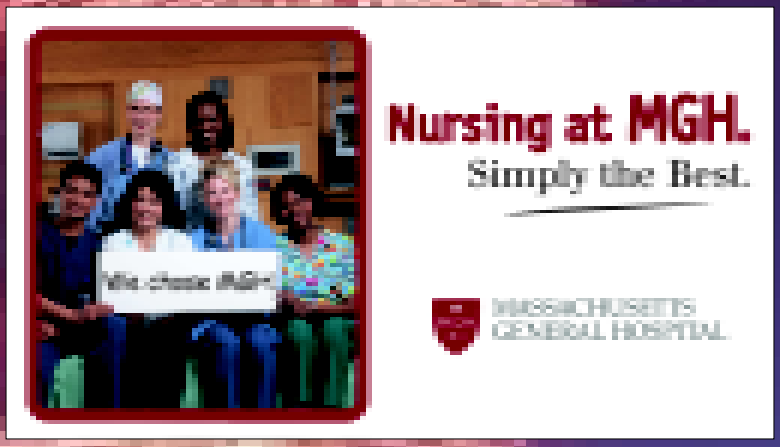
Caring HEADLINES

July 18, 2002

Inside:



No lost opportunities!

At the suggestion of the Staff Nurse Advisory Committee, the MGH Nursing banner: "Simply the Best," was prominently displayed on a billboard near the Charles Street/MGH T Station over the July 4th weekend. At this location, the banner was visible to thousands of passers-by making their way to the esplanade for the annual Independence Day celebration.

MGH Patient Care Services

Working together to shape the future

Drug diversion: the problem, the policy, our response:

an interview with Joan Fitzmaurice, RN, director of the MGH Office of Quality & Safety

There has been much talk in the news of late about the issue of drug abuse and drug diversion in our nation's hospitals and nursing homes. A front-page article in The Boston Sunday Globe *recently, entitled, "Critical care: when nurses steal drugs on the job," spurred many conversations right here in our own hospital. To learn more about this issue and how it affects us, I asked Joan Fitzmaurice, RN, director of the MGH Office of Quality & Safety to speak with us. My interview with her follows:*

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

Jeanette: Joan, we know that drug diversion is a problem in many hospitals and nursing homes across the country. Is it a problem here at MGH?

Joan: I can't tell you it's not a problem; but I can tell you it's not a big one. Incidents of drug diversion at MGH are extremely rare.

Jeanette: What constitutes drug diversion at MGH?

Joan: I would suggest that employees read our Substance Abuse Policy in the *HR Policy & Procedure Manual* for a detailed explanation, but for the purposes of this conversation, drug diversion is any unauthorized use of drugs, which includes procuring drugs for personal use or profit. The policy pertains to all employees.

Jeanette: If staff suspect that a co-worker may be diverting drugs, what should they do?

Joan: We operate under the assumption that if someone is abusing or diverting drugs they're doing so for reasons of illness or addiction (until proven otherwise). For that reason, if you suspect a co-worker has a problem, we suggest discussing it with your manager in a sensitive and confidential way.

Keep in mind that there may be ramifications beyond what you know about the situation. Managers are specially trained to deal with sensitive issues.

Jeanette: Does MGH/PCS have a policy for addressing drug diversion?

Joan: Again, our approach is based on the belief that individuals abusing drugs have a problem or an illness. Our concern is protecting our patients, the patient-care environment, and each other. Our goal is to get the employee into an assistive program, giving him/her every opportunity to recover, while at the same time meeting our regulatory requirements.

Jeanette: Can you walk us through the steps of what would happen if an employees is suspected of diverting drugs?

Joan: As soon as an incident or event is brought to our attention, we initiate an internal investigation. Within twenty-four to forty-eight hours, I call a meeting of all participants, including an HR representative, unit leadership, and anyone else directly involved in the situation.

