

Caring

Headlines

November 2, 2017

Burke named new chief nurse and senior vice president for Patient Care Services

Senior vice president for Patient Care and chief nurse, Jeanette Ives Erickson, RN (left), and her newly named successor, associate chief nurse, Debbie Burke, RN, in 'their' office on Bulfinch 2.

(For more on the story, turn to page 2)

Nursing & Patient Care Services
Massachusetts General Hospital

Burke named new chief nurse and senior vice president for PCS

I've known Debbie for more than 20 years and have admired and respected her as a person, as a nurse, and as a committed and effective leader. One of the many wonderful things about Debbie taking over this role is that I *know* she's ready.

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s you've no doubt heard, On Monday, October 16, 2017, MGH president, Peter Slavin, MD, formally announced that associate chief nurse, Debbie Burke, RN, will be taking over as senior vice president for Patient Care and chief nurse, effective January 1, 2018. And I could not be more thrilled. Like many of you, I've known Debbie for more than 20 years and have admired and respected her as a person, as a nurse, and as a committed and effective leader.

One of the many wonderful things about Debbie taking over as senior vice president and chief nurse is that I *know* she's ready. I vividly recall a few years ago when Debbie was working toward her DNP, she let me know she was ready for bigger challenges. Those who know me know that mentoring and succession planning are high priorities of mine, so I was only too happy to work with Debbie to help chart a career path and guide her development.

A key function of leaders is helping others learn and grow so they can fulfill their own professional goals and aspirations. While it's good for the individual, it's also critical to the success of an organization to have a pipeline of accomplished, experienced professionals who can step up to lead. My own career has been influenced by generous and knowledgeable mentors, so it was important to me to give back by mentoring others. And mentoring Debbie has been a joy.



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

Throughout her career at MGH, Debbie has worked as a staff nurse, clinical teacher, nurse manager, and of course as associate chief nurse for women and children, mental health, the MGH Cancer Center, and Community Health Nursing. In each of those roles, Debbie brought innate compassion and humanity to the work. And in each of those roles, she excelled because of her passion, commitment, and eagerness to learn—all qualities of an exceptional leader.

Perhaps what makes me happiest about Debbie's selection as my successor is that we share the same values. We both love MGH; we both understand the importance of inter-professional collaboration; and we both treasure the friendship and dedication of our colleagues. I have the utmost confidence in Debbie's ability to lead Nursing and Patient Care Services, and I will do everything in my power to ensure a smooth and seamless transition. Please help me welcome Debbie to her new role.

continued on next page

What I want
you to take
away from this
message is that
we're in a good
place, literally
and figuratively.
We work at one
of the greatest
hospitals in the
world, and we
employ the best
people on the
planet...Thank-you
for the kindness
and support
you've shown me
already, and I hope
I can count on
your continued
support.

Debbie Burke

I can't tell you what an honor it is to have been selected the next senior vice president for Patient Care Services and chief nurse. I'm truly humbled. As you can imagine, these past few weeks have been a whirlwind. It's been so gratifying to receive texts, phone calls, and e-mails of congratulations and to feel so warmly welcomed to this new role.

Since coming to MGH in 1981, I've had the pleasure of working alongside many of you, and I look forward to building on those long-standing relationships and cultivating new ones. And of course, I've had the privilege of working with Jeanette, especially in the last 15 years in my role as associate chief nurse. I've been learning from her for a long time. I feel fortunate to have had the benefit of her wisdom and insight. And as she generously reminds me, she's not going anywhere—she's simply 'stepping aside'—so I'll continue to have access to her knowledge and wealth of experience. I don't know how I could be any luckier.

I know there are probably questions about the transition, the time line, how things will change, if things will change. What I can tell you is this:



Debbie Burke, RN, incoming senior vice president for Nursing & Patient Care Services and chief nurse

Jeanette has assembled a talented executive team. Patient Care Services is stronger than ever. While I have many ideas for the future, I don't foresee a need to make any immediate changes or alter our existing structure. Because of Jeanette's visionary leadership, staff throughout Patient Care Services are empowered and satisfied. We have strength and expertise at all levels.

Between now and January 1st, I plan to wrap up as much of my current work as possible. Of course, we'll need to begin the process of finding a new associate chief nurse to take my place. And you'll be seeing me at a lot more meetings as I start to learn the full extent of my new responsibilities.

