff lounge of the Ellison 17 Pediatric Unit and the waiting area of the Pediatric ICU. The trees filled up quickly, especially on weekends when families and friends visited.

Soon after that, Kathryn Beauchamp, RN, clinical nurse specialist in the PICU, brought the tree to a CNS meetings thinking it might be something other units would enjoy. Sure enough, Blake 12 clinical nurse specialist, Stephanie Ball, RN, reached out to her unit's chaplain, Rabbi Ben Lanckton, to see if a prayer tree could be made for their unit. And other units have created their own versions of prayer trees.

What I love about this idea, is that it's hopeful. It allows others to lift up their prayers and intentions in their own private and individual way; after all, prayer at its best can be a quiet, gentle activity that creates community.

For more information about the Prayer Tree Ministry, call Kate Gerne at (617) 724-3613.

Social work

it's more than coordinating resources, referrals, and financial support

In our current economy, financial and employment concerns can cause distress, even for those whom we typically think of as financially secure. Such was the case with 'Gail,' a newly diagnosed breast-cancer patient with whom I shared a short-term counseling relationship.

My name is Julie Berrett-Abebe, and I've worked at MGH as an oncology social worker for the past eight years. I've been fortunate to collaborate with skilled, compassionate colleagues from all disciplines who've shared much with me about exciting developments in the treatment of breast cancer. Many of these advances relate to personalized medicine and targeted therapies. Prognoses for women with both early-stage and metastatic breast cancer have improved as they've received treatments targeted specifically to 'their' cancers. However, the psychosocial impact of receiving longer-term treatment and living with a chronic illness is often profound. In our current economy, financial and employment concerns can cause distress, even for those whom we typically think of as financially secure. Such was the case with 'Gail,' a newly diagnosed breast-cancer patient with whom I shared a short-term counseling relationship.

Gail is a 39-year-old woman with no family history of breast cancer, diagnosed with a particularly invasive form of cancer. Immediately upon being diagnosed, she asked to speak with a social worker to address anxiety about her diagnosis, worries for the future, and concerns about employment. Gail lives with her husband and two young daughters in a Boston suburb. She is an executive at a local company and accounts for a large share of her family's income. Gail had met with therapists in the past to work through bereavement issues following significant losses.

Julie Berrett-Abebe, LICSW
clinical social worker

My initial meeting with Gail took place one week after she was diagnosed. Although still experiencing shock regarding the diagnosis, Gail decided she wanted to treat the cancer 'aggressively' and had made plans to have bilateral mastectomies and reconstructive surgery right away. She came to my office with a list of concerns.

"How do people cope with this?"

"How much information should I share with my children?"

"My father died unexpectedly last year; how do I talk to my mother and siblings about this without scaring them?"

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I normalized shock and anxiety related to her diagnosis and offered strategies on how to manage anxiety, such as distraction, diaphragmatic breathing, relaxation, and cognitive behavioral therapy (CBT). CBT is the evidence-based practice of consciously changing unhelpful thought patterns in order to change feelings and behaviors.

"I'm in a new position at work. I want to be forthcoming with them but also maintain my privacy. I don't want to be fired or have others think I can't do my job. How do I do that?"

In our first counseling session, I provided several interventions: I listened as Gail shared her story. I normalized shock and anxiety related to her diagnosis and offered strategies on how to manage anxiety, such as distraction, diaphragmatic breathing, relaxation, and cognitive behavioral therapy (CBT). CBT is the evidence-based practice of consciously changing unhelpful thought patterns in order to change feelings and behaviors. I find this type of therapy particularly helpful in addressing illness-related anxiety.

I provided education about sharing age-appropriate information with children. I informed them about programs such as the Family Medical Leave Act (FMLA) and short-term disability, and suggested consulting her Human Resources department at her company. I helped Gail consider who at work needed to know about her diagnosis and what decisions she needed to make right away. She wrote down a preliminary plan for managing work concerns as we spoke.

Gail called me later in the week for assistance with two communications she was preparing: one for sharing information about her diagnosis with her employer (stating her preference that the information not be shared with other employees); and one for sharing information with her family. Gail was very appreciative for my insights related to illness and employment, my communication skills, and my ability to help her process her own feelings and concerns.