Because we have so few incidents, most people have little or no experience with these issues. That's where my participation becomes key. I am the one consistent entity across all set-

continued on page 7

BORN
Substance Abuse & Rehabilitation Program (SARP)

In 1989, the Massachusetts Board of Registration in Nursing (BORN) established a rehabilitation program to assist nurses with alcohol and/or drug problems. This five-year program is designed to provide adequate safeguards and monitoring to protect the public health and safety, maintain professional standards of nursing practice, and support nurses' ongoing recovery and safe return to practice.

The rehabilitation program provides assistance to nurses through individualized treatment plans and monitoring. It may serve as a voluntary alternative to the disciplinary process, provided nurses cooperate fully with the recommended Treatment Contract and comply with the requirements for monitoring of their continued well-being until completion of the Program.

Licensees assume financial responsibility for all aspects of the rehabilitation program.

MGH Substance-Abuse Policy

Employees are Massachusetts General Hospital's most valuable resource and, for that reason, their health and safety are of paramount concern.

Massachusetts General Hospital is committed to maintaining a safe, healthy and efficient environment that enhances the welfare of its employees, patients and visitors. It is the policy of the Hospital to maintain an environment that is free from impairment related to substance abuse by any of its employees.

Our patients and the Hospital expect employees to arrive for work in a condition free from the influence of alcohol and drugs, and to remain so while they are on the job and to refrain... from their use, possession, sale or unlawful distribution on Hospital property. All new employees must sign the MGH Drug-Free Workplace Statement upon hire.

For more detailed information, see the HR Policy & Procedures Manual

New restraint policy; and information about HIPAA

The Fielding the Issues section of Caring Headlines *is an adjunct to Jeanette Ives Erickson's regular column. This section gives the senior vice president for Patient Care a forum in which to address current issues, questions or concerns presented by staff at meetings and venues throughout the hospital.*

Question: I've heard we're making changes to our restraint practice and policy. Is that true?

Jeanette: The use of restraints has long been considered an effective means of protecting some patients. Recent research indicates that restraints actually increase the risk of injury to patients. In addition, patients report feeling a loss of dignity as well as physical discomfort in situations where restraints have been used. In response to these findings, we want to move toward limiting overall restraint use. Restraints should be considered only after an individualized patient assessment has been completed and less restrictive interventions have been explored.

FYI: regulatory agencies are placing a greater emphasis on minimizing the use of restraints.

Question: How will the change be rolled out?

Jeanette: A comprehensive program to address patient risk is being rolled out this month and includes:

- components to assess patients' risk for harm to themselves and others
- alternative interventions to keep patients safe, including continuous and intermittent use of observers
- in circumstances where restraints are indicated, there are changes in the frequency with which patients are assessed and orders written to continue restraints.

Support for this practice change will include:

- comprehensive education
- revisions to the observer program
- revisions to the restraint policy
- availability of alternative interventions
- consultations with clinical nurse specialists regarding complex patients

Question: What are the specific changes to the policy?

Jeanette: Standards describe the use of restraints in two situations:

- medical and post-surgical care
- emergency use for behavioral management

In all circumstances, restraints should be considered only as a temporary intervention. Because the use of restraints is no longer protocol-driven, even after medical and post-surgical care, a physician's order is required before applying any restraint. The decision must be based on an individualized assessment of the patient's risk and an examination of alternative interventions. The patient's behavior should be assessed every two hours to re-evaluate the appropriateness of continued restraint use. The goal will always be to safely move toward less restrictive alternatives. If the use of restraints continues to be indicated, a new physician's order must be written every 24 hours.

When restraints are used in an emergency situation for behavioral management, a physician needs to assess the patient face-to-face within one hour of restraints being applied. In this case, the patient's behavior should be assessed every 15 minutes for appropriateness to move to less restrictive alternatives. If restraint use continues to be indicated, a physician's order must be written every four hours for adults; every 2 hours for children aged 9-17; and every hour for children under age 9.

Question: When will the changes be implemented?

Jeanette: The education of clinical staff to the Patient at Risk Program will occur over the summer. Changes include edits to Provider Order Entry and a new Patient at Risk Flow Sheet (which will allow clinicians to track patients' response to alternative interventions and, if necessary, their safety while restrained).

