In celebration of National Occupational Therapy Month and its theme, “Serving our Military,” the MGH department of Occupational Therapy hosted Captain Katie Yancosek, OTR/L, chief of the Amputee Unit at Walter Reed Hospital in Washington, DC. Yancosek’s lecture, entitled, “Care of the Military Upper Extremity Amputee Patient,” highlighted advancements in prosthetic care for amputee patients and described the role of occupational therapists in helping soldiers regain independence in performing basic activities of daily living and transitioning back to military or civilian life. Yancosek brought new awareness of the healthcare issues facing our soldiers and the challenges facing clinicians who care for them.
Meeting the need for accurate, effective, timely communication

Every generation thinks its need for improved communication is greater than the last. Each generation thinks its events and circumstances warrant faster, better, more widespread communication than ever before. The truth is, the need for effective communication is a universal constant. There will always be a need to disseminate information quickly and accurately to the right people, at the right time, in the right way.

As with other large organizations, communication is very much on the minds of everyone at MGH as we strive to deliver the highest quality care to our patients and their families. We employ a number of 'tried and true' methods to keep staff informed, and we're always on the lookout for new ideas and suggestions.

Our collaborative-governance committee structure is one example of a successful model of interdisciplinary communication. Eight committees comprised of clinicians and support staff from all disciplines within Patient Care Services have built-in mechanisms by which to share information among and between themselves and with the greater hospital community. Since its inception, it has been a reliable means of identifying issues of concern to clinicians and sharing accomplishments and best practices with colleagues and peers.

The Staff Nurse Advisory Committee offers a tremendous opportunity for two-way communication between staff nurses and nursing leadership. This has been a great forum for trouble-shooting and information-sharing. And I, personally, enjoy hearing from staff nurses in a relaxed setting where we can have a meaningful exchange of ideas. Social Services has formed a staff advisory committee, and Physical and Occupational Therapy are in the process of creating one, as well.

A number of tools have proven extremely successful in providing staff with a way to give feedback on a variety of issues. Our annual Staff Perceptions of the Professional Practice Environment Survey is one of the most effective vehicles we have for tapping into staff's thoughts and feelings on important topics. We're fortunate to have a workforce that values professionalism, advocacy, and participation, which is evidenced by the fact that the response rate for this survey has increased steadily over the years. And we've implemented many new programs and initiatives as a result of this tool.

The Patient Care Services Communications Council recently conducted a random survey to determine staff's likes and dislikes, preferences and aversions, in terms of communication needs. We heard loud and clear that there's a desire for more accessible, concise, easy-to-read information that's delivered in a reliable and timely fashion. You may have noticed that Caring Headlines has been redesigned in an effort to respond to these preferences. The new layout makes use of color, sidebars, more white space, and eye-catching graphics, all intended to make information easier for readers to access. We're already hearing that staff find it, "warmer, cleaner, and more inviting."

Our communications survey told us staff appreciate receiving letters at home shedding light on important issues affecting their work and practice. We will continue to reach out to staff in this way.

Staff want timely updates on events and initiatives of
Jeanette Ives Erickson (continued)

We all need to take responsibility for keeping abreast of important events and initiatives. If everyone makes an effort to share information in a timely and accurate manner, we will all contribute to the continuing success of this organization.

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Cover photo by Abram Bekker

In many ways, communication is like food and water — it’s critical to our survival, but we often take it for granted. We all need to take responsibility for keeping abreast of important events and initiatives. If everyone makes an effort to share information in a timely and accurate manner, we will all contribute to the continuing success of this organization.

One of my newest strategies in trying to keep staff as informed as possible is an open-forum, question-and-answer session to which everyone in Patient Care Services is invited. The first one was held on April 4, 2007, in O’Keeffe Auditorium. We’re still in discussions as to how often these sessions will be offered. The first open forum was very well attended and gave us a chance to talk about some important issues, including our recent JCAHO survey. I realized there were some rumors and misinformation circulating, so it was nice to have an opportunity to set the record straight.

Other questions brought up during the open forum focused on parking; scheduling; employee benefits (including short-term disability); our new and soon-to-be-implemented automated systems (including CBEDS and our electronic medication-administration system); and opportunities for clinicians to participate in global-health and humanitarian-aid missions. There was an insightful conversation about conflict-management, and an excellent suggestion to incorporate conflict-management training into our new-employee orientation program.

I’m always energized when I have an opportunity to talk to staff one-on-one. I will continue to offer these open forums and look for ways to include night and weekend staff, as well. Watch future issues of Caring Headlines and PCS News You Can Use for dates and times of upcoming forums.

In several ways, communication is like food and water — it’s critical to our survival, but we often take it for granted. We all need to take responsibility for keeping abreast of important events and initiatives. If everyone makes an effort to share information in a timely and accurate manner, we will all contribute to the continuing success of this organization.
What is the difference between speech and language?