Gail and I had a few other face-to-face meetings after her surgery. Her surgery was quite extensive and required a lengthy recovery period, after which she completed several rounds of chemotherapy. When her chemotherapy was over, I helped Gail craft a plan for her return to work, prioritizing good communication with her employer and emphasizing her own self-care. Gail worked from home for several weeks; when she did return to work full-time she said she felt 'ready.' Gail and I also addressed her anxiety about cancer recurrence (which was an impediment to her ability to focus on work and family responsibilities). We did some counseling work together, and I provided her with referrals for longer-term counseling in the community if she felt it was necessary.

Gail often expressed appreciation for my counseling, oncology experience, and knowledge of policy, saying they had made a difference in her ability to cope with her illness. It was gratifying to work with someone who was so motivated to participate in her own care and who made such good use of what I bring to the team as an oncology social worker.

My work with Gail caused me to think about our country's public policy related to work and disability. The US does not have (nor has it ever had) a *comprehensive* policy for paid time off during disability, child care, or illness. I'm inspired by Gail and countless other women like her to pursue this issue as it relates to cancer care. I plan to make it an area of research for my social-work doctoral studies. I've also begun to reflect on how social workers might be able to better articulate the support we provide to patients around cancer and employment. Often, people think of social workers as providing financial support and resources (and that's an important part of the role) but more broadly, we're experts at helping people manage relationships (and the workplace is no exception). This will become even more important as we see more and more people surviving cancer each year.

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

Like so many people who receive a cancer diagnosis, Gail's life was changed in an instant. And her diagnosis affected not only Gail, but her family, her company, and her colleagues. Julie's experience caring for patients and families in similar situations was a source of substantive guidance and information as well as comfort and solace. Her strategies for coping with anxiety, reigning in fear, and 'getting on with life' were key to Gail's ability move forward in a constructive way. Not only did Julie focus her expertise on Gail's needs, she saw this situation as part of a larger discourse on how our nation supports its citizens in times of illness and disability. What an excellent topic for a nursing research study.

Thank-you, Julie.

Oral History Project looks at early days of MGH nursing (part II)

—by Mary Larkin, RN, chair of the NAA's Oral History Project

In the last (March 7, 2013) issue of *Caring Headlines*, we learned about Marion Bates, RN, the oldest living active member of the MGH Nurses' Alumnae Association (NAA). What follows is the second half of Mary Larkin's interview with Bates as part of the Oral History Project.

When we left off, Bates had accepted a position as supervisor during the early years of World War II. Said Bates, "We were very short-staffed during the war years, so we did whatever had to be done; from admissions to sweeping the floors.

"The Cocoanut Grove fire occurred when I was a new supervisor. Most of the severely burned patients were brought to the White Building. Every corridor was like a morgue. I was on duty that night, I'll never forget it.

"In 1955, there was the polio epidemic. When you stepped onto White 9, all you could hear was the hissing of iron lungs lined up in a big room side-by-side. Patients' beds rolled right into the iron lung; with a few openings where you could provide care. Some patients could stay off the lung for a few minutes; others couldn't stay off at all due to their respiratory status.

"The Cocoanut Grove fire and polio epidemic were really quite overwhelming.

"Ms. Ruth Sleeper, director of Nursing, asked if I'd take on the supervision of Shepard Gill LPN students and students from the Trade High School for Girls. When the hospital purchased the MGH Shepard Gill School of Practical Nursing, I became assistant director, which is where I spent the remainder of my career."

"The Cocoanut Grove fire occurred when I was a new supervisor. Most of the severely burned patients were brought to the White Building. Every corridor was like a morgue. I was on duty that night, I'll never forget it."

When asked how the MGH School of Nursing shaped her character, Bates replied, "It made you able to take responsibility. And it rubbed off on everything you did, like your family, you took charge. There was something about MGH that made you capable. I remember being on rotation at Boston Lying-In Hospital, and there was a very sick patient in an oxygen tent that wasn't working correctly. The resident had come from MGH, found the oxygen tent not working, and yelled, 'Is there an MGH nurse around?' It really made you proud.