Question: I've heard a lot of talk about HIPAA recently. What exactly is HIPAA?

Jeanette: HIPAA stands for the Health Insurance Portability and Accountability Act. It describes standards for the privacy of individual health information. It covers health plans, healthcare clearing houses and healthcare providers who conduct financial and administrative transactions electronically.

Question: When does HIPAA take effect?

Jeanette: The act took effect on April 14, 2001. Most covered entities must comply with the privacy rules by April 14, 2003. Small health plans have until April 14, 2004.

Question: Why was HIPAA enacted?

Jeanette: HIPAA creates national standards to protect an individual's personal health information and gives patients access to their medical records. Under the new act, covered entities are required to make reasonable efforts to limit the disclosure of, and request for, protected health information. Security and privacy standards promote a higher quality of care by ensuring that consumers' personal health information is protected from inappropriate use and/or disclosure.

Currently, healthcare providers, pharmacies, and other healthcare entities use a variety of systems to track health information. Insurers and providers spend a lot of time and money ensuring that each claim contains the required format, codes, and other details. The hope is that by implementing national standards, lowering the cost of developing and maintaining software, and reducing the time and expense needed to handle transactions, billions of dollars can be saved.

Educational Offerings and Event Calendar Now Available On-Line

The Center for Clinical &Professional Development now lists educational offerings on-line at

http://pcs.mgh.harvard.edu

To access the calendar, click on the link to CCPD Educational Offerings.

For more information or to register for any program, call the Center at 6-3111.

Cameron Calef receives Cronin-Raphael Award for Patient Advocacy

Award recipient, Jan Cameron Calef, RN, wipes a tear as senior vice president for Patient Care, Jeanette Ives Erickson, RN (left), and nurse manager, Kathy Myers, RN, look on.

Phillips House 21 staff nurse, Jan Cameron Calef, RN, was honored at an informal reception, June 24, 2002, as this year's recipient of The Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy. The Cronin-Raphael Award was established in 2000 to recognize the extraordinary care provided to Cronin and Raphael by the staff of Phillips 21, and to encourage the recognition of caregivers who consistently identify individual patient needs and advocate to ensure those needs are met.

In a letter of recommendation, one of Cameron Calef's colleagues wrote: "Jan is always willing to do the unconventional if it brings joy or peace to a patient. She has a way of helping people feel safe in the most difficult situations."

Cameron Calef was the unanimous choice of her colleagues to receive this award.

Above (l-r): Barbara Dunderdale, RN; Lillian Ananian, RN; Lori Powers, OC; Nancy Dorris, OC; Ed Ciesielski, RN; Aileen Tubridy, RN; David Noonan; Michael Noonan; and a Noonan family friend
At right: David and Michael Noonan with televisions, VCRs, and CD players

A gift that keeps on giving

Patients on Ellison 9 and 10 are resting a little more comfortably lately thanks to a generous donation from David and Michael Noonan in loving memory of their brother, Stephen. Following Stephen's death, the Noonan brothers created The Stephen Noonan Foundation and have sponsored two memorial golf tournament to raise money for scholarships, research and charitable gifts in Stephen's name.

Recently, the Noonans delivered four televisions, four VCRs, and two CD players for use by patients on Ellison 9 and 10, free of charge.

Said David Noonan, "We wanted to do something that would make a difference in a patient's day. And this is something Stephen would have liked."

Hepatitis C: what clinicians need to know

—by Susan Loomis, RN, MSN, CS
director, Occupational Health Services

Hepatitis C is a virus that causes liver disease. While similar to hepatitis A and B in regard to the organ it affects, it is caused by a completely different organism. Hepatitis C may be of greater concern to healthcare workers than other infectious diseases because unlike Hepatitis B, there is no vaccination for hepatitis C; and unlike HIV, there are no effective FDA-approved post-exposure medications to prevent transmission.