What I want you to take away from this message is that we're in a good place, literally and figuratively. We

work at one of the greatest hospitals in the world, and we employ the best people on the planet. I'm excited to take on this new role. I'm energized to work with all of you. And I'm ready to tackle the challenges and opportunities that lie ahead. Thank-you for the kindness and encouragement you've shown me already; I hope I can count on your continued support.

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(Cover photo by Sam Riley)

The SAFER Fair

showcasing the work of collaborative governance committees

— by Mary Ellin Smith, RN, professional development manager

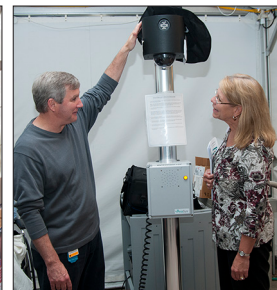
Champions from eight collaborative governance committees, and representatives from Pharmacy; Police, Security, & Outside Services; Magnet; the Joint Commission; and Excellence Every Day, showcased their efforts to make MGH a safer, more efficient organization.

On Wednesday, October 11, 2017, under the Bulfinch tent, collaborative governance held its 5th annual SAFER Fair, answering the question once and for all, Can you do good and still have fun? And the answer was a resounding, Yes! as evidenced by the participation of hundreds of staff members and community visitors who came to the fair to see how collaborative governance is impacting our mission and work.

Ever wonder how much waste is generated when a patient is discharged? The Clinical Practice Committee worked with Materials Management to figure out that more than \$35,000 in supplies is wasted every month. Raising awareness is the first step toward improvement. Committee champions shared ideas on how units can reduce waste.

Visitors to the Diversity & Inclusion Committee table learned about ‘implicit bias.’ When you hear ‘peanut butter,’ you think, ‘jelly.’ It’s not a conscious thought; you’ve just heard it so many times. Committee champions showed how views and opinions are shaped without our being aware of how and when it happens. The first step toward eliminating implicit bias is understanding that everyone has it and paying attention to how it may manifest itself in your interactions with others.

The Ethics in Clinical Practice Committee highlighted the many resources available to staff and patients by providing mock Health Care Proxy forms; raffling off a beautiful, hand-made, ethics-oriented quilt; and soliciting feedback as to, ‘what gives people’s lives meaning.’ Champions collected old cell phones for recycling to support veterans organizations.



The Informatics and Patient Experience committees joined forces to showcase how eCare can improve the patient experience with its: huddle report, patient calendar, care coordination note, and future appointment capabilities. Committee champions answered questions and provided resources on how patients and families can join patient and family advisory committees at MGH.

The Patient Education committee focused on health literacy, offering suggestions on how providers can improve communication with patients, how to safely use medications, and how to identify safe, evidence-based health resources on the Internet. Champions demonstrated how staff can maintain patient engagement while entering information in eCare.

The Quality & Safety Committee highlighted their work around suicide-prevention and the use of checklists to ensure patient safety. They shared a video highlighting the many ways MGH speaks up for safety; and by popular demand, they brought back Quality & Safety Jeopardy, where visitors had an opportunity to answer questions related to quality and safety efforts at MGH.

The Research & Evidence-Based Practice Committee shared recent *Did You Know?* posters and

offered a 'Pin the drainage bag' on the patient game where participants had to place a urinary drainage bag (always below the bladder) in different patient care scenarios.

Champions from eight collaborative governance committees, and representatives from Pharmacy; Police, Security, & Outside Services; Magnet; the Joint Commission; and Excellence Every Day, showcased their efforts to make MGH a safer, more efficient organization.