"We worked hard for that reputation. Of about ninety students who entered the MGH School of Nursing, only about fifty graduated. Either they left on their own or the rigor of the training was too intense. Ms. McCrae would come up to the floors and inspect us. Our long cuffs weren't supposed to come off (and it was very awkward to give baths and provide treatment with those cuffs). We wore long sleeves most of the time, short sleeves in summer. A sign would be posted outside the classroom telling us when to wear short or long sleeves and what floor we should report to each day."

Bates recounted an interesting story about nursing practice in the 30s. A patient had developed a GI fistula, and the draining bile was causing his skin to break down. Said Bates, "A doctor suggested putting a piece of meat at the end of the tube to protect his skin. I went to the kitchen and got a piece of steak, cut it to fit over the end of the tube, and all of a sudden the drainage increased dramatically, it actually stimulated the flow of bile making it worse. The patient's body was secreting more bile because it sensed that the meat needed to be digested. I'll never forget that!"

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"The med closet was organized by number. Numbers 48 and 52 were for urinary tract infection. Number 22 was cough syrup with codeine; 26 was without codeine. Medications were ordered by number.

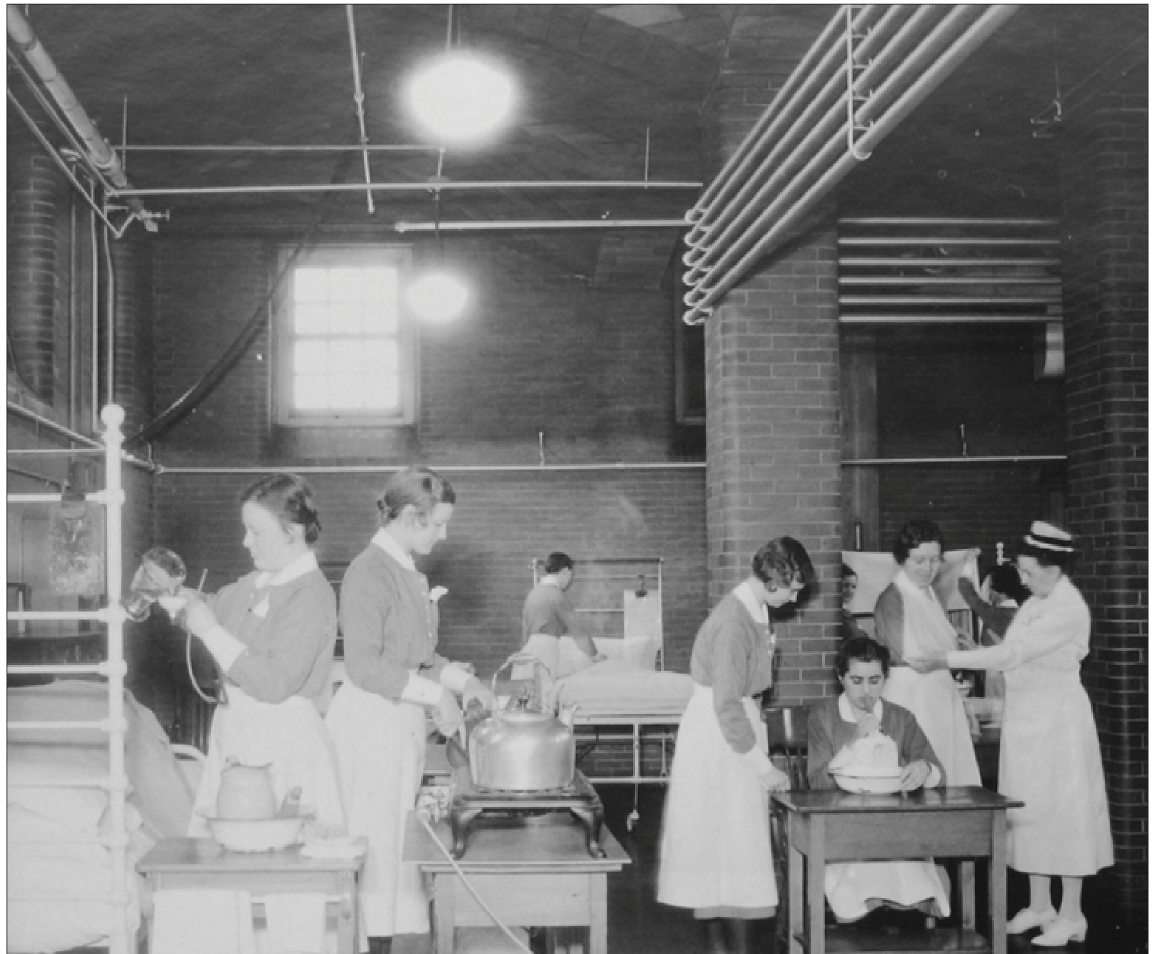
One of the most common procedures used to treat infections before antibiotics was a flaxseed poultice. Bates recalled the process: "Cook flaxseed meal, boil water, add meal till thick, spread on thin paper, cover with gauze, wrap in towel, put on the patient and lift up edges to prevent burn or blister. We did that every two hours to draw out infection. Then we started to see sulfa drugs, then of course penicillin, which resulted in a big change in practice.

