

# Caring

Headlines

July 17, 2014

## New nurse staffing legislation

*protecting  
our most  
vulnerable  
patients*



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

Staff nurse, Stefanie Navarro, RN, with patient,  
Bridget McGuire, in the Medical ICU

The newsletter for **Patient Care Services**  
Massachusetts General Hospital

# New nurse staffing legislation a fair compromise

*patient-safety is  
preserved*

Many of us have been very vocal in our advocacy for patient safety and our insistence that nurses have a say in determining the staffing needs of patients and families, versus implementing broad, one-size-fits-all staffing requirements for all nurses.

**W**e've all been following the debate over nurse staffing guidelines that's been playing out in the news and in the Massachusetts State House for the past several months (15 years, if you go back to when it first started). Many of us have been very vocal in our advocacy for patient safety and our insistence that nurses have a say in determining the staffing needs of patients and families, versus implementing broad, one-size-fits-all staffing requirements for all nurses.

We lobbied that nurses spend the most time with patients; nurses know the intricacies and complexities of their patients' needs; nurses need to drive the decision-making around nurse staffing to ensure optimal safety.

We pushed to have patient acuity factored into staffing decisions, knowing that the severity of illness and injury can greatly impact the level of care required, and that these factors can vary from moment to moment, day to day, and setting to setting.

We spoke of the importance of evidence-based practice and monitoring quality indicators to ensure the staffing decisions and safety precautions we're taking are validated by the outcomes we're achieving.



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

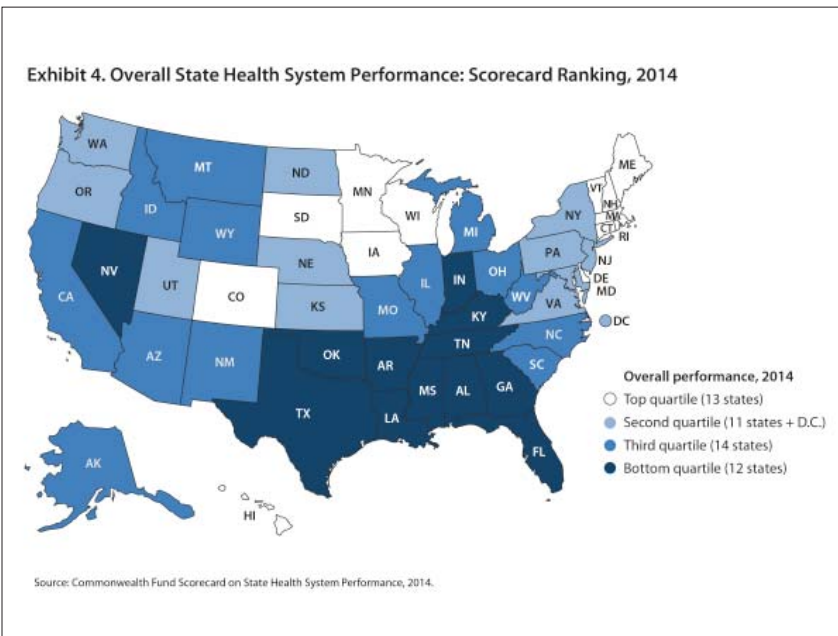
In late June, both chambers of the Massachusetts legislature unanimously approved, and on Monday, June 30, 2014, Governor Patrick signed into law, House Bill 4228: An Act for Patient Limits in All Hospital Intensive Care Units, establishing nurse staffing levels for intensive care units (ICUs) in hospitals throughout the state. The bill calls for a one- or two-patient-per-nurse ratio in ICUs depending on the stability of the patient "as assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager's designee when needed..." According to the text of the bill, the acuity tool, "shall be developed or chosen by each hospital in consultation with the staff nurses and other appropriate medical staff and shall be certified by the department of public health."

MGH has used the Quadramed acuity tool since 1985; it allows us to quantify patients' needs for nursing care. Every five-to-seven years, MGH (along

*continued on next page*

This year, the Commonwealth Fund reviewed 42 aspects of states' healthcare performance and ranked Massachusetts 2nd overall and best in the nation for access and affordability, prevention and treatment, and equity.

with other hospitals that use Quadramed) participates in a re-validation of the tool to ensure it remains relevant and reliable. Most recently, MGH participated in the validation process in 2008 prior to implementing the AcuityPlus software. We conduct an on-going evaluation of the tool to continuously incorporate and reflect changes in patient populations. And MGH nurses are integrally involved in the development and testing of this important tool.



The new bill calls for public reporting of staffing compliance and the identification of three-to-five patient-safety quality indicators to be measured and reported to the public. MGH and all hospitals in Massachusetts report nurse staffing on the publicly available website, *Patient Care Link*. The site provides information about each hospital's staffing and other key nurse-sensitive indicators. See graphs on the following page for examples of some of the quality indicators we monitor and report in public forums.