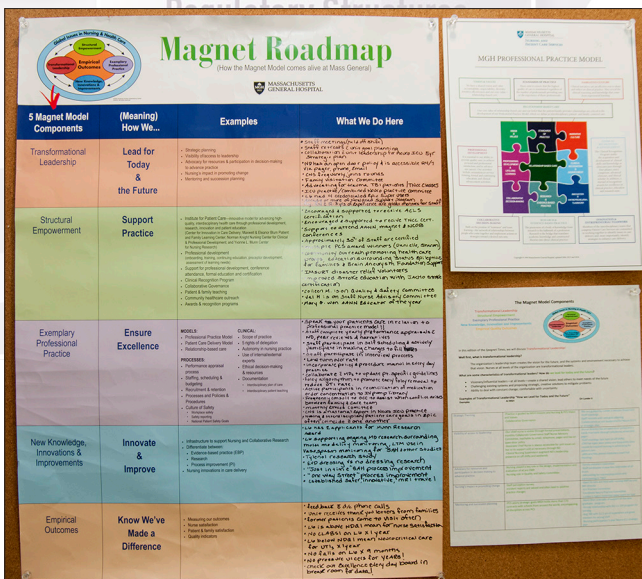
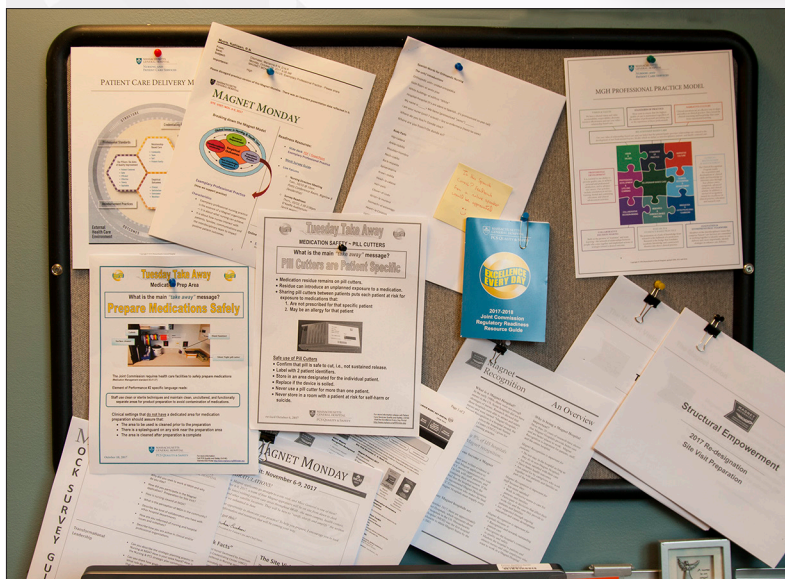
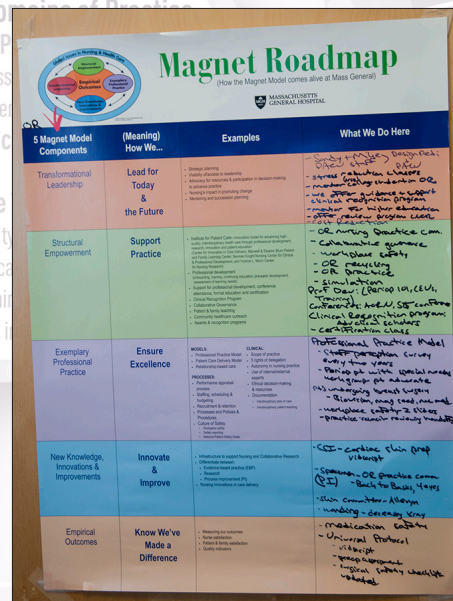
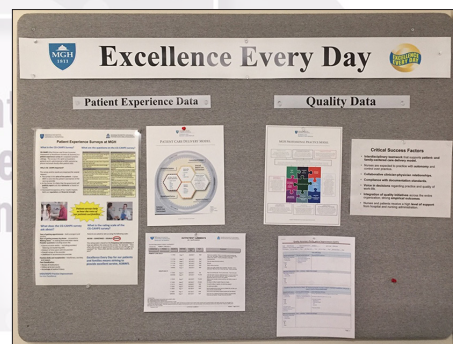
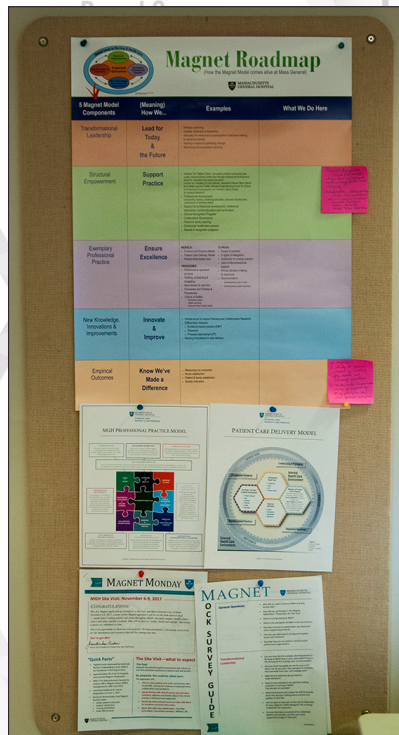
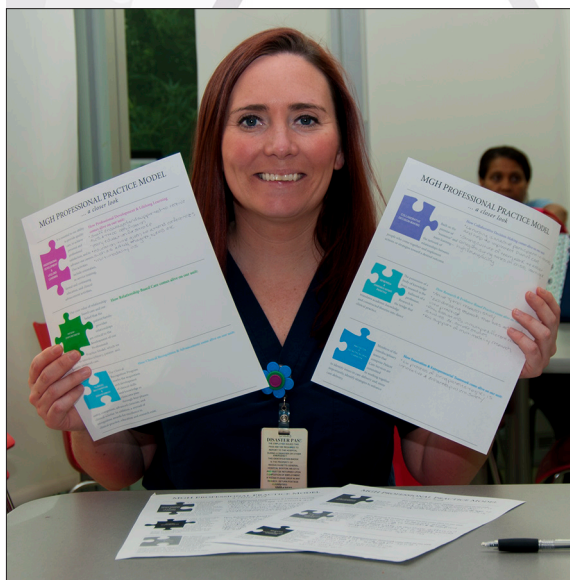
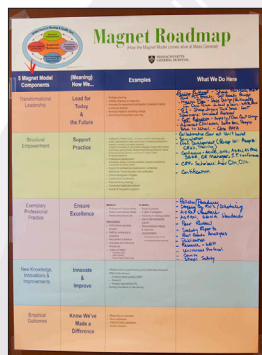
And if that wasn't enough, there were raffles, contests, and plenty of pop corn to go around. Jenna Hall, RN, staff nurse in the Burn Unit, won the Excellence Every Day drawing for a decorated pumpkin (see photo on opposite page).