"The med closet was organized by number. Numbers 48 and 52 were for urinary tract infection. Number 22 was cough syrup with codeine; 26 was without codeine. Medications were ordered by number. We had an alcohol lamp, a tablespoon, and a 'boat' with syringes. Using transfer forceps, you picked up the pieces soaking in disinfecting solution, put them together, boiled water in the spoon, took up some water, a quarter or sixth grain of medicine, put the water in and dissolved it, then drew it back up.

"The work required great physical strength. We didn't have crank beds; we manually lifted them. If beds had to go on shock blocks, we lifted them off the floor and put blocks underneath. We always tried to get an orderly to help when we had to lift a bed with someone in it."

As the interview drew to a close, Bates reflected, "Once in a while, I remember things so clearly, like it was yesterday." She recalled that across from the Walcott House was a city morgue and a stable for horse-dawn ambulances. They weren't being used anymore, but they were still stored there. She remembered 'Mini's' (Minicello's) market on the corner of North Grove and Cambridge Streets, where she went for her favorite—a western sandwich.

Bates now lives with one sister, who's in her early 90s, and talks on the phone frequently with another sister, who's 105 and also a nurse. She eagerly absorbs news of MGH and its many alumnae.



In the Thayer classroom, circa 1930s, Miss McRae teaches oil-retention enemas, inhalations, and proper use of ether beds.

Changes to the advanced-clinician and clinical-scholar portfolios

For many, the interview is a source of anxiety. The best way to reduce anxiety is to practice. Ask a colleague from another discipline who's familiar with the CRP criteria to participate in a mock interview with you.

Question: I've heard there have been changes in the Clinical Recognition Program for advanced clinicians and clinical scholars?

Jeanette: Yes. Recently the decision was made that nurses in grade 55 (in such roles as attending nurse and resource nurse) are eligible to seek recognition as advanced clinicians and clinical scholars.

Based on feedback from staff, there have also been changes in the documents required for portfolios. Portfolios for advanced clinicians and clinical scholars are now the same; they require:

- cover letter
- narrative
- resume
- signed endorsement form from the applicant's director
- letter of support from the applicant's department or unit leadership
- letter of support from within the applicant's discipline
- letter of support from outside the discipline or from a nurse practitioner, certified nurse atesthetist, or certified nurse midwife.

Question: Why was the decision made to have a letter from unit leadership?

Jeanette: The intent is to have someone involved with the development of your practice provide a letter of recommendation. These individuals are in a position to speak knowledgeably about your practice.

Question: Is help available as I prepare to submit my portfolio?

Jeanette: Many resources are available to you. The Clinical Recognition Program website has excellent information and resources (http://www.mghpcs.org/IPC/Programs/Recognition/Index.asp). Unit leadership is an excellent resource as you develop your portfolio and prepare for the interview. And many clinicians who've already been recognized have given permission for their portfolios to be reviewed by future applicants.