- Speech involves the oral-motor act of articulation and/or the use of phonological patterns (i.e., speech sound patterns) for use in forming words.
- Language involves the comprehension and use of verbal codes (i.e., words, sentences, discourse structures) and non-verbal codes (i.e., body language, facial expressions, tone of voice, etc.) for the purpose of communication. The modalities of language include listening, speaking, reading and writing.

What is language?
Language is composed of:

- **Form**
  - Morphology: word endings that carry meanings (plural, past tense)
  - Phonology: the sound system of a language
  - Syntax/Grammar: word order in sentences, phrases, and extended contexts

- **Content**
  - Semantics: word meaning/vocabulary, word relationships, multiple-meaning words, the use of figurative language

- **Use**
  - Pragmatics: use of verbal language (social amenities, topic-maintenance) and non-verbal language (eye contact, etc.)

What other areas are critical in using and understanding language?

- Attention
- Memory
- Storage/retrieval
- Reasoning/integrating skills
- Organization/executive function
- Meta-linguistic skills (an awareness of words and language)

What is ‘typical’ language development?

- Over the course of a lifetime, language develops from vocal play (at birth) to babbling (6 months), jargon (12 months), imitation (18 months), phrases (24 months), sentences (3 years), connected sequences of ideas (4–5 years), more advanced language forms/structures and content-development throughout school-aged years.

What is a language disorder?

- A language disorder is a significant deficit in a child’s level of development in the form, content, or use of language.
- The American Speech, Language and Hearing Association recognizes that language impairments include those of receptive and expressive language in both its spoken and written forms.
Children can be described as having a language disorder if they have a significant deficit in learning to talk, understand, or use any aspect of language appropriately.

What are problems to look for in children with language disorders?
- Difficulty following directions
- Delayed vocabulary development
- Difficulty using and understanding grammar in sentences
- Difficulty finding words needed to express basic thoughts and ideas
- Use of non-specific language (thing, stuff, you know)
- Difficulty following rules of conversation
- Difficulty listening and understanding quickly and easily
- Reading-comprehension weaknesses
- Difficulty summarizing an event or information that was read
- Trouble sounding out words when reading
- Difficulty consistently recognizing familiar printed words
- Difficulty spelling
- Difficulty writing (constructing) sentences and stories
- Organizing homework and school work, including drafting papers and planning long-term assignments

How do speech-language pathologists formally evaluate a language disorder?
- Review previous testing
- Review background history, including development
- Parent interviews

Assessment using standardized measures and language sampling
- Comparison of observable skills to developmental norms
- Standardized measures assess the ability to understand and use language in spoken and written contexts
- Depending on the profile of the child, evaluations may formally assess the following areas:
  - Vocabulary (single word level)
  - Contextual expressive and receptive language (sentence and narrative level)
  - Written language (decoding, encoding, reading comprehension, story-writing skills, phonological awareness skills)
  - Social pragmatics and verbal problem-solving
  - Auditory Memory (short term, working memory, rote memory, contextual memory)
  - Executive functioning (generating ideas, organizing, planning, executing)

What results from the evaluation?
- Recommendations for treatment if necessary (individual, small group, social group, reading intervention)
- Planning measurable goals and objectives
- Recommendations for classroom modifications, or in some cases, classroom placement
- Recommendations for home activities/strategies
- Referrals for additional testing (Neuropsychological, Occupational Therapy, etc.)
- Resources for parents and school (articles, websites, products)

Speech-Language... (continued)

Understanding the differences between speech and language, and knowing what’s involved in evaluating language are important prerequisites for obtaining help.

Language disorders in school-aged children

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<thead>
<tr>
<th>Reading:</th>
<th>Writing:</th>
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<tr>
<td>Difficulty reading and/or sounding out words</td>
<td>Difficulty putting thoughts on paper</td>
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<tr>
<td>Difficulty reading quickly and accurately</td>
<td>Difficulty spelling words</td>
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<td>Difficulty comprehending stories and text</td>
<td>Difficulty writing complete sentences</td>
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<th>Listening:</th>
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<td>Difficulty comprehending spoken information</td>
<td>Difficulty with word-retrieval (finding and using words)</td>
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<td>Difficulty following connected speech</td>
<td>Difficulty with sentence formulation</td>
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<td>Difficulty following complex directions</td>
<td>Difficulty describing and/or defining words</td>
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<td>Difficulty understanding relationships between words, sentences, and ideas</td>
<td>Difficulty responding to open-ended questions</td>
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<td>Difficulty understanding abstract language (figurative language, ambiguous language)</td>
<td>Difficulty using grammar forms and structures</td>
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<tr>
<td>Difficulty understanding peer-group slang, sarcasm, and humor</td>
<td>Difficulty telling or re-telling a story</td>
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<td></td>
<td>Difficulty with pragmatic expression such as topic-maintenance, tone of voice, perspective-taking</td>
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Beware the same or similar names