For more information about any of the collaborative governance committees, or the annual SAFER Fair, contact Mary Ellin Smith, RN, professional development manager, at 617-724-5801.



How does Magnet come alive on your unit?

Below: staff nurse and Magnet champion, Katelyn Sparks, RN, displays her idea to explore the Patient Care Services Professional Practice Model similar to the way we explore the Magnet Model via the new Magnet Roadmap, listing the ways that individual elements of the Professional Practice Model come alive on her unit. Elsewhere throughout the hospital from the perioperative setting to medical units, Neurology, Oncology, and the health centers, staff have been using the 'roadmap' to display many of the ways the Magnet Model is visible in their daily practice. How does the Magnet Model come alive on your unit?



The Magnet site visit is scheduled for November 6–9, 2017.

Reaching out to improve the long-term care of burn patients

—by Vanessa Dellheim, PT, physical therapy clinical specialist

Ellison 14 case manager, Deborah Kiely, RN, identified a need to augment the training of staff at the center, given the complex nature of burn injuries and the long-term complications burn patients often endure.

Part of the MGH and the Burn Service's mission is to educate and improve the health of the communities we serve. On October 4, 2017, the multi-disciplinary team on the Sumner Redstone Burn Unit came together with staff of St. Joseph's Rehabilitation Center in Dorchester to help educate them about the unique care burn patients require.

Ellison 14 case manager, Deborah Kiely, RN, identified a need to augment the training of staff at the center, given the complex nature of burn injuries and the long-term complications burn patients often endure. Kiely and St. Joseph's screener, Judie Quinlan, RN, arranged to have staff from St. Joseph's come to MGH for a day of observation and training. Two occupational therapists, a physical therapist, and a nurse manager attended a presentation given by occupational therapy clinical specialist, Leslie McLaughlin, OTR/L, and physical therapy clinical specialist, Vanessa Dellheim, PT.

The presentation was followed by two patient-observation visits. Nurse manager, Yveda Brutus, RN, from St. Joseph's, met with MGH nurse practitioners, Jason McSweeney, RN; Mary Liz Bilodeau, RN; and Amber Lessard, RN, to review special care needs and dressings.

Patients requiring burn care and/or plastic surgery benefit from remaining close to Boston due to the need for frequent follow-up visits and close monitoring of wounds. There's a limited number of skilled nursing facilities able to meet the specialized needs of burn patients and who are familiar

and knowledgeable enough to provide the necessary care. Continuing education is important. We know the long-term issues these patients face, and reaching out to facilities in the community is essential to optimize their recovery.

For more information about this innovative outreach program, call Vanessa Dellheim, PT, at 617-724-0149.



Standing (l-r): Yveda Brutus, RN, director of Nursing, St. Joseph's Rehabilitation Center; and from MGH, Leslie McLaughlin, OTR/L; and Vanessa Dellheim, PT. Seated (from St. Joseph's): Renee Arakelian, assistant director of Therapy; Megan Floyd, OT; and Trisha Herbert, PT.