Applicants may also submit portfolios for a 'pre-review' prior to submitting it to the Review Board. Former Review Board members provide a blind review, assessing portfolios for completeness. If you'd like to obtain a sample portfolio or submit your portfolio for pre-review, e-mail MGH PCS Clin Rec.

Question: Do you have any suggestions to help ensure successful application?

Jeanette: For many, the interview is a source of anxiety. The best way to reduce anxiety is to practice. A mock interview can be very helpful. Ask a colleague from another discipline who's familiar with the CRP criteria to participate in a mock interview with you. This is helpful because someone unfamiliar with your practice will ask questions similar to those asked by Review Board members, such as: What were you thinking in a particular situation? What was your decision-making process? How do you influence practice on your unit?

For more information about any aspect of the Clinical Recognition Program, call 4-5801.

Large-volume infusion-pump conversion

> The new pumps are the same model as what we used before, but work only with Baxter-manufactured primary tubing sets. They come with new software, advanced safety features, and a new drug library.

Question: I know we're in the process of changing infusion pumps. What's the scope of the conversion?

Jeanette: The conversion affects all areas using Sigma Spectrum large-volume infusion pumps and areas that use the same primary tubing, even if the tubing is used for gravity infusions only.

Hospira-tubing calibrated Sigma Spectrum pumps will be replaced by Baxter-tubing calibrated Sigma Spectrum infusion pumps. The new pumps are the same model as what we used before, but work only with Baxter-manufactured primary tubing sets. They come with new software, advanced safety features, and a new drug library.

Areas that don't use the pumps, but use the same tubing as the pumps, will also be converted to Baxter sets. Hospira tubing sets not used in the pump will not be affected.

Question: Will there be training on utilization of the new pumps and software?

Jeanette: Professional development specialist, Sheila Burke, RN, is coordinating the training, which includes:

- a HealthStream module highlighting changes to pump software and safety enhancements as well as an introduction to secondary infusions. This is a required HealthStream course
- super-user training (two-hour sessions throughout the month of March)
- end-user training (one-hour sessions, through March 24th in set rooms, daily from 7:30am–5:00pm. And Baxter educators are visiting units at night from 8:00pm–6:00am. Training in ambulatory settings is on-going
- a special Baxter HealthStream module covering all functionality issues is also available for users who wish to refresh their skills. This course is optional

Question: When will we go live with the new pumps?

Jeanette: Conversion of the pump and tubing is taking place simultaneously. The go-live date is Monday, March 25th.

Units closed on Sunday, the 24th (the day before), will be converted another time, and on-site support will be available; leadership of those units will be contacted to schedule a date.

Off-campus units will be converted later in the week; leadership of those areas will be contacted to schedule a date.

MGH is working with Baxter to limit conversion time to minimize the overlap of old and new pumps.

Question: Do you anticipate a smooth conversion?

Jeanette: Absolutely. A point person has been assigned on each unit, whose responsibility it is to:

- communicate with the conversion team ahead of time and keep staff informed to ensure everything and everyone is ready
- meet the conversion team when they arrive on the unit and help them navigate during conversion
- assist in locating old tubing for swap-out

While demand for pumps remains high, everyone can help by returning unused pumps to the soiled rooms.

Question: Whom should we call for more information?

Jeanette: Contact Sheila Burke (6-1651) for questions about training. Contact Caitlin Fairneny (4-6939) for general questions.

Collaborating in a crisis

MGH welcomes US Army Lieutenant General P. K. Keen

—submitted by the MGH Center for Global Health

Founded in 2008, the MGH Center for Global Health was created to support the entrepreneurship of MGH clinicians, students, and administrators in their desire to help vulnerable populations around the world. By leveraging the considerable knowledge, experience, and resources of the MGH community, the Center for Global Health helps create systemic change in marginalized populations facing serious health-related challenges.

After the devastating earthquake in Haiti in 2010, MGH mobilized teams of first responders to care for the injured and establish collaborative partnerships to help improve public health going forward. The US military played a vital role in the initial response, as well, deploying the *USNS Comfort* and thousands of troops to aid the people of Haiti.