In a letter to her constituents, Tara Tehan, RN, Lunder 6 nursing director and president of the Massachusetts chapter of the American Nurses Association, wrote:

“Massachusetts patients win! Bill H4228... calls for the establishment of a statewide limit on the number of patients that can be assigned to registered nurses in intensive care units... We see the wisdom behind setting a staffing standard for hospital ICUs and we applaud the inclusion of an ‘acuity tool’ to assess patient stability. In our testimony on nurse staffing legislation in March, we recommended that the bill be amended to include a, “valid and reliable” acuity system and that input from registered nurses be part of the staffing assessment process.”

This was never a political issue for MGH nurses. It was always about ensuring the best possible care

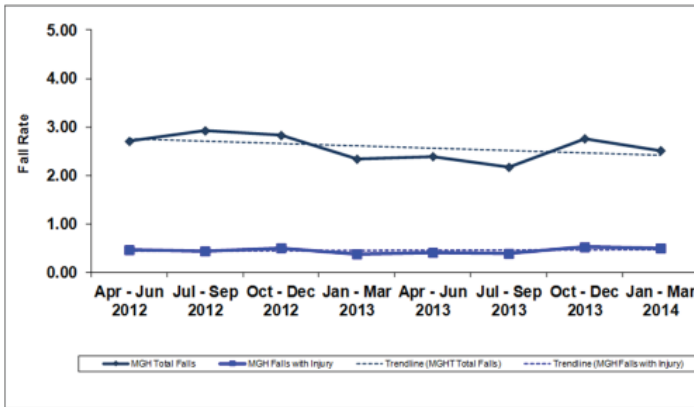
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With no government intervention, Massachusetts significantly improved patient outcomes, as the graphic above clearly demonstrates.

## In this Issue

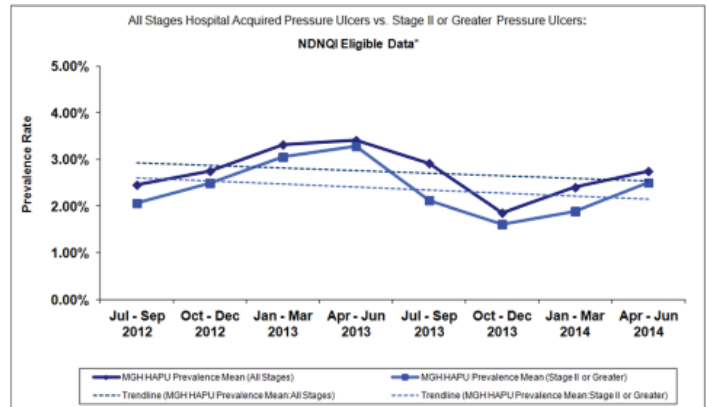
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Falls vs. falls with injury  
(per 1,000 patient days)



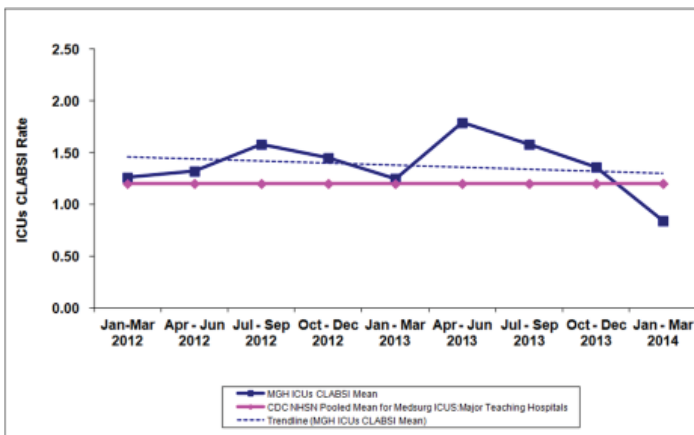
MGH falls and falls with injury continue to be favorable as compared to the NDNQI benchmark.

Hospital-acquired pressure ulcers (HAPUs)  
(all stages vs. stage II or greater; percentage of patients with HAPUs)



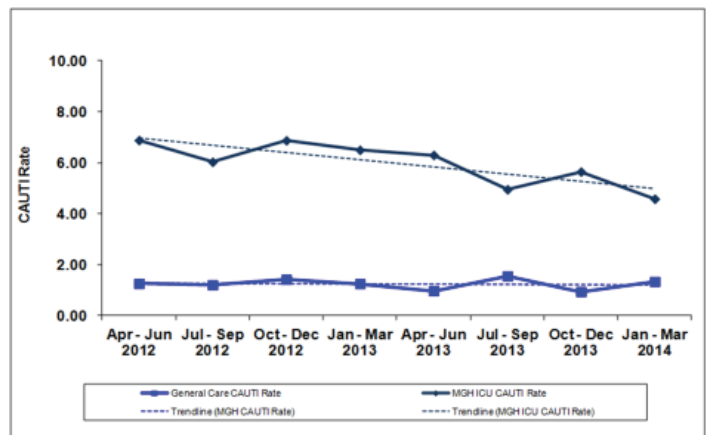
MGH pressure ulcers: All stages and Stage II or greater are favorable as compared to the NDNQI benchmark.

Central-line-associated bloodstream infections in ICUs  
(per 1,000 line days)



MGH ICU CLABSI rates have been trending down over the past three quarters. Quarter 1 of 2014 was favorable as compared to the CDC NHSN benchmark.