Recently, information has appeared in the media and brochures have been disseminated via public-health agencies alerting healthcare workers to the risks of hepatitis C (HCV) exposure. While it is important to recognize the risks, it is also important to understand that standard precautions and on-going attention to safety recommendations are the best means of preventing transmission.

HCV is the most common chronic blood-borne infection in the United States today. The Centers for Disease Control (CDC) estimate that approximately 1.8% of the population is infected with HCV, and many of these individuals don't know they're infected, because they're not currently experiencing symptoms of the disease.

Clinicians should understand that healthcare workers are infected with HCV at about the same rate as the general population. The average incidence of transmission following a needlestick to an HCV-positive patient is 1.8%, and it appears the risk is even lower if the exposure involved a solid sharp or splash, or if the body fluid involved was something other than blood.

At MGH, following a blood or body-fluid exposure, care is provided to employees through the Occupational Health Service. Post-exposure care is geared toward identifying the source patient's HCV status and early testing of the exposed employee. HCV testing for employees may begin as early as four weeks after high-risk exposure to allow for early identification of transmission. Early recognition is crucial to allow for expert evaluation by a hepatologist and treatment, if necessary, to prevent damage from HCV infection.

Most HCV testing checks for the presence of HCV antibodies. These tests are limited in that they don't distinguish acute from chronic or resolved infection, so if positive, additional testing is necessary. Subsequent steps may include confirmatory testing for positive antibodies or testing for the presence of HCV RNA.

Healthcare workers exposed to HCV do not need to take any special precautions, although employees exposed to blood and body fluids should refrain from donating blood, serum, plasma, organs, tissue, or semen for at least six months.

The best course of action to prevent HCV is using standard precautions and safer sharps as much as possible to decrease the risk of exposure.

For more information about hepatitis C and/or preventing the risk of exposure, please call the Occupational Health Service at 6-2217.

An Arrow Through the Heart: an MGH Patient Shares Her Story

Author, Deborah Daw Heffernan and representatives from the cardiac surgical nursing staff will explore the MGH experience from the perspectives of the patient and the provider.

All clinicians are welcome

Thursday, July 18, 2002
1:30–2:30pm
O'Keeffe Auditorium

Reception to follow

1.2 contact hours

For more information, call 6-3111

NU College of Nursing honors DMAT nurses

On Friday, June 14, 2002, the Northeastern University College of Nursing's class of 2002 donated a plaque honoring the work of nurses at Ground Zero following the September 11th attack on the World Trade Center. Traditionally, the graduating class donates something to the NU Nursing Program, but after hearing a presentation about their experience at Ground Zero by Marie LeBlanc, RN, nurse manager and supervising nurse of the DMAT team, the 2002 class decided to honor their contributions instead. The plaque will be displayed in a new building in the College of Nursing.

FDNY Burn Center Foundation thanks MGH/Shriners nurses

The New York Firefighter's Burn Center Foundation extended their heartfelt thanks to MGH nurses, Jennifer Albert, RN; Frank Curtis, RN; Bob Droste, RN; Pam Griffin, RN; Julie Ann MacGrath, RN; Barbara McGee, RN; Dawn Moore, RN; Sally Morton, RN; Michael Spiro, RN; and Shriners nurse Patrick Kadillac, RN, for their contributions above and beyond the call of duty in caring for victims of September 11th in burn units in New York City. Each nurse received a photo of a plaque dedicated to those who made a difference and a commemorative Maltese cross pin honoring the 343 members of the FDNY who perished in the attack.

Sometimes caring is quiet …and sometimes it's loud

Sally Lai, RN
staff nurse, White 8

My name is Sally Lai, and I am a staff nurse on the White 8 Medical Unit. As a nurse, my goal and purpose is to help patients reach their optimal level of health and functioning, despite the color of their skin, race, or social status. A clinical situation on White 8 recently reminded me how important this concept is in my practice. I felt I made a difference in a patient's life simply because I believe in this concept of care.

This exemplar is about my experience caring for Mr. C, a black, middle-aged, homeless man, who was admitted to the hospital with complaints of back pain. At some point during his stay, he developed pleural effusion in his right lung, which needed to be treated as well.