On February 25, 2013, as part of the Development and Defense: the Role of the US Military in Global Health seminar, the MGH Center for Global Health welcomed US Army Lieutenant General P. K. Keen to discuss his command of efforts in Haiti. Keen outlined the military's initial priorities, which included opening the country's critical points of entry.

Said Keen, "We recognized that the lifelines for assistance were the airport and seaport, both of which were damaged, but not to the extent that we couldn't repair them. We flew in special ops teams, and within twenty-six hours, they had set up a card table near the runway. They operated off that card table for three weeks."

Keen said the use of military training and expertise was key in supporting relief efforts. "The mission was simple. We were there to save lives and mitigate the suffering of the Haitian people. My experience there showed me that the muscle of humanitarian assistance and disaster relief are NGOs [non-governmental organizations]. The only way we could help was with unity of effort."

(Photo by Joseph Ferraro)

(L-r): Ross Boyce, MD; Margaret Bourdeaux, MD; Hilarie Cranmer, MD; US Army Lieutenant General P.K. Keen; and David Bangsberg, MD.

Joining Keen for the presentation and panel discussion were moderator, David Bangsberg, MD, director of the MGH Center for Global Health; Hilarie Cranmer, MD, director of the center's disaster response; Ross Boyce, MD, medical resident and former Army captain; and Margaret Bourdeaux, MD, from BWH. Actor, Sean Penn, founder of the J/P Haitian Relief Organization and long-time humanitarian advocate, was also in attendance.

Said Bangsberg, "As our disaster-response mission continues to grow, partnerships with the US military will be invaluable in supporting clinicians as they deliver care under extremely difficult circumstances."

For more information about the MGH Center for Global Health, call 617-643-4294.

Announcements

Blum Center Events

Shared Decision Making:
Colon Cancer Screening
Thursday, March 21st
12:00–1:00pm
speaker: Daniel Chung, MD

Harp Music
Wednesday, March 27th
12:00–12:35, 12:40–1:00pm
Harpist: Becky Wertz

Programs are free and open to MGH staff and patients.
No registration required.
All sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

Holy Week 2013 Passover 5773

Services held in the MGH Chapel.
Call 6-2220 for specific times.

Shabbat HaGadol; pre-Passover preparation

Palm Sunday Roman Catholic Mass

Eve of Passover Prayer Service

Ecumenical prayer service for Holy (Maundy)

Passover; Shabbat service

Good Friday service

Ecumenical Easter service with Holy Communion (Protestant)

Roman Catholic Easter service with Holy Communion

Passover begins Monday night, March 25, 2013, and goes through April 1st or 2nd (depending on your custom).
For more information, call Rabbi Ben Lanckton at 4-3228.

Save the Date

Connell Visiting Scholar

Angela Barron McBride, RN, international nurse leader and Connell visiting scholar is coming to MGH to work with staff, leaders, and Connell scholars to advance the nursing research agenda.

McBride will present, "Orchestrating a Career for Nursing Leadership," to the MGH community.

April 5, 2013
9:30am
O'Keeffe Auditorium

Internationally renown for her scholarship on leadership-development and career-planning, McBride is currently chair of a Nursing Advisory Board for the Robert Wood Johnson Foundation.

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'Keeffe Auditorium

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

Re-certification (one-day class):
March 28th
5:30–10:30pm
Founders 130 Conference Room

For information, contact Jeff Chambers at 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.

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.

Senior HealthWISE events

All events are free for seniors 60 and older

Hypertension Screenings:
Monday, March 25th
1:30–2:30pm
West End Library
151 Cambridge St.
Free blood pressure checks with wellness nurse, Diane Connor, RN.

Special Presentation from the Museum of Fine Arts
Guest educator, Nicole M. Claris, will explore the Impressionist period in France, Northern Europe, and the US.
Thursday, March 28th
10:00–11:00am
Haber Conference Room

Special Event

Boston Conservatory Cabaret will perform songs from favorite Broadway musicals
Monday, April 8th
2:30–3:30pm
Thier Conference Room

(RSVP is required
call: 617-724-6756)

For more information, call 4-6756.