— by Katie Farraher; senior project specialist

On April 9, 2007, new same/similar name signs became available on inpatient units. The new signs are intended to help staff more easily identify patients who have the same or similar last names. The new same/similar name policy has been incorporated into the “Identity Verification Policy” in the Clinical Policy and Procedure Manual. Where there is more than one patient with the same or similar last name on a unit, signs will be posted in the patient’s room, on the spine of the patient’s chart, on the green medication book, and on the addressograph. A magnet on the white board at the nurses’ station will signal there’s another patient on the unit with the same or similar name. Operations associates will place the signs in the appropriate locations when two or more patients with the same or similar names are identified. If you see the sign next to a patient’s name or on his/her medical record, always verify you have the correct patient before proceeding. Same/similar name signs are available from Standard Register. For ordering details, please see the “Identity Verification Policy” in Clinical Policy and Procedure Manual. For more information, contact Katie Farraher in the Office of Quality & Safety at 6-4709.

Research nurses going beyond the borders of the GCRC

— by Pat Moran, RN, staff nurse, General Clinical Research Center

In an exciting new venture, clinical research nurses are going beyond the doors of the General Clinical Research Center (GCRC) on White 13 to conduct research studies on other units throughout the hospital. GCRC nurses are conducting protocols in the Emergency Department, the Transplant Unit, and the Yawkey Outpatient Care Center. Some studies being conducted in other areas of the hospital include: an evaluation of our Pet Therapy Program, validation of a swallowing-screening tool in patients on the acute Neuroscience Unit, and a study of the impact of Therapeutic Touch. The Robert Wood Johnson Foundation is funding an exciting outcome-based study on the model of care-coordination during a patient’s transition between hospital and home that will enhance our understanding of the contribution of nurses in improving the quality of care in hospitalized older adults.

Some frequently asked questions:
Q: How would a research nurse help me with my study?
A: Research nurses work in ‘clusters.’ Clusters are comprised of several nurses with expertise in Endocrine (diabetes), Reproductive Endocrine, Infectious Disease (HIV, Hepatitis C), Neurology (ALS, Huntington’s disease), cardiac care, GI, wound care, Psychiatry, Pediatrics, and Oncology. Research nurses work collaboratively with study investigators and staff to maintain the integrity of the data and protocol orders, and offer support whether the study is conducted on the research unit or at the bedside.

Q: What if study participants need to be seen on weekends?
A: Research nurses are available seven days a week, 24 hours a day.

Q: How can I find out if my study can take advantage of these services?
A: If an investigator or staff member is interested in utilizing this innovative move toward bedside science, please call the GCRC at 726-3294 or visit our website at http://www.massgeneral.org/gcrc.
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What’s new in OB food service?

—by Susan Doyle, RD, senior manager, Patient Food Services

Do you like breakfast first thing in the morning? Would you rather sleep in? How does tea at 10:00 sound? Or hot chocolate? Perhaps a fresh baked cookie for you and your guest? These are just a few of the personal touches Nutrition & Food Services is implementing to improve care for OB patients. When Blake and Ellison 13 nursing director, Lori Pugsley, RN, approached us for help in better meeting the needs of patients on her units, we put our heads together.

From surveys and bedside feedback on OB units, we know patients don’t like to make menu selections a day in advance. To accommodate this preference, we’ve started distributing menus to patients just prior to meal times. The menu has been re-designed so that fewer items rotate daily, and a special is offered at each meal to ensure variety. Menu items include descriptions, just like you’d find on a menu in a restaurant. And long-term, ante-par-tum patients require special consideration with regard to menu selections.

Survey respondents asked for more vegetarian options, which we now offer. Patients with gestational diabetes asked that carbohydrate information be included on menus so they can make more informed food choices. We now note the carbohydrate content for each selection. Patients expressed different preferences as far as when breakfast should be served, so we now offer each patient a choice between two morning meal times.

And we’re in the process of translating the OB menu into Spanish. A food cart containing complementary snacks and beverages makes the rounds on OB units morning and afternoon to accommodate those off-hour cravings.

These changes have resulted in better service and a cost savings because less food is being wasted.

On the Labor & Delivery unit, we’re working closely with nursing director, Susan Caffrey, RN, to improve the process for providing meals to patients and coaches after babies are born. We are meeting with staff to get their feedback on how best to change the current system.

Our efforts to improve service for all patients is an ongoing, collaborative process.

For more information, contact Sue Doyle, senior manager for Patient Food Services, at 6-2579.