Catheter Associated Urinary Tract Infections (CAUTIs)  
MGH ICUs vs. general care rate  
(per 1,000 catheter days)



MGH ICU CAUTI rates continue to trend downward toward the CDC NHSN benchmark. MGH general care units overall are favorable as compared to the CDC NHSN benchmark.

for the patients we serve, especially the most vulnerable. Our ICUs are regularly occupied by patients of a higher acuity level than most other hospitals of similar benchmarking criteria. These patients need and deserve a higher level of nursing and intra-professional care. Thanks to this new legislation, decision-making in these areas will remain where it belongs—with staff nurses. This has been our goal from the outset. Also as a result of this legislation, there is no longer a need for a November nurse-staffing ballot referendum.

We are fortunate that our legislators heeded our counsel and acted in the best interest of patients and families. But if history is any indication, this will not be the last we hear of fixed nurse staffing ratios. We must remain vigilant and continue to work to preserve patient safety by empowering nurses at the bedside. Nurses are the best judge of nurse staffing needs. We will continue to advocate for patients at the bedside, in the boardroom, at the State House, and anywhere else we perceive a threat to patient safety.



# Carol A. Ghiloni Oncology Nursing Fellowship

*providing educational opportunities  
for future oncology nurses*

—by Mandi Coakley, RN, staff specialist

The Carol A. Ghiloni Oncology Nursing Fellowship has provided educational opportunities for student nurses for 14 years. Ghiloni fellows spend 10 weeks in the Oncology Nursing Service at MGH observing and learning about the varied roles nurses play in the oncology setting and career opportunities available upon graduation. The fellowship was developed in 2001 as a means of educating student nurses with the hope of recruiting them into oncology nursing positions when they graduate. This year, due to additional funding from the Susan D. Flynn Nursing Training and Development Fund, the fellowship expanded to include four student nurses.

This year's fellows, Meaghan Finn, from the William F. Connell School of Nursing at Boston

College; Bintou Marong, from the University of Rhode Island; Caitlin Brown, from the Nell Hodgson Woodruff School of Nursing at Emory University; and Stephanie O'Neil from the University of Rhode Island, spent time on Lunder 9 and 10, Phillips House 21, Radiation Oncology, the Infusion Unit, and the outpatient oncology centers in Yawkey. They attended Schwartz Center Rounds, HOPES programs, spent time in the Blood Transfusion Service, Interventional Radiology, and took advantage of other learning opportunities within the Cancer Center.

The Carol A. Ghiloni Oncology Fellowship receives funding from the Hahnemann Hospital Foundation and the Susan D. Flynn Nursing Training and Development Fund. For more information, call Mandi Coakley, RN, staff specialist, at 617-726-5334.

Below, l-r are: Bintou Marong and Stephanie O'Neil; Meaghan Finn and Caitlin Brown; and (l-r): Mandi Coakley, RN; Caitlin Brown; Stephanie O'Neil; Meaghan Finn; Bintou Marong; and Carol Ghiloni, RN.



# Bellack is 2014 Linda Kelly visiting scholar

—by Jane Keefe, RN, program development manager

The 5th annual Linda Kelly Visiting Scholar Program, named in honor of Linda Kelly, RN, nursing director for Ambulatory Gynecology in the Vincent OB/GYN Department whose collaborative leadership has spurred many patient-safety and patient-satisfaction improvements over the years, was held, May 15, 2014.

Jan Bellack, RN, president of the MGH Institute of Health Professions was named this year's Linda Kelly visiting scholar. Bellack is internationally recognized for her work in curriculum-development, health-professions leadership and workforce development, and inter-professional education.

Below are (l-r): Linda Kelly, RN, nursing director; Deborah Kelly, benefactor; visiting scholar, Jan Bellack, RN; and Isaac Schiff, MD, chief of Obstetrics and Gynecology.



(Photos by Michelle Rose)

Bellack's work to strengthen education in the health professions and increase focus on workforce-development could not be more timely. Her work is closely aligned with efforts at MGH to advance inter-disciplinary collaboration and community-based learning.

Bellack's visit kicked off with Obstetrics-Gynecology grand rounds, where she presented, "Preparing the Next Generation of Health Professionals for Inter-Professional Practice." Bellack spoke about the urgent need for inter-professional practice, the current practice-education disconnect, and the need to engage faculty and students in practice re-design while engaging practitioners and practice leaders in education re-design.

Bellack visited two inpatient units to engage front-line staff in dialogue about their experience with inter-professional education and practice in clinical areas.

On Phillips 21, nursing director, Adele Keeley, RN, clinical nurse specialist, Julie Cronin, RN, and staff discussed the importance of cultivating cultural competence in nursing schools in order to meet the needs of an increasingly diverse patient population. Discussion touched on challenges presented by disparate systems in Nursing and Medicine, scheduling issues, and time constraints due to increased patient volume. Staff stressed that nurses spend more time with patients so are better positioned to build meaningful relationships and understand their needs and concerns.