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For more information, call: 617-724-1746

Next Publication
April 4, 2013

Jeanette Ives Erickson (continued from page 3)

of our hospital, is because of you—your commitment, your enthusiasm, your leadership, and your ability to think *way* outside the box. Thank-you for your exceptional practice.

I'd like to single out a few people for the special roles they played in preparing for this Magnet site visit. First and foremost, Marianne Ditomassi, RN, our executive director for PCS Operations, who coordinated our evidence-collection and provided oversight for the Magnet Core and Education teams. Those of you who know Marianne know she never does anything half-way, and I think she raised the bar to a whole new level this time around.

I'd like to thank associate chief nurses, Dawn Tenney, RN; Theresa Gallivan, RN; Debra Burke, RN, and Kevin Whitney, RN, for their exemplary support and oversight of nursing practice in their respective areas of responsibility.

And the individuals who worked so diligently to capture our practice and ensure it was well represented to the ANCC, the members of the Magnet Core and Education teams:

- Paul Arnstein, RN
- Linda Akuamoah-Boateng, PT
- Gaurdia Banister, RN
- Jess Beaham*
- Carol Camooso Markus, RN
- Judith Carr, RN
- Gino Chisari, RN
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- Claire O'Brien, RN
- Alice Peck, RN
- Georgia Peirce
- Lori Pugsley, RN
- Cheryl Ryan, RN
- Patricia Shanteler, RN*
- Mary Ellin Smith, RN*
- Colleen Snydeman, RN
- Tara Tehan, RN
- Mary Ann Walsh, RN
- Kevin Whitney, RN
- Clayton Wiggins (student)
- Christopher Wilterdink

**asterisk indicates evidence writers and production team members*

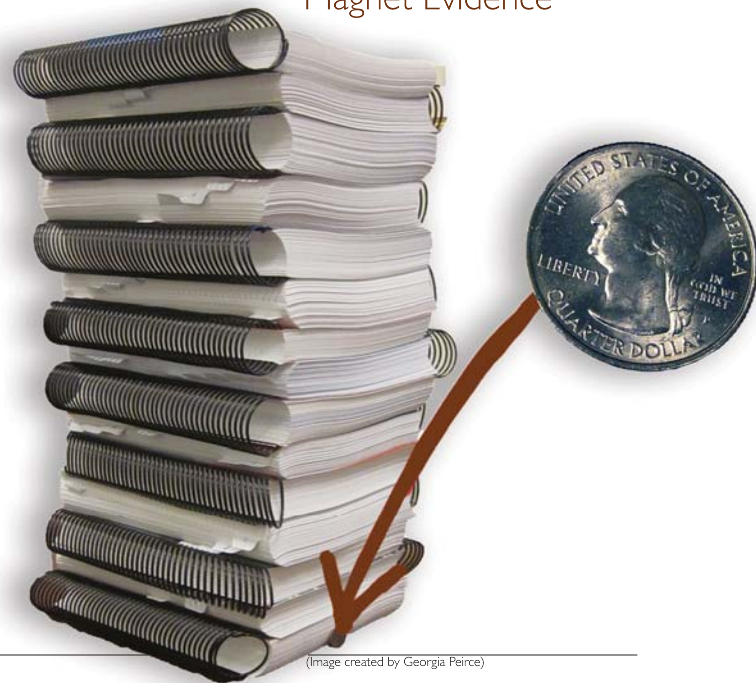
Thank-you to our team of Magnet nurse guides, Christine McCarthy, RN; Heidi Nichols-Baldacci, RN; Claire Mary Paras, RN; and Claire Seguin, RN, who accompanied appraisers from location to location. Not only did they escort our visitors, they were able to speak knowledgeably about our practice and culture in those 'down times' between interviews.

In closing, I'd like to leave you with one last quote from a colleague at the North Shore Cancer Center, who wrote: "When we get that letter letting us know we were re-designated, I think Aerosmith, Tricorne hats, and muskets shooting confetti will be in order for the next Magnet conference."

And while I share his optimism, we do have to wait for official notification from the ANCC.

I'll keep you posted!

Magnet Evidence



(Image created by Georgia Peirce)

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