Nutrition service coordinators for the OB units (l-r) are: Julie Mackey, Irene Lenat, Maylin Ochea, and Michelle Durand. Not pictured are: Maria DeRosario, Leyinska Berbere Reyes, Maria Abad, Kate Medina, Kim Mack, and Martine Yoyo.
My name is Ann Quealy, and for the past five years I have worked as a nurse in Anticoagulation Management Services (AMS). AMS is a nurse-managed, primarily out-patient clinic that follows more than 3,700 patients annually for anticoagulant drug-therapy. The most common drug prescribed to our patients is warfarin (Coumadin), though some may receive other anticoagulants (by injection) for intermittent periods of time. Our patients have various and complex medical problems for which anticoagulation is prescribed to treat an existing thrombo-embolic condition or to prevent a serious blood clot from developing.

Using a primary nursing model, nurses in AMS assess, educate, monitor, and manage patients who require anticoagulation therapy. As a primary nurse for more than 470 patients, I am in frequent contact with my patients to discuss various aspects of their anticoagulation-medication needs. My communication is not limited to patients and families; I’m in touch with physicians and other care providers as necessary. Since warfarin is a drug that has high potential to cause harm (bleeding or thrombo-embolic events), it’s important to promote and maintain open communication to ensure best outcomes.

Warfarin has recently been identified as one of the top ten drugs that can cause harm when not managed optimally. Warfarin has a narrow therapeutic index, interacts with many medications, and is impacted by changes in a patient’s health status or activities. Frequent monitoring of patients’ International Normalized Ratio (INR) is necessary in order to evaluate their response to warfarin dosing. INR is a test that evaluates the blood’s ability to clot and is commonly used to monitor the effectiveness of blood-thinning drugs.

Patients can become easily overwhelmed and anxious because of the frequency of testing. There is a high risk for complications, and it’s very important to keep AMS staff informed of any changes in medications or health. My goal is to make my patients’ experiences on warfarin as smooth and safe as possible by encouraging timely communication and education. When I see a patient’s INR trending up or down, I contact them. These phone calls provide me with invaluable information I wouldn’t have if I didn’t prioritize my time to make those calls. Informed by the information I get from these calls, I make better dosing decisions and create opportunities for ongoing dialogue with patients.

My greatest challenge working in AMS has been developing open, trusting relationships with patients when virtually my only contact with them is via telephone. I have met some of my patients face-to-face, but not often. ‘Mary’ is one of those patients.

Mary is a 59-year-old woman who is taking warfarin because she has anti-phospholipid syndrome with underlying systemic lupus erythematosus. It is an auto-immune disorder characterized by anti-phospholipid antibodies in the blood, and it is associated with excessive clotting. I began managing Mary’s anticoagulation care in 2005. She had recently moved from England where she’d had an embolic event to her eye and a cerebral vascular accident (stroke). Mary developed complex partial seizures and, thinking they were related to more clotting in the brain, her anticoagulation was increased to a higher INR range of 4-5. This required much closer monitoring.

Over the phone, Mary told me she was very anxious about having a new physician and having her warfarin managed by the Anticoagulation Clinic because her warfarin needed to be managed so closely. Mary is knowledgeable about her condition and clearly needed to be informed and involved with her care. She told me she’d need to be tested weekly and could only tolerate small dose changes to remain in range.

My therapeutic plan called for me to telephone Mary
Over time, Mary came to admit, “Okay, now you know me.”

I listened carefully to her concerns, obtained her INR, and documented all relevant information to ensure the best dosing decisions. Over time, Mary came to admit, “Okay, now you know me.”

From the beginning, I knew how important it was for Mary to play an active role in her care. I always made time to call her, listen to her concerns, and discuss my plan. Recently, Mary was admitted to the hospital after a fall in which she suffered a fractured elbow and badly bruised hip. Fortunately, she didn’t bleed heavily into her elbow or hip. Her physician wanted to keep her in the hospital for a few days of observation. Her INR results went from low to high on her regular dose in a matter of a few days while she was hospitalized. Her physician was unsure of how to manage her warfarin. Mary told her physician to call me, as she felt I knew her best when it came to her warfarin dosing. The medical team asked me to assist with her warfarin dosing while she was an inpatient and participate in her discharge planning. I was honored and proud to collaborate with her care team around her warfarin management. It’s an unusual situation for an AMS nurse to be asked to consult while a patient is still in the hospital.

I made time that day to go to Mary’s room. I knew my input and presence would mean a great deal to her. It was wonderful to finally meet her and put a face to the voice I’d come to know so well on the phone.

But the real challenge still lay ahead.