On the Ellison 8 Cardiac Unit, staff shared some of the challenges and advantages of practicing on the Inter-Professional Dedicated Education Unit (IPDEU), a model launched in 2011 that pairs stu-

*continued on next page*

## Visiting Scholar (continued)

dents from the IHP's Nursing, Physical Therapy, and Speech-Language Pathology programs. Students work in teams for their clinical rotations supervised by staff on the unit and under the direction of IHP faculty. Staff noted that IPDEU students have a better understanding of each discipline's responsibilities and their impact on the patient experience. The model offers bi-directional learning as instructors also gain greater insight into other disciplines as they work with students pursuing different professions from their own.

During an inter-disciplinary luncheon, Julie Cronin presented the work being done on Phillips 21 around Care Innovations and Transformation (CIT), focusing on communication and collaboration, patient- and staff-satisfaction, efficiency and equitable care, and developing future leaders in the process. Michele O'Hara, RN, nursing director for Labor & Delivery, shared her unit's Baby-Friendly Health Initiative (BFHI), an international program that recognizes facilities that provide optimal care in infant feeding and mother-baby bonding. Nursing director, Hiyam Nadel, shared Ambulatory Obstetrics' multi-disciplinary approach to post-partum depression screening and intervention using the Edinburgh Depression Scale. Since 1994, Vincent OB/GYN has delivered more than 61,000 babies, roughly the equivalent of the population of Waltham.

The day culminated with Bellack's presentation, "Innovations in Inter-Professional Care: Nurses Leading the Future," which highlighted the need for

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"The coordinated efforts of a range of health disciplines will be needed to achieve the goals of improving access, quality, and cost-effectiveness of health care, reducing the social and economic burden of illness, and ensuring optimal health of the public which is served by the inter-disciplinary healthcare team."

—Greenberg & Bellack, 1999,  
*Catalysts in Interdisciplinary Education:  
Innovation by Academic Health Center*

inter-professional education to prepare clinicians to practice more collaboratively. Bellack spoke of nurses' obligation to help students cultivate skills to practice collaboratively, thereby laying the foundation for inter-professional practice as healthcare continues to evolve.

This year's program not only provided a wonderful opportunity to dialogue with an internationally recognized nurse leader, it was a reminder of how important inter-professional practice will be as we work to make care more efficient, more effective, and more affordable.

The Linda Kelly Visiting Scholar Program is made possible through the generosity of Deborah M. Kelly, who has enjoyed a long-standing relationship with Isaac Schiff, MD, and Linda Kelly. For more information, contact Jane Keefe, program development manager, at 617-724-0340.



Top: at inter-disciplinary luncheon are (l-r) Fredric Frigoletto, MD; Linda Kelly, RN; and Debra Burke, RN; Bottom left: Vincent OB presents Bellack, with two books about MGH by William R. Baker, Jr; Bottom right: on Phillips 21, (l-r): Northeastern nursing student Ali Delrosso; Bellack; Adele Keeley, RN; and Linda Kelly, RN.



# Insight, observation, and specialized knowledge contribute to pediatric OT success

'Harry' is a 3-year-old boy who was referred to Occupational Therapy following a neuro-psychological evaluation that showed some potential sensory-processing issues.

**M**y name is Sharon Serinsky, and I am an occupational therapist. 'Harry' is a 3-year-old boy who was referred to Occupational Therapy following a neuro-psychological evaluation that showed some potential sensory-processing issues. The day before Harry's visit, I called his mother to learn more about him. She reported that he had difficulty self-regulating and had a low tolerance for change. I reviewed his medical record and found that Harry had recently been diagnosed with autism spectrum disorder and speech-language delays.

On the day of his visit I greeted Harry and his parents and escorted them to the treatment room. My goal for evaluation was to help Harry become comfortable in the testing area. As he wandered around the room looking at the toys, his parents told me he enjoyed physical play with his father but had difficulty interacting with unfamiliar people.

I explained that pediatric occupational therapy often looks like 'play.' This is an important concept to understand because play is the occupation of children. Most everyone becomes motivated to try new activities when they're perceived as fun.

Harry wasn't interested in playing with toys, and he didn't easily make eye contact. As we progressed through the evaluation, Harry insisted on not sitting at the table and climbed onto his father's lap. Though Harry had been referred for suspected sensory-processing issues, he was exhibiting other challenging behaviors, such as limited attention span,



Sharon Serinsky, OTR/L,  
occupational therapist

avoidance of tasks, frequent whining vocalizations, and limited social interaction. These behaviors can have a significant impact on the development of social, educational, and self-care skills. My objective was to determine which sensory issues were contributing to Harry's developmental delays and gain information about his responses to sensory input, his strength and weaknesses, and his interactions with his parents.

'Top-down, bottom-up inhibition' is a well-accepted sensory-integration theory. It purports that the top part of the brain is used for cognitive thinking functions while the bottom and back of the brain are responsible for regulating arousal levels through muscle and joint stimulation. I surmised that engaging Harry in an activity that provided 'bottom-up inhibition' would move him into a more optimal state of self-regulation and provide calming sensory input.