PACU nurse sets aside 'usual practice' to do what's right in the moment

'Amy,' had required general anesthesia due to her inability to lie flat for the MRI scan... After further testing, it was determined that she was suffering from wide-spread, metastatic cancer.

My name is Carol McMahon, and I am a staff nurse in the Ellison 3 Post Anesthesia Care Unit (PACU). One busy evening recently, I received a call from an anesthesiologist requesting that we recover a young woman who'd undergone a diagnostic MRI. The patient, 'Amy,' had required general anesthesia due to her inability to lie flat for the MRI scan. She'd been admitted weeks earlier for decreased appetite and weakness. Initial testing had been negative, and due to her history of anxiety and depression, her symptoms were thought to have been psychological. But as time progressed, Amy became weaker, her appetite decreased even more, and she became more depressed. After further testing, it was determined that she was suffering from wide-spread, metastatic cancer.



Carol McMahon, RN,
staff nurse, PACU

In addition to anxiety and depression, Amy also suffered from severe claustrophobia. She was unable to ride in elevators, and for that reason, was brought to the PACU still sedated. In recovery, it was reported that Amy would need to be medicated in order to be transferred back to her inpatient unit, which was three flights up from the PACU.

Amy was asleep when she arrived, accompanied by her husband. He sat quietly at her side, appearing sad, thin, and tired. He talked a little about the

continued on next page

I'll never regret taking that time out of our busy evening to grant a simple request for a dying, young woman. Ultimately that's what it's all about. It's so important to know when to put aside 'usual practice' and protocols and do what's right in the moment. Even when you think there's not enough time, there is.

past few weeks and how difficult it had been to watch her decline. Gradually, Amy began to wake up, and she joined the conversation. She was an easy person to get to know. She opened up to me, and I spent time listening to her talk about her hospital journey. She told me she felt embarrassed at having to ask nurses to help her bathe, and it added to her anxiety when people implied that her condition was psychological.

When it was time for Amy to be discharged from the PACU, she asked not to be medicated. She wanted to be awake and alert and walk the three flights of stairs back to her unit under her own power. I considered her request. I thought about how much control she'd lost over these past few weeks.

It's not our usual practice to let patients walk back to their units. In fact, after almost 30 years of PACU experience, I've never walked a single patient back to their unit. But the reason Amy was making this request seemed to outweigh our 'usual practice.'

I carefully assessed Amy's clinical status, checking her oxygen saturation, orthostatic blood pressure, and heart rate. We stood her up, and with assistance from a colleague, asked her to take a few steps around the room to get a sense of her stability. I could see the determination on her face.

Amy's husband supported the idea of letting her walk up the stairs. I consulted our anesthesiologist. I was concerned that we might get stranded in the stairwell if Amy became unable to continue after a flight or two of exertion. The anesthesiologist concurred that Amy was fit to walk up stairs with our assistance, and he assured us he'd be ready to help if we needed his assistance.

I gave report to the nurse who'd be receiving Amy back on her unit, including Amy's request to walk up the stairs. Amy's nurse agreed it would be

nice to give her some control over her situation. She said she'd meet us at the door to the stairwell with a wheelchair so that Amy would be able to sit right away when we arrived on the unit.

So, with a nurse on either side of her, Amy began to climb the three flights of stairs. As we slowly made the ascent, we laughed and joked with Amy, who was clearly thrilled to be making this trip. The look on her face reminded me of why I wanted to become a nurse more than three decades ago.

Sadly, a short time later, I learned that Amy had passed away. I'll never regret taking that time out of our busy evening to grant a simple request for a dying, young woman. Ultimately that's what it's all about. It's so important to know when to put aside 'usual practice' and protocols and do what's right in the moment. Even when you think there's not enough time, there is.

This is the part of nursing that's most rewarding to me—our ability to make a difference in the lives of patients.

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

When the phrase, "That's not how we usually do things," is all that stands between you and a creative solution, I hope you can see past that platitude the way Carol did in this narrative. She understood what motivated Amy to want to climb those three flights of stairs. She carefully weighed the risks and benefits, developed a plan, communicated the plan, then literally took that journey with her patient. This story is a beautiful reminder of the importance of clinical judgment and compassion as we advocate for our patients in all aspects of their care.

Thank-you, Carol.