Mary was discharged and is slowly recovering from her fall. The need for anti-inflammatory medication and the fall itself (change in health status) contributed to fluctuations in her INRs (high to low over a period of a few days). These fluctuations happened even with the smallest dose adjustment. She hadn’t experienced such notable swings in her INRs before. For Mary this was significant. Prior experience told me that patients requiring higher doses of warfarin per week generally need higher dose increases or decreases to maintain a therapeutic value. Mary’s dose was usually 145mg per week and generally achieved results within a 4–4.5 INR range. Usually a 10–20% increase or decrease is made to a patient’s weekly dose. But I knew Mary could not tolerate even a 2% adjustment following her discharge from the hospital. So I planned to follow her INR response much more closely—every three to four days. In doing so, I could anticipate sooner if a dose adjustment would be indicated.

Because Mary required a high level of monitoring, I asked a colleague in the AMS to be my co-primary nurse during my vacation. I reviewed very specific instructions about Mary’s dosing needs, and I made sure Mary had the nurse’s name and phone number.

Mary has continued to do well and hasn’t experienced any problems. She sounds less worried and thanks me for taking such good care of her. Mary continues to amaze me with her courage and determination to maintain her quality of life. I admire her strength and positive outlook. Every week, and sometimes more frequently, she has to get her blood tested. She goes without complaint or question.

Mary has taught me the importance of listening and involving patients in their care. This personal connection is so important in building trusting, therapeutic relationships and can be achieved whether you’re on the phone or in the room. It’s a bonus for me to meet my patients face-to-face, but I know I don’t need it to gain their trust or respect.

Whether my patients are on anticoagulation medications for a short period of time or for life, my objective is to help them live as normally and complication-free as possible. I believe strongly that to do so requires ongoing communication and collaboration between patients and clinicians, whether it’s on the telephone or by the bedside.

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

Ann demonstrates an expert understanding, not only of the effects and complexity of warfarin treatment, but the care and management of patients receiving this treatment. Ann respected Mary’s knowledge of her condition and how closely she needed to be monitored and dosed. Ann allowed Mary to teach her; Mary allowed Ann to get to know her; and soon Mary recognized she had a caring, skillful partner in her primary nurse. Ann’s ability to reveal her critical thinking, her clinically sound risk-taking and decision-making gives us insight into the complex management of patients receiving this treatment.

Thank-you, Ann.

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In 2001 the Nursing Organizations Alliance was formed to increase the visibility of nursing and have a positive impact on public health through communication, collaboration and advocacy. The Alliance encourages nursing organizations to join and lend a voice to important nursing and health issues. As a delegate to the American Nurses Association’s 109th Congress, I had an opportunity to cast my vote on issues such as the nursing shortage, workplace rights, workplace health and safety, and patient advocacy. This was the last Congress presided over by Barbara Blakeney, RN, former president of the ANA, who is currently an innovation specialist at MGH. As a staff nurse, my practice is directly affected by many of these issues, and my participation in the American Nurses Association led me to the Nurse in Washington Internship (NIWI).

NIWI is a week-long program sponsored by the Nursing Organization Alliance. Topics included how nurses play a role in public policy development; advocacy training; and how to bring your skills back to your state. In advocacy training, we were given a basic civics lesson as Capitol Hill lobbyists cited from the Constitution: “We have the right to petition the government to redress grievances.” We learned how bills are passed and had a private tour of the House of Representatives and Senate chambers.

The Massachusetts team consisted of eight nurses, each representing a professional nursing organization, including the Oncology Nursing Society, The American Society of Peri-Anesthesia Nurses, The American Nephrology Nurses Association, the National Association of Orthopedic Nurses, and the American Society of Pain Management Nursing. Many of the nurses attending the conference were national organization presidents. Due to the large size of our group, we had one spokesperson represent us in discussing generic legislative issues. We had an opportunity at the end of each session to ask how certain bills would affect our individual organizations. The week’s activities culminated with a visit to Capitol Hill.

Because we were from different parts of the state, when we went to the House of Representatives, we split into smaller groups. In the afternoon, my group visited Senator Ted Kennedy and Senator John Kerry’s offices. In every office we shared information about the Nursing Caucus. Three nurses currently serve in Congress, and we asked our Congressmen to go on record in support of the Nurse Reinvestment Act, which was passed in 2002 to help stem the nursing shortage. The bill ensures that Title VIII funding is available to nursing students, nursing faculty, and specialty nurses such as geriatrics nurses. We learned that just passing a law is not enough. The Appropriations Committee must then approve money to support the bill. This was described by lobbyists as a ‘checking account with no checks.’ With 42,000 qualified nursing students turned away from nursing programs last year due to a shortage of faculty, we asked that funds be increased not slashed.