As Harry continued to cling to his father, I introduced some soft theraputty, similar to Play Doh, or

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Harry became more joyful during treatment. His eye contact increased, and he was more easily engaged to work on fine-motor tasks like stringing beads and learning to cut with scissors. One of the goals of sensory-integration treatment is to provide the child with just the right amount of challenge to enable him to develop skills and self confidence.

children's clay. Most 3-year-olds are familiar with it and enjoy manipulating it. Harry used only his finger tips, not his whole hand, to mold the putty, which suggested an over-sensitivity to touch input.

Next, I introduced a plastic accordion tube that provided a type of tactile or sensory input known as tactile or proprioceptive input. When manipulated, the toy provides resistance to movement and sensory input to the muscles and joints. This provides information about body-awareness and the ability to detect speed, force, and direction of movement. Harry required hand-over-hand assistance to manipulate the tube, which he tolerated well, his vocalization decreased, and his whole body calmed. Most 3-year-olds have enough hand strength to push and pull the accordion tube independently. Harry didn't.

I introduced a medium-sized therapy ball as Harry's father had reported that he enjoyed active play. Harry allowed me to place him on the ball and bounce him up and down gently. He allowed me to move him side-to-side and back-and-forth. Again, the activity calmed him and led to a decrease in his vocalizations.

As I introduced other activities, I continued to gather information about Harry and his sensory processing. He tolerated slow, linear movements when suspended on a piece of equipment but became upset if his feet didn't touch the mat. He resisted changes in body and head position. These responses indicated gravitational insecurity, another sign of difficulty with sensory processing of movement and sensory integration.

Though I was unable to complete an extensive evaluation, I was able to identify Harry's strengths and weaknesses and develop an initial course of treatment. One of my goals was to assist Harry's parents to understand and observe his sensory-motor needs as a first step toward sensory integration treatment. Harry's parents were able to implement simple sensory activities at home that helped prepare and familiarize Harry with activities we'd be doing in treatment.

Going forward, I changed the way I prepared the environment and myself for Harry's visits. I reduced visual distractions and prepared materials to minimize disruptions in the flow of treatment. I soon realized that planning fewer activities was better suited to Harry's ability to process sensory input. I applied this same principle to the way I interacted with Harry. I increased the time it took to go from the waiting area to the treatment room, spending more time talking with his parents in order to reassure Harry. I began using the same activity at the beginning of every session,

which enabled Harry to transition more easily. As I approached treatment at a slower pace, my own interactions slowed down, as well.

By the fourth session, Harry was becoming more comfortable and began to participate more actively in treatment sessions. While he continued to jump in place and appear anxious in the waiting area, he was eager to go to the treatment room as he visually recognized me. I actively incorporated his parents into our activities, which was reassuring to Harry and helped reduce his need to constantly check in with them. I began to incorporate music into the sessions, singing familiar songs to him. This was also calming and brought out Harry's sense of humor—he would laugh when I purposefully sang the wrong words, which he would eventually correct. Harry became more joyful during treatment. His eye contact increased, and he was more easily engaged to work on fine-motor tasks like stringing beads and learning to cut with scissors. One of the goals of sensory-integration treatment is to provide the child with just the right amount of challenge to enable him to develop skills and self confidence.

Harry's progress was a combination of strong parental involvement to ensure carry-over and support of treatment goals, and direct occupational therapy. My role was to empower Harry's parents to become active participants in the treatment process, in the clinic as well as at home. My goal was to help Harry integrate sensations more appropriately so he could engage in adaptive responses and have more success mastering the developmental tasks of childhood. The process will be ongoing for Harry and his family. Harry needs to have more successes in order to feel comfortable and take on new challenges. My goal as a therapist will be to guide him through this process.

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

Sharon showed a keen sense of analysis as she observed Harry's response to touch and activity and tailored her interactions to fit his needs. She selected each toy specifically for how it could assist her evaluation. Sharon was mindful and deliberate in her interactions with Harry, knowing how each action would impact his progress (or lack thereof). And she engaged Harry's parents so they could build on the success they saw in the clinic when they were at home. A wonderful story.

Thank-you, Sharon.

# Cardiac Nursing visiting scholar comes to MGH Heart Center

—by Diane L. Carroll, RN, nurse researcher

**O**n June 12 and 13, 2014, in recognition of the contributions of cardiac nurses, the Cardiac Nursing Practice Committee welcomed Vicky Vaughn Dickson, RN, nurse practitioner and assistant professor at New York University College of Nursing, as this year's Cardiac Nursing visiting scholar.

Dickson's research focuses on the multi-factorial influences on self-care specifically among ethnic minority populations with heart failure and aging workers with coronary heart disease (CHD). She is the principal investigator on a grant to develop and test the feasibility of a community-based intervention to improve self-care among older adults with heart failure and another to examine self-care among older workers with CHD.

Dickson's first session focused on improving health outcomes in patients with ventricular assist devices (VADs). She shared research conducted with special heart-failure populations, specifically those with multiple chronic conditions, ethnic minorities, and those with low health literacy. At Nursing Grand Rounds, Dickson focused on her work with the aging workforce and the impact older adults have on cardiovascular nursing practice.