According to other clinicians on the unit who had taken care of Mr. C, he was only receptive to taking pain medications and refused all other medications or attempts to care for him, such as taking vital signs, blood draws, and any other type of diagnostic or preventive procedures. Mr. C had been bed-bound for a long time. He said he was unable to get out of bed. He could be demanding, rude, and unappreciative. For this reason, many staff on the unit were unable to get along with him despite repeated efforts to be nice to him.

The first day I cared for Mr. C, he refused everything except pain medication. He wouldn't allow me to draw blood, or check his vital signs. When transportation arrived for Mr. C to go for a diagnostic procedure that he'd agreed to earlier, he refused to go. Though I'm a strong advocate for patient autonomy, I felt that Mr. C shouldn't have agreed to the procedure if he hadn't intended to go.

Mr. C called the front desk looking for me multiple times. He wanted me to bring him water, juice, soda, food, pain medications, as well as a "boost." He called every five to ten minutes. I began to feel more like his servant than his nurse. This made me feel like I wasn't doing my job as a nurse, and that bothered me. I realized I wasn't helping him get better in terms of his health and overall functioning.

When I went into Mr. C's room to attempt to check his blood sugar, he wanted me to get him more juice before I did anything to him. I told him I'd get his juice after I did what I had to do. He got very angry. He told me to, "Get out of his face."

I was so dissatisfied with his response that I said, "Mr. C, why do you refuse everything I try to do for you? I'm your nurse. I'm trying to help you get better. You wouldn't be in the hospital if you weren't sick. All we want to do is help you get better. How am I supposed to help you if you don't help yourself? Tell me! I'm not your servant, I'm not just here to bring you food and narcotics. I can't treat you if you won't let me assess you."

He looked at me and said, "Get out of here!"

I told him I'd stay out of his room until he decided he wanted my help. I walked out thinking I hadn't accomplished anything. But there was nothing I could do if he refused my care. And it was unreasonable for me to put up with that kind of verbal abuse.

About an hour later, Mr. C called for his nurse. When I went to his room, he asked me for pain meds. I told him very calmly that I would be glad to give him his pain meds, but that I had to do my part in assessing him first. Mr. C agreed. He allowed me to take his vital signs, check his blood sugar, and he also took all his medications. Mr. C was cooperative for the rest of the day.

Later, I went into his room and apologized for raising my voice. I explained to him that it was my job to take care of all my patients, and by refusing my care, he wasn't allowing me to do my job. Mr. C expressed some feelings about trust issues in the hospital because of his race and the fact that he was homeless. He said he appreciated my anger, which was driven by concern for him as a person and frustration at not being able to help him.

Since that day, other nurses continue to report behavior problems with Mr. C; they still say he isn't the most pleasant patient to work with. However, I saw a man who had changed from being bed-bound and completely dependent to someone who was ambulatory and independent, and most important, compliant with his medical care.

This situation impressed me because my role as a nurse is not to change a patient's personality, but improve his health and promote an optimal level of functioning. It doesn't bother me that Mr. C continues to have an unpleasant attitude, because I had witnessed the medical improvement of a patient under my care. And to me, that's what nursing is all about.

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

As clinicians we meet patients from all realms of life who cope with illness in many different ways. Sometimes coping takes the form of anger or denial. There's usually one common denominator that helps us get through: and that's our ability to care. As soon as Sally helped Mr. C realize that her actions were an extension of her concern for him, Mr. C became cooperative.

As Sally showed us, sometimes caring is quiet, and sometimes, it's loud! Thank-you, Sally.

Chaplaincy holds Interfaith Vigil for Peace

Leading employees in an interfaith service of peace and healing on June 24, 2002, are members of the MGH Chaplaincy (l-r): Ben Hall; Karen Schmidt; Father Phillip McGaugh; Sheila Crowell; Imam Talal Eid; Rabbi Susan Harris; Mike McElhinny; Reverend Mary Martha Thiel, director; Reverend Charles Kessler; Linda Knight; and Father Celestino Pascual.