Over there

—submitted by the MGH Nursing History Committee

The MGH Nursing History series continues with reflections of MGH nurses, graduates of the MGH School of Nursing, who served in France during World War I. Quotes are drawn from surviving letters and diaries. Most of these nurses were quite young at the time of their service; many went on to serve in executive and leadership roles. Their stories tell of the volume, severity, and variety of cases they saw while overseas.

Photos (l-r): Frances Ladd's dog tag; MGH SON graduate, Lenore Field, in painting commissioned by American Red Cross for its Washington, DC, headquarters; Frances Ladd in 1911, the year she graduated; (inset) nurses at Base Hospital No. 13 in standard-issue rain gear; operating room at Base Hospital No. 6.



October 8, 1917: We have 50 patients in A5 and for 3 days I have taken about half hour at tea time and we, Drap, Proctor, and I, are on the double all day long. Every bed in camp is filled. Church tents and all, and they are expecting to divide our mattresses to make up beds on the floor.

October 9: Still on the double, but I never in my life have felt better, took but 20 minutes for tea and have been dancing in the mess all evening.

October 10: Camp remains full up. Rain continues and no time off duty. Some dressings take $\frac{1}{2}$ or $\frac{3}{4}$ hour to do. Amputation of one leg, fractured femur of other, and sore backs. Surgeons are operating all day, and we have all the dressings to do—still I am happy as a bee!

—Helen Jordan, class of 1916, staff nurse, General Hospital #22, the Harvard Surgical Unit.

Published in the *Quarterly Record* of the MGH Nurses Alumnae Association, June, 1917: The cases are admitted at night and word that a convoy is expected is usually circulated 2 or 3 hours before it arrives. On admittance, each patient is relieved of his muddy, dirty clothes and given a bath. His temperature and a brief history are taken and then if he does not need immediate attention, he is tucked into bed and given a hot drink, something to eat, and left undisturbed until morning.

—Victoria Mayer, class of 1915

Date unknown: Several times Capt. [Henry] Marble and his team have done from 20 to 22 surgeries in one day... This may seem more or less of an impossibility to the casual reader considering the time needed in starting the anesthetics. To overcome that, another table was placed in the room and as soon as the anesthetic stopped on one patient, it was immediately started on the next patient. During our entire work, nurses did all anesthetizing and most of the assisting, and during operations frequently numbered 50 and on some occasions rising to 92. Our personnel numbered 9 surgeons, 7 nurses and enlisted men.

—Frances Ladd, class of 1911, head nurse, Operating Room, Base Hospital No. 6



February 22, 1918: We are getting a lot of trench feet now. Horrible things! One lad struggled in here the other night, slightly wounded in the leg but with fearful trench feet. His trousers had been nearly shot off and hung in ribbons, pinned here and there with nails. He was soaked to the waist from lying in a shell hole full of water and he had not slept for four days and nights. His feet, which were hideously swollen and purple, were raw with broken blisters and were wrapped in muddy, dripping bandages. He walked into my ward! I got him to bed and warm blankets as quickly as I could, filled him full of hot drinks and morphine and left him in peace—and clean bandages.

He fell asleep while I was putting them on.

March 24, 1918: Matron sent us to the lines reserved for the walking wounded. She said there were only 500 in the convoy, but that there were stretcher cases coming. If she sent Topsy Allen with us, did we think the three of us could clean up 500 walkers? We thought we could. We made a frantic effort to systematize our work. We had a small medical table for the medical officer, a large table piled with bandages, splints, boric ointment, sponges, and a basin of Dakin's solution for wet dressings. Then there were two smoky lanterns and an enfeebled primus stove. Ruth, armed with dressing scissors, stood in the

doorway of the dressing tent and beckoned the boys in 2 or 3 at a time. Because there was so much to do, it was impossible to take the dried and stiffened bandages off carefully. The only way was to snatch them off with one desperate yank. Poor Ruth! Her tender heart nearly broke... The medical officer looked at the wound, said, "Wet-dry-boric ointment, splint," to the orderly at the table. The orderly scribbled the order on a bit of paper and gave it to

the lad, who moved on to Topsey and me. They came much too fast for us, and within 15 minutes were standing 20 deep around the dressing table. As the hours went by, we ceased to think. Our hands moved automatically. We were hardly conscious of the shuffling of feet and the steady drip-drip of wounds bleeding from surface vessels torn open when Ruth took off the dressing... We're through now, just as the dawn is coming.