A panel discussion with cardiac nurses, Michelle O'Leary, RN; Mary Ellen McNamara, RN; Lori Mazzarelli, RN; and Kelly Cordo, RN, focused on a particularly difficult heart-failure patient. Each nurse spoke about specific challenges in caring for heart failure patients, and clinical nurse specialist, Kate Benacchio, RN, posed questions to Dickson about

each case. Dickson shared her expertise in the areas of self-care maintenance, symptom-recognition, symptom-evaluation, and self-care management.

A moderated poster session highlighted the innovative clinical practice in The Knight Center for Interventional Cardiology Laboratory, the cardiac surgical units, the Cardiac ICU, the Cardiac Step-Down Unit, the Cardiac Interventional Unit, and the Cardiac Operating Room. The Cardiac Practice Committee, advanced clinicians, and clinical scholars in cardiovascular nursing engaged in conversation with Dickson about clinical issues affecting practice and demands posed specifically by heart-failure patients.

Dickson engaged in dialogue with staff of the Nuclear Cardiology Stress Lab around fostering an inter-disciplinary approach to motivating, educating, and caring for heart-failure patients and their families.

The Cardiac Nursing Visiting Scholar Program provides cardiac nurses with an opportunity to share and discuss the clinical needs of their patients and learn from an expert. Dickson's visit was an enriching experience for clinicians throughout MGH. For more information about the Cardiac Nursing Practice Group, contact Erika Ehnstrom Carr, RN, at 4-3771, or Cris Bethune, RN, at 4-5020.



Vicky Vaughn Dickson, RN,  
2014 Cardiac Nursing visiting scholar

# Settle presents at More than Just a Journal Club

—by Christina Jewell, RN, and Emily Pelletier, RN, co-chairs of More than Just a Journal Club

Settle became interested in nurse activism when one of her staff was struggling with a treatment decision; the nurse didn't know what resources were available to help work through her distress.

**O**n April 10, 2014, More than Just a Journal Club hosted nurse researcher, Peggy Doyle Settle, RN, nursing director of the Newborn Intensive Care Unit (NICU), who presented her study, “Nurse Activism in the Newborn Intensive Care Unit: actions in response to an ethical dilemma,” which was published in *Nursing Ethics* in March. Settle was interested in identifying predictors of actions taken by NICU nurses when faced with an ethical dilemma.

According to Settle's article, ethical dilemmas in the NICU have increased as advances in treatment for premature neonates has improved over the years. Now, infants born as early as 23-25 weeks gestation may survive with intensive medical intervention; some suffer permanent complications as a result of early birth. There's no way to predict the prognosis, which can lead to disagreements about treatment among families, physicians, and nurses.

Settle became interested in nurse activism when one of her staff was struggling with a treatment decision; the nurse didn't know what resources were available to help work through her distress. This prompted Settle to wonder how nurses respond when faced with ethical dilemmas and what factors affect their activism.

The study consisted of an on-line survey of hospitals in the Northeast with a Level III NICU and an obstetrical service. Participants were asked about their experience and education, as well as other demographic information. They were given a hypothetical ethical dilemma and asked what they would do. Of the 224 NICU nurses who responded, the study found that NICU nurses are most likely to talk with their colleagues, both physicians and nurses, and request a team meeting when faced with an ethical dilemma involving a treatment disagreement. Nurses with higher levels of ethical sensitivity and



Peggy Settle, RN, nursing director, Newborn Intensive Care Unit

higher perception of influence are more likely to take action to resolve ethical dilemmas.

The presentation was co-sponsored by the Research and Evidence-Based Practice Committee and the Newborn Intensive Care Unit. The article can be accessed through the Treadwell Library.

The next More than Just a Journal Club meeting will be held in September, when Sara Looby, RN, will present her study, “Increased hot-flash severity and related interference in peri-menopausal human immunodeficiency virus in infected women,” from *The Journal of The North American Menopause Society*.

For more information about More than Just a Journal Club, contact Chrissy Jewell, RN, at [cjewell1@partners.org](mailto:cjewell1@partners.org).

# Spirituality a big part of patient care

*clinical pastoral education available to all caregivers*

*Question:* Spirituality is an important part of many patients' lives. How would you define "spirituality"?

*Jeanette:* According to Reverend John Polk, our director of Chaplaincy, there are many ways to define spirituality. At MGH, patients, families, and staff come from a broad range of religious and spiritual backgrounds. Reverend Polk thinks of spirituality as that which drives the way individuals seek and express meaning. It's the way people connect to the moment, to self, to others, to nature, to the sacred or significant.

*Question:* How can healthcare professionals know if patients are struggling with spiritual issues?

*Jeanette:* Patients might say something like:

- Why am I sick? I always say my prayers
- Is God trying to teach me a lesson?
- God isn't listening to me

Others might express spiritual distress in more secular ways, such as:

- What is my legacy?
- How do I want to be remembered?
- I never realized how precious each day is

*Question:* Why is it important for healthcare providers to address these issues?

*Jeanette:* Research suggests that addressing patients' spiritual and religious struggles has a positive impact on medical outcomes. Patients with life-threatening illnesses often turn to spiritual coping strategies, and patients and families are more satisfied with care when their spiritual concerns are addressed. We want our patients to be spiritually as well as physically healthy, so we need to be consistent in addressing the spiritual aspects of their experience.