Clergy from all faiths offered readings and personal observations about peace, understanding, and the hope for all peoples of the world to one day live together in harmony on this planet.

Amen.

Jeanette Ives Erickson (Drug Diversion)

continued from page 2

tings. Other participants change from incident to incident; I'm there to ensure consistency and fairness in every situation.

Jeanette: And if the investigation indicates that an employee has taken or diverted drugs?

Joan: If the investigation warrants, or if a nurse comes forward and admits to using or diverting drugs, a period of 'investigatory leave' is initiated. During this time the nurse does not work, but still gets paid. Investigatory leave usually lasts for a week, maybe two.

Jeanette: Is there any difference in our policy if an employee is diverting drugs for re-sale (profit) versus personal addiction or illness?

Joan: If it's determined that an employee is diverting drugs for the purpose of selling them, that scenario would result in termination of employment, and Police & Security may have to exercise their external (criminal) reporting responsibilities.

Jeanette: And if an employee is diverting drugs for personal use due to addiction?

Joan: We are required to report any knowledge we have of drug abuse to the Massachusetts Board of Registration in Nursing (BORN). At the same time, we would encourage nurses to enter the substance abuse program offered by BORN in an effort to help them move toward recovery.

BORN's Substance Abuse Rehabilitation Program (SARP) is a five-year program that involves voluntary compliance with a comprehensive rehabilitation regimen.

Nurses accepted into SARP are initially prohibited from practicing. As they progress in the program, they may be able to return to work, usually in a limited capacity with some restrictions (no access to drugs) and close supervision. When they do re-enter the workplace, HR representatives are available to assist them in locating positions in settings that don't require handling drugs.

We have in the past worked with staff enrolled in SARP and others who have completed the program to successfully re-enter and resume their nursing practice.

Jeanette: Thank-you, Joan. That's very helpful.

Updates

Please join me in welcoming Patricia Flanagan, RN, MSN, to her new position as Emergency Department clinical nurse specialist. Tricia joins clinical nurse specialist, June Guarente, RN, MSN, in supporting patient care, education and research in the ED.

Cynthia (Cindy) LaSala, RN, has also joined our leadership team as the clinical nurse specialist for White 9.

Welcome, Patricia and Cindy.

The role of the CNS in the fight against nosocomial infection

—by Katie Brush, RN, MS, CCRN, FCCM
clinical nurse specialist

Katie Brush, RN, MS, CCRN, FCCM
clinical nurse specialist

My name is Katie Brush. I am the clinical nurse specialist for the Surgical Intensive Care Unit (SICU), a 20-bed general surgical and trauma ICU. My role as the CNS is frequently about troubleshooting and facilitating. I look for obstacles to excellence in patient care and facilitate ways to remove them. Obstacles to excellence can be related to systems, education, practice and technology. Rarely, however, do events or problems occur in isolation, and sometimes they require a multi-faceted, multi-disciplinary approach. Generally, the more complex a problem is, the more complex and collaborative the solution needs to be.

My philosophy about multi-disciplinary collaborative practice and improved patient-care outcomes was recently rewarded when I was inducted as a fellow in the American College of Critical Care Medicine. I share this honor with only 29 other critical care nurses in the world.

One example of the nature of my work is the battle against nosocomial infection (infections acquired in the hospital). Nosocomial infections present an obstacle to excellent care. In 1998, the Infectious Disease Team approached the Critical Care Committee about the excessive number of microbiological cultures being sent for critically ill patients. I was asked to join a multi-disciplinary task force whose mission was to review the literature, benchmark practice locally and nationally, and make recommendations for obtaining cultures in critically ill patients. We completed our review and made recommendations about frequency of cultures, skin preparation, and the elimination of some practices altogether. From this work, the ICU Culturing Guidelines were adapted into critical-care practice. My role was to ensure nursing and physician awareness of, and adherence to, the practice change. This multi-disciplinary change in practice resulted in a reduction in the number of cultures sent for critically ill patients. This task force recently re-convened (with some changes in membership) to ensure that practice remains current and that the recommendations of the committee are implemented throughout all critical care units. This time, I will be joined by several of my critical care CNS colleagues.