This was a truly a unique experience. Every legislative aide we met asked what we thought about staffing ratios and licensure compacts. They assured me they read and print and count every e-mail they receive. They want to hear from nurses. I am earmarking a section of the Phillips House 21 collaborative governance bulletin board to display bills that affect nursing. I invite you to come read the bills or e-mail me, and I can direct you to an on-line link. It’s so important for your voices to be heard. Nurses have always made a difference!
The MGH Summer Jobs Program may be the solution to your department’s summer-vacation needs. The MGH Summer Jobs Program provides meaningful, part-time employment to Boston youths who apply through MGH partnerships with the Timilty Middle School, East Boston High School, and Health Careers Academy. Through participation in the program, students provide staffing support to departments that may require additional coverage during peak vacation times.

This resource is available through two Community Benefit youth-employment programs: Summer-Works and Jobs for Youth. The programs are supported by an on-site program manager who works closely with participating departments and students to ensure the department’s needs are being met and students understand the scope of their work assignments. Both programs are funded through Human Resources and are available at no cost to the ‘hiring’ departments. The only requirement is a commitment to provide a meaningful work experience for students in a supportive, professional environment.

Students spend 25 hours per week at the worksite, Monday–Friday from early July through the end of August. For more information, call Dan Correia, project coordinator, at 4-6424.

Elizabeth Sheehy, nursing innovator, dies at age 75

The MGH community was saddened to learn of the passing of Elizabeth Sheehy, RN, on April 4, 2007, after a long illness. A graduate of the MGH School of Nursing, Sheehy was a nurse at MGH for many years, serving as a nurse administrator from 1976 to 1983. During her tenure as nurse administrator, Sheehy acted as executive nursing liaison in the planning and design of the Burn Unit. She is remembered fondly by many MGH employees who recall her, ‘extraordinary vision, leadership, and sense of humor.’ One former Phillips House colleague says, “What I remember most about her is that she had an open-door policy. If there was ever anything you wanted to talk about, you could always stop by. She strived to make nursing more professional; she hired bachelor’s prepared nurses before it was the norm. She held us to high standards, always asking what our goals were for the future. We were encouraged to join committees (back before collaborative governance). She made MGH a better place to work for so many of us.”

Linda Gorham Ryan, RN, Phillips House 22 staff nurse and former Sheehy colleague, recalls, “Elizabeth Sheehy was the ‘go to’ person in the old Phillips House, back when each building had its own leadership. She hired me in 1978. I was so sad to hear of her passing; she was a very big part of the history of the Phillips House.”

A visiting professor, consultant to the national Department of Health, Education & Welfare, international nursing representative, and loving wife, mother, and grandmother, Sheehy was the recipient of numerous awards and a contributor to the development of the special bacteria-controlled care units used for extensively injured burn patients.

Elizabeth Sheehy left an indelible impression on the lives of many at MGH. She will be missed.
he MGH Institute of Health Professions is adding Doctor of Nursing Practice (DNP) to its growing list of programs for advanced practice nurses. With a focus on applied clinical knowledge, the new program is designed to educate master’s-prepared nurses for leadership in a broad range of executive, teaching, and clinical settings. Applications for the first DNP class are now being accepted, with courses scheduled to begin in September.

The DNP program was developed in response to the American Association of Colleges of Nursing’s decision that advanced-practice education for nurses should move from a master’s level to a doctoral level by 2015. The practice doctorate focuses on competencies directed toward enhancing population health, clinical investigation and outcome measurement, and effecting change in complex healthcare systems.

Says Karen Anne Wolf, RN, clinical associate professor and associate director of the Institute’s Graduate Program in Nursing, “The DNP program provides elective, interdisciplinary training in education, informatics, clinical investigation, and international health to provide the skills needed to advance the evidence base of nursing and improve the delivery of care.” With this preparation, nurses can take up leadership positions as managers of quality initiatives, executives in healthcare organizations, directors of clinical programs, or faculty responsible for clinical teaching.

Says Jeanette Ives Erickson, RN, senior vice president for Patient Care, “Introducing a nursing practice doctorate at the Institute is a visionary move. The program will expand the pipeline and help build the clinical faculty we desperately need to respond to the nursing shortage.”

Candidates with a master’s in Nursing can complete their DNP requirements in as little as three to six semesters. The curriculum includes 43 credits of instruction, with up to 18 credits awarded for prior work through a post-admissions portfolio process. DNP candidates also complete a clinical residency when they carry out an independent capstone project.

While academically rigorous, the DNP program is designed with flexibility in mind for today’s working professionals. Students have the option of full- or part-time study, a mix of on-line and classroom instruction, and course schedules that can accommodate the demands of career and family.

For more information on the DNP program, visit dnp.mghihp.edu or call 617-726-3164.
The past 100 years have seen many changes in the care of pregnant women and their newborns. In 1900, a woman giving birth would have been home in her own bed, cared for by a midwife, and never separated from her baby or family. Pain medication was not standard practice. One in 150 women died before, during, or after childbirth, and infant mortality was approximately 13%. Hospitals were considered 'unpleasant places' where only homeless or poor women went to give birth.