*Question:* It seems like a delicate area. What might be helpful to one person, may not be helpful to another.

*Jeanette:* That's very true. Healthcare professionals need to be comfortable raising spiritual issues. Training is necessary to be able to support patients when their beliefs differ from our own. Spiritual care-giving includes being able to perform a spiritual assessment, create a spiritual care plan, and know when to make a referral to the Chaplaincy.

*Question:* How can clinicians learn to integrate spirituality into their practice?

*Jeanette:* The Chaplaincy offers a training program specifically tailored to healthcare professionals. Spiritual care fellowships sponsored by the Schwartz Center for Compassionate Care are available to staff. The next program begins September 2, 2014, and runs through December. Another begins in January. Fellows participate at no cost to themselves. Once accepted into the program, tuition is covered by the Schwartz Center.

*Question:* Who can participate in the fellowship?

*Jeanette:* Any healthcare professional who has direct patient contact is eligible to apply. Nurses, physicians, psychologists, social workers, and patient care administrators have gone through the program. Applications are available in the Chaplaincy Office. For more information, contact Reverend Angelika Zollfrank, CPE supervisor, at 4-3227.



# MGH community mourns loss of beloved USA, Maude Forrester

**T**he MGH community was saddened to learn of the passing of White 8 unit service associate, Maudeline 'Maude' Forrester, on Wednesday July 2, 2014. Forrester had worked at MGH for more than 35 years; in January of 2009, she was a recipient of the Anthony Kirvilaitis Jr. Partnership in Caring Award. At that time, Ellen Robinson, RN, nurse ethicist, wrote of Forrester, "Maude exemplifies the kind of caring toward her work—and those she encounters in her work—that was so characteristic of Tony Kirvilaitis. I know Tony would be proud to see Maude receive this award created in his honor." Another co-workers wrote, "Maude starts each day hoping she will be a helping hand to a needy person. She establishes a bond with patients from the moment she says, 'Good morning,' and strives to bring some normalcy to their hospitalization."

Nursing director, Colleen Gonzalez, RN, says, "The White 8 team is deeply saddened. Maude was a kind and caring woman, much loved by everyone who knew her. She was a dedicated and loyal member of our team; everything she did showed how much she loved working at MGH."

Forrester was a nurturing presence for so many. Says White 8 operation manager, Jeremy Banchiere, "Maude was like family to many of the people who work here. I know, for me, she was like a grandmother. I will forever miss her kindness and warm smile and continue to be grateful that she was part of my life."

Co-worker, Sheila McCarthy, recalls, "I worked with Miss Maude forever. She was one of the kindest people I ever had the pleasure to know. Not only did she love what she did on White 8, she cared about people whether they were USAs, PCAs, or nurses. She treated everyone the same. And patients always spoke fondly of her. Rest in peace my friend."



Maudeline Forrester  
White 8 unit service associate

Says Stephanie Cooper, associate director of PCS Clinical Support Services, "Maude Forrester exemplified everything you could hope for in an employee. She didn't think of herself; others didn't see her as 'only' a housekeeper—she was an integral part of the patient care team. When Maude came to work, she was impeccably dressed, ready to greet her patients with a warm smile and a calm, 'Good morning.' She got to know patients, often bringing her observations to the attention of nurses; letting them know if someone didn't look well or seemed a little off. Colleagues had encouraged her to retire for years, but this is where she wanted to be. I'm honored to have known her and will always hold her in my heart as someone I admire, look up to, and try to emulate."

Forrester was featured recently in the MGH Hand-Hygiene Poster Campaign (see back cover). She will be missed.

"I know, for me,  
she was like a  
grandmother. I  
will forever miss  
her kindness and  
warm smile and  
continue to be  
grateful that she  
was part of  
my life."  
—White 8  
operation manager,  
Jeremy Banchiere,

# Announcements

## Free one-day bereavement program for children

Saturday, July 19, 2014  
8:30am–4:00pm  
at the MGH Institute  
for Health Professions in the  
Charlestown Navy Yard

For information, call  
617-724-4525

## Biomedical Engineering updated website

Questions about one of the  
35,000 medical devices at MGH?  
Visit the Biomed website.

Biomedical Engineering has updated its website to be more user-friendly and useful for clinicians. In direct response to feedback from staff, Biomed has significantly augmented the content of its website to include more device types and information, such as operator's manuals, training videos, and links to manufacturer's websites and policies. Areas such as Technology News, Safety Tips, FAQs, alarm management, and infusion pumps are regularly updated.

Check out the updated site, available through Clinical References → "Biomedical Engineering Websites at BWH and MGH," then click on MGH.

For more information, or to offer comments or suggestions, contact Eileen Hall at 617-724-3216.

## New Fibroid Program at MGH

Radiology and Obstetrics & Gynecology are introducing the new Fibroid Program to provide access to a multi-disciplinary team of specialists who collaborate to offer a full range of treatments for women with uterine fibroids.

A nurse coordinator helps navigate care throughout the course of treatment, including scheduling and connecting patients to available resources.