The Critical Care Committee joined forces with the Microbiology Laboratory to address issues related to false-positive blood cultures resulting from skin-surface bacteria. The change in skin preparation to 2% tincture of iodine-surface preparation has been shown to significantly reduce skin contaminants in blood cultures. With a reduced number of false-positive blood cultures, patients would be less likely to be put on antibiotics unnecessarily.

In an effort to reduce the number of false-positive blood cultures, Susan Tully, RN, nurse manager of the SICU, Bill Hurford, MD, medical director of the SICU, and I agreed to trial the new skin-preparation package in 1999. The package included all the materials necessary to draw blood cultures, including the addition of a 2% tincture of iodine swab. The package, but most importantly the 2% tincture of iodine swab, was successful in reducing the number of false-positive blood cultures. We worked together with the Center for Clinical and Professional Development (CCPD) to train nurses and critical-care technicians in the new procedure. The trial was a success. The practice change was implemented hospital-wide by the CCPD and the Nursing Practice Committee.

Overuse of antibiotics and the development of multi-drug-resistant organisms (MDROs) is well documented in the literature. In the spring of 2001, we were faced with a growing number of nosocomial MDRO infections *(*methecillin-resistant *staphyloccocus aureus*, vancomycin-resistant *enteroccocci*, *clostridium difficile*), and a rising rate of line-related bacteremias. The most obvious and concerning aspect of this problem was that cross-contamination was resulting in infection. The less obvious aspects included longer ICU stays, longer overall hospitalizations, an increase in nursing workload due to contact precautions, and cancellation of surgeries due to reduced bed capacity on units and in ICUs. We were challenged by Infection Control to correct the problem in the SICU.

The initial recommendation from Infection Control was to place all patients on glove precautions and check all patients, at admission, for MDROs. We began the process of decreasing MDROs by examining our own practice around hand-disinfection, managing patients, and shared equipment. We began documenting MDROs. I kept staff (nurses and physicians) informed of culture reports, both positive and negative swab results.

We had been using the hand disinfectant, Calstat, for a few years, but now realized we needed dispensers at every location a clinician would be upon entering or leaving a patient's room. Susan Tully worked with our operations coordinator and Environmental Services to install additional Calstat dispensers. I made hot pink "Glove Precaution" signs that included instructions to use Calstat upon entering and leaving a patient's room.

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CNS

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We changed our philosophy about what surfaces in the room could be potential sources of contamination. Our belief was that although patients may rarely come in direct contact with surfaces in their room, caregivers could serve as vectors and transmit bacteria via gloves to every surface in the room. We instituted 'precautions upon entrance to the room.' Charts were kept outside patients' rooms to ensure they didn't become vectors as well. We changed our practice around terminal room cleaning, stocking, and transport. Unit service associates were re-educated on how to clean and stock patients' rooms for patients on glove as well as contact precautions.

We developed a culture of constructive confrontation when colleagues didn't comply with infection-control practices. Including unit staff, visitors and consultant services, perhaps 200 people enter the SICU each day (clinicians and support staff from Nursing, Anesthesia/Critical Care, Surgery, Respiratory Therapy, Physical Therapy, Occupational Therapy, Food & Nutrition Services, Social Services, Case Management, Radiology, the Vascular Lab, orthopedic technicians, and others). We challenged each of these disciplines to become compliant with proper hand disinfection and glove precautions. When educational needs arose they were addressed immediately. When products needed to be changed or obtained, they were.

It was determined that vinyl gloves had the weakest tensile strength of most commonly used gloves. They became porous in a very short amount of time, affording the wearer and the patient limited protection. We eliminated them from use for all but the most skin-sensitive wearers. We reinforced the need for hand disinfection with families. Our work resulted in a significant decrease in VRE, MRSA and *C. difficile* infections. Staff joke that