With the advent of anesthesia, pain medication, and in-hospital deliveries, Obstetrics became a respected profession. The introduction of oxygen, incubators, antibiotics and improved maternal nutrition contributed to a decline of infant and maternal mortality. But along with these advances came a ‘disconnect’ in mother-baby care. Mothers and babies were often separated and cared for by different nursing staffs. Rigid rules evolved to suit hospitals and staff instead of patients. Babies were seen through nursery windows and only brought to their mothers at scheduled times. Today, as you walk through Blake and Ellison 13, you see a completely different picture as the care of parents and newborns has returned to a family-focused approach.

Mother-baby nursing is a nursing plan that supports the family’s role as primary caregivers. Mother-baby nursing promotes education and family-involvement, allowing us to design care plans specifically tailored to each family. This approach honors diversity, fosters discussion, and respects parents’ rights to participate in the care of their infants. As our obstetric and pediatric philosophy states: We believe parents are the most important caregivers their children have; education is the cornerstone of obstetrical care; family-involvement is promoted throughout the process; and we work in partnership with families to design care plans that are right for them.

In the past year, Vincent Newborn Family units have increased the use of the mother-baby care model, whereby the same postpartum nurse cares for both mother and baby. This moves care of the baby out of the nursery and into the mother’s room, which we call, ‘couplet care.’ Baths, hearing tests, blood draws, weighing, vital signs, and medication administration for new babies is now done in the mother’s room in the presence of the family. This approach promotes the family’s role as primary caregivers and recognizes the physical and psychosocial needs of the mother, the family, and the newborn.

Parents are taught to do immersion baths in their room so they can experience the joy of exploring their new baby. This is both an opportunity to learn and to bond with their infant. After the bath, the infant is placed naked on the mother’s chest. This skin-to-skin contact has enormous developmental benefits and is another opportunity to bond. The smell and touch of a parent calms the baby, reduces anxiety, promotes weight-gain, and helps the baby become oriented and aware of her outside world.

Staff nurse, Joan Lovett, RN, says, “I think it’s great for parents to see their baby receive treatments, such as injections or medications. It prepares them for when they take the baby to the pediatrician. Before, we used to hide it from the family thinking it was the right thing to do. Now, we get to know families while they’re here and support them through these experiences.”

Says staff nurse, Laura O’Toole, RN, “I feel as if parents trust you more because you’re not taking their baby away to do procedures. They see you do it and how their baby responds. This model aids in communication so teaching occurs much more spontaneously. I find the atmosphere more relaxed and patients’ anxiety decreased. When parents see their baby wiggling in the bath, it all becomes real to them.”

Every effort is made to avoid separating mother and baby, but there are times when this isn’t possible. Mothers may be exhausted, have pain-management issues, or babies may need closer monitoring in the nursery. Nurses individualize care so the needs of each family are met. In some cultures, family caregivers for newborns instead of the mother, and this needs to be respected. The staffs of Blake and Ellison 13 are vigilant to these special needs and strive to make the family’s birthing experience a ‘family affair.’
Coaching Boys to Men

Partners Employee Assistance Program brings this seminar to you in collaboration with MGH Men Against Abuse/Domestic Violence Working Group

As fathers, brothers, coaches, teachers, uncles and mentors, men are in a unique position to promote positive attitudes to the next generation to prevent violence before it begins.

The Family Violence Prevention Fund has started a global campaign called, “Coaching Boys to Men” to engage men in the prevention of violence against women and children. This seminar is designed to motivate us to prevent violence and give us the tools and information to guide our young men.

Thursday, May 17, 2007
12:30–1:30pm
Thier Conference Room

Clinical Pastoral Education fellowships for healthcare providers

The Kenneth B. Schwartz Center and the department of Nursing are offering fellowships for the 2008 MGH Clinical Pastoral Education Program for Healthcare Providers

Open to clinicians from any discipline who work directly with patients/families and who wish to integrate spiritual caregiving into their professional practice

This is a part-time program

Mondays from 8:30am–5:00pm
Additional hours are negotiated for the clinical component

Deadline for application is September 1, 2007
For more information call the Chaplaincy at 726-4774

Blum Center goes wireless

The Maxwell & Eleanor Blum Patient and Family Learning Center now has a wireless signal available for MGH patients and visitors. The joint project between the Blum Center, Patient Care Services Information Systems, and Partners Information Systems gives patients and families direct Internet access separate from the Partners network. The service comes in response to numerous requests from families and visitors who need to be in contact with work and others while visiting loved ones in the hospital.