Treatments and services include:

- Diagnostic imaging
- Minimally invasive surgery
- Image-guided procedures

Consultations are available on Tuesdays from 8:00am–12:00pm in the the Yawkey 4 OB-GYN suite.

For more information go to:  
[massgeneral.org/fibroids](http://massgeneral.org/fibroids).

For appointments,  
call 857-238-4733 or submit an on-line appointment request.

## The Brian A. McGovern, MD, Award

### Nominations now being accepted

The MGPO is now accepting nominations for the 2014 McGovern Award for Clinical Excellence. Nominate a physician who is a superb clinical role model, may be considered an 'unsung hero,' and is focused on patient care. Physicians in every clinical department are eligible to be nominated.

All attending and trainee physicians, clinicians, volunteers, students, and patients are welcome to submit a nomination.

Nominations are due by Saturday, July 19, 2014. To submit a nomination, go to <https://mgpo.massgeneral.org/mcgovern/>, or send an e-mail to Shaina Druy at [sdruy@partners.org](mailto:sdruy@partners.org).

For more information,  
call 617-726-3680.

## ACLS Classes

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

Day one:  
September 12, 2014  
8:00am–3:00pm

Day two:  
September 22nd  
8:00am–1:00pm

Re-certification (one-day class):  
August 13th  
5:30–10:30pm

For information,  
call 617-726-3905.

Class locations will be announced upon registration.

To register, go to:  
[http://www.massgeneral.org/emergencymedicine/assets/Library/ACLS\\_registration\\_form.pdf](http://www.massgeneral.org/emergencymedicine/assets/Library/ACLS_registration_form.pdf).

## Atrial Fibrillation Patient Education Classes

Patients and family members are invited to join the Cardiac Arrhythmia Service to learn more about atrial fibrillation and current therapies used to treat 'A fib.'

Upcoming classes:

"Stroke-Prevention and Blood Thinners 101"  
July 28th  
November 24th

"AF Treatment: When, Why and How"  
August 25th  
December 22nd

"Ablation A-Z"  
September 22nd

Classes are free and held monthly in the Haber Conference Room from 5:00–6:00pm.

For more information or to register for a class go to the Atrial Fibrillation Program website:  
[www.massgeneral.org/atrialfibrillation](http://www.massgeneral.org/atrialfibrillation)

## SAFER FAIR

Join champions from our collaborative governance committees to learn how we're working to make a SAFER environment for patients, families and the MGH community.

Games, refreshments, and prizes!

September 17, 2014  
11:00-2:00pm  
under the Bulfinch Tent

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

## Senior HealthWISE

All events are free for seniors 60 and older

The Isabella Stewart Gardner Museum: a Virtual Visit

Thursday, July 24, 2014  
11:00am–12:00pm  
Haber Conference Room

Speaker: Marcia Stein Adams, educator; Gardner Museum  
A virtual tour of the historic building, focusing on how Gardner arranged her collection, which remains today.

Discovering the Peabody Essex Museum

Thursday, August 7th  
11:00am–12:00pm

Haber Conference Room  
Speaker: Claudia Chuber, director of Community Affairs, Peabody Essex Museum

Presentation will focus on the museum's history, collections, exhibitions, special events, and festivals.

For more information,  
call 4-6756.

# The World Cup MGH-style



The 2014 FIFA (Fédération Internationale de Football Association) World Cup competition (soccer world championship) began June 12th in Brazil. Teams from 31 countries advanced through qualifying matches that began in 2011 to participate along with the host nation in this tournament that occurs only once every four years. In honor of the occasion, medical interpreters celebrated with an international potluck lunch wearing the jerseys of their respective teams/countries, which at MGH translated to 14 of the 32 competing nations. Viva diversité!

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For more information, call: 617-724-1746

**Next Publication**

August 21, 2014





MASSACHUSETTS GENERAL HOSPITAL

Maud Forrester, White 8 Unit Service Associate, **SPEAKS UP** for good hand hygiene

Forrester observes the actions of others, recognizes good leadership and compliments excellence. She commended Dan Hunt, MD, Chief, Hospital Medicine Unit and Director, Inpatient Clinician Educator Service, for his use of Cal Stat by saying, "If I could give you a grade for hand hygiene, it would be an A+!"

EXCELLENCE EVERY DAY

A message brought to you by the **STOP** (Stop the Transmission of Pathogens) Task Force.

## Speak Up!

*See something, say something*

Clean hands can help stop the spread of germs and reduce the risk of infection. Clean hands are especially important in the hospital setting. MGH is committed to achieving excellence in hand hygiene through vigilance and collaborative practice.

At MGH, healthcare workers are required to use Cal Stat, an alcohol-based hand sanitizer, before and after contact with patients or patients' environments. Patients, families, and visitors are encouraged to do the same, and sometimes a polite reminder is appreciated.

Help spread the message. Speak up for hand hygiene and promote Excellence Every Day.

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At left: Maud Forrester, unit service associate and hand hygiene champion on White 8, compliments Dan Hunt, MD, director, of the Inpatient Clinician Educator Service, for his diligent attention to hand hygiene.

# Caring

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