March 27, 1918: Already we hold the record for British Hospitals on the Western front. In ten days we have admitted four thousand eight hundred and fifty-three wounded, sent four thousand to Blighty (England), have done nine hundred and thirty-five operations—and only twelve patients have died.

—Diary of Helen Dore Boylston, staff nurse, General Hospital #22, the Harvard Surgical Unit



Look for more installments from the MGH Nursing History Committee in future issues of *Caring Headlines*. For more information, contact Georgia Peirce, special projects manager, at 617-724-9865.

Celebration on Ellison 16 marks successful transition to oncology care

On October 5, 2017, staff of the Ellison 16 Medical Unit came together to celebrate their successful transition to a unit able to safely and effectively care for oncology patients. The day marked several key milestones, including 500 days as an official oncology unit, more than 150 doses of IV chemotherapy administered, and approximately 50 nurses in various stages of oncology and chemotherapy-administration training.

Said Nursing director, Lee Ann Tata, RN, “It has been wonderful building collaborative relationships with our oncology colleagues and we look forward to growing our knowledge of oncology nursing to ensure excellent care for all our patients.”

Tata thanked colleagues on Lunder 9 and 10, Phillips House 21, the Yawkey Infusion Unit, associate chief nurses, Theresa Gallivan, RN, and Debbie Burke, RN, the clinical nurse specialists who guided the transition, and the entire nursing staff on Ellison 16. Said Tata, “Your willingness to adapt to the changes we’ve experienced while continuing to deliver uninterrupted, exceptional patient care is impressive.”

For more information, call Tata at 617-724-5320.



Staff and leadership of medical and oncology units came together to celebrate their successful collaboration in preparing Ellison 16 to care for oncology patients.



(Photos by Paul Butica)

Catching up with the Office of Patient Advocacy

Question: What exactly does the Office of Patient Advocacy do?

Jeanette: In addition to advocating for the best healthcare experience for patients and families, the Office of Patient Advocacy supports staff in ensuring that care delivery is compassionate and equitable. Patient advocates meet with patients and families to hear concerns and try to resolve issues. They may facilitate meetings, serve as liaison between patients and providers, help set clear expectations, resolve conflicts, and identify patterns or trends that can impact the delivery of safe, quality care. They participate in Patient & Family Advisory Councils, patient experience committees, the Diversity & Inclusion Task Force, and the Workplace Safety Committee.

Question: Does the Office of Patient Advocacy have a big staff?

Jeanette: The Office has four advocates, a disability program manager, a navigator for patients with autism spectrum disorders, and an office coordinator.

Question: What does the disability program manager do?

Jeanette: Zary Amirhosseini, our disability program manager, was instrumental in forming focus groups to advise us on our efforts to reduce barriers and enhance accessibility for patients with disabilities. This past year, The Office of Health and Human Services asked hospitals to report on the kind and amount of equipment they have for patients with disabilities. This has been an enormous undertaking and is likely to become an ongoing quality initiative. Identifying patients with

disabilities and being able to proactively provide accommodations for them is now supported by eCare with the special-needs designation flag. That information is visible to all clinical and administrative users. Look for more information on this function in future issues of *Caring Headlines*.

Karen Turner has been the navigator for patients with autism since May of 2016. She's had a significant impact on the experience of care; her collaboration with Perioperative Services led to improving care for patients undergoing MRIs and the creation of educational materials for patients, families, and staff. Karen has collaborated with staff in the ED to help manage behavioral issues, providing a toolbox of options for calming patients. This is a model we hope to replicate for patients with other disabilities.

Question: How is the Office of Patient Advocacy involved with workplace safety?

Jeanette: The Office of Patient Advocacy has been part of the Disruptive Patient Behavior and Staff Safety Committee for several years. This multi-disciplinary group reviews safety reports, looks at the severity of events, the likelihood of re-occurrence, and other factors to determine whether an FYI safety flag should be added to the patient's record. We are also involved in educational efforts to raise awareness of factors that may increase patients' agitation and develop strategies to minimize or avoid harm.

For information about any of the services provided by the Office of Patient Advocacy, call director, Robin Lipkis-Orlando, RN, at 617-726-3370.

In addition to advocating for the best healthcare experience for patients and families, the Office of Patient Advocacy supports staff in ensuring that care delivery is compassionate and equitable.

Announcements

Blum Center Events

**Wednesday, November 15, 2017
11:00am–12:00pm
Haber Conference Room**

“The myths and facts of gluten-related disorders”
Join Maureen Leonard, MD, and Pamela Cureton, RDN, to learn more about the two most common gluten-related disorders, celiac disease and non-celiac gluten sensitivity.

**Monday, November 20th
12:00–1:00pm
Blum Center**

“Facing difficult medical decisions: tips and tools that can help”
Join Karen Sepucha and Leigh Simmons, MD, to discuss tips and techniques to promote shared decision-making between patients and clinicians, including an interactive session where attendees can use the Ottawa Personal Decision Guide to identify information gaps and unclear preferences.

Programs are free and open to MGH staff and patients.
No registration required.

For more information,
call 4-3823.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Collaborative Governance

Applications are now being accepted for collaborative governance, the formal, multi-disciplinary decision-making structure of Patient Care Services.

To learn more about collaborative governance, or to download an application, go to: www.mghpcs.org/IPC/Programs/Governance.asp, or contact Mary Ellin Smith, RN, at 617-724-5801.

**Applications are due by
November 6, 2017.**

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

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

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

Platelet donations:

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

Friday, 8:30am – 3:00pm

Appointments are available

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

Flu season is here! Get vaccinated

Getting the flu vaccine is the number-one way to protect yourself, your patients, and your loved ones from the flu. MGH offers several flu clinics for employees and patients, on and off campus. The MGH Central Clinic will run through Friday, December 8, 2017.

**Monday–Friday
8:00am–6:00pm
Wang Lobby and
Yawkey 2nd floor mezzanine**

Those unable to make one of the clinics may visit Occupational Health Services at 165 Cambridge Street, 4th floor, from 7:00am–5:00pm or call 617-726-2217 to make an appointment.

All employees are encouraged to be vaccinated as the first line of defense. The Massachusetts Department of Public Health requires all hospitals to track their employee vaccination rate as well as how many employees decline the seasonal flu vaccine.

For more information, go to: www.massgeneral.org/flu.

Have a healthy fall!

Simchat Torah: the annual, 'Joy of Torah'

—by Rabbi Ben Lanckton, staff chaplain

"It is a religious commandment to be happy at all times."
—old Jewish saying

Early fall is a time of many Jewish holidays and celebrations, none more joyous than Simchat Torah, or 'Rejoicing with the Torah.' The Torah, a long scroll containing the first five books of the Bible, is especially sacred to Jews. On Simchat Torah, we celebrate the end of the annual cycle of reading the Torah aloud in synagogue and beginning the cycle anew.

At MGH these past few years, we've been fortunate to partner with the local Jewish house of worship, the Boston Synagogue, for this celebration. On the morning of Simchat Torah, escorted by MGH Police & Security, members of the Jewish community arrive bearing Torahs and make their way to the MGH Chapel. The service is marked by raucous singing and dancing 'parade-style' around the Chapel seven times.

The Torah is then opened, and the end of the story is read aloud, followed immediately by the opening of another scroll to the beginning of the story to start the process anew.

Festivities are broadcast throughout MGH on channel 16, so patients can observe from their rooms.

For more information about Simchat Torah or any of the religious observances at MGH, contact Rabbi Ben Lanckton at 617-724-3228.



(Photo by Michelle Rose)

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Next Publication

November 16, 2017

Responding to the nationwide IV-fluid shortage

—by Sheila Golden-Baker, RN, professional development specialist; and Sheila Burke, RN, clinical educator

An inter-disciplinary team was assembled to design a safe and effective alternative to administer a select group of medications.

Following the recent hurricane in Puerto Rico, a critical, nationwide shortage of intravenous (IV) fluids is impacting many healthcare facilities, including MGH, and the shortage is expected to continue for the foreseeable future. An inter-disciplinary team was assembled to design a safe and effective alternative to administer a select group of medications. These medications, typically given by intermittent IV infusion, will now be administered by slow IV push after nurses reconstitute the powder into fluid form. The medications (all antibiotics) include; ceFAZolin, cefTAZadime, cefepime, and Meropenem.



As of Thursday, October 26, 2017:

- Provider orders have been changed in eCare to reflect this practice change
- Supplies required to reconstitute and administer these antibiotics are currently available
- Training includes a mandatory HealthStream course, nursing education on demand, unit-based posters, and in-service training conducted by staff of the Norman Knight Nursing Center
- Medications must be administered soon after being reconstituted

This change in practice is intended to ensure continued safe, high-quality care while not placing an undue burden on nurses, physicians, or pharmacists.

For more information, please consult your unit leadership.



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