The signal can be accessed from the Blum Center; on the first floor of the White Building. Patients and families are given instructions on how to access the Internet from their laptops. We are pleased to be able to provide this service to MGH patients and families.

The Blum Center is open Monday–Friday, 9:30am–6:30pm; Saturday, 11:00am–3:00pm. The center is closed on Sundays and all major holidays.

Nurse Recognition Week
May 6–11, 2007

Sunday, May 6, 2007; Staff Nurse Breakfast 7:00–9:00am, Trustees Room, Bulfinch 2

Monday, May 7, 2007
“Nursing Makes a Difference: a Global Perspective” presented by Beverly Malone, RN president, National League for Nursing 10:00–11:00am, O’Keeffe Auditorium (Reception to follow: O’Keeffe Lobby)

“Engaging the Masses: Making Magnet Matter” presented by: Patricia S. Yoder-Wise, RN president, American Nurses Credentialing Center 1:30–2:30pm, O’Keeffe Auditorium (Reception to follow: O’Keeffe Lobby)

Tuesday, May 8, 2007 (Research Day)
Nursing Research Scientific Sessions 10:00–11:30am, O’Keeffe Auditorium

“Music as a Therapeutic Intervention in the Care of Neuromuscular and Neurosurgical Patients” presented by: Marion Phipps, RN; Anastasia Tsiantoulis, RN; and Diane Carroll, RN

“Psychological Insulin Resistance: a Study of Patients’ Attitudes, Perceptions and Fears” presented by: Mary Larkin, RN, and Virginia Capasso, RN

13th Annual Yvonne L. Munn Nursing Research Lecture and Awards 1:30–3:00 pm, O’Keeffe Auditorium

“Cultivating a Program of Research: Merging Clinical and Research Interests” presented by: Cheryl Beck, RN professor and coordinator; Honors Program and co-coordinator; Doctoral Program, University of Connecticut School of Nursing

Presentation of the 2007 Yvonne L. Munn Nursing Research Awards (Reception to follow: Trustees Room, Bulfinch 2)

Wednesday, May 9, 2007
“Florence Nightingale: a Medical Revolutionary” performed by: Kathleen Duckett, RN 10:00–11:00am, O’Keeffe Auditorium (Reception to follow: O’Keeffe Lobby)

MGH Nursing Research Fair 12:00–4:00pm, under the Bulfinch Tent

Thursday, May 10, 2007
Staff Nurse Breakfast 7:00–9:00am, Trustees Room, Bulfinch 2

“Nurses: Everyday Heroes” Jeanette Ives Erickson, RN, chief nurse 2:00–3:00pm, O’Keeffe Auditorium (Reception to follow: O’Keeffe Lobby)
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Unacceptable abbreviations

**Question:** Why are some abbreviations unacceptable when documenting in the medical record?

**Jeanette:** The Joint Commission and other agencies, including the Institute for Safe Medication Practices and the National Coordinating Council for Medication Error Reporting and Prevention, have found that certain abbreviations, symbols, and dose designations contribute to medication errors. These organizations advocate banning these abbreviations and dose designations to help decrease the incidence of medication errors. Studies suggest the greatest fear of hospitalized patients is receiving the wrong medication, and nearly 50% of preventable medication errors occur when drugs are prescribed.

Beginning in 2003, the Joint Commission identified improved communication among caregivers as one of its National Patient Safety Goals. One provision of this goal requires hospitals to standardize a list of abbreviations, acronyms, and symbols that should not be used.

**Question:** How are we doing with our documentation? Has there been improvement?

**Jeanette:** Our policy, entitled, “Abbreviations: Appropriate Use to Prevent Errors,” lists abbreviations that shouldn’t be used at MGH. Unacceptable abbreviations apply to all hand-written and free-text electronic documentation. In a recent audit of patient records, nursing progress notes, and medication-administration records, most unacceptable abbreviations were not present, but the following culprits were found:

- “U” was used instead of “units” ten times
- “IU” was used instead of “international units” once
- “HS” was used instead of “at bedtime” six times
- “SS” was used instead of “sliding scale” twice
- “MgSO4” was used instead of “Magnesium Sulfate” once
- “QOD” was used instead of “every other day” once

Our computerized systems do contain abbreviations such as, QD and QOD. That is acceptable. It’s only when these abbreviations are written by hand or typed into the computer that they’re unacceptable. When orders are transcribed onto medication sheets, no unacceptable abbreviations can be used.

**Question:** How can I find out more about this policy?

**Jeanette:** The policy, “Abbreviations: Appropriate Use to Prevent Errors,” can be found in the on-line Clinical Policy and Procedure Manual, which can be accessed through Partners Handbook. Pocket cards and cards you can attach to computer terminals containing the list of Unacceptable Abbreviations have been distributed in the past and are available through Patient Care Services Information Systems at 6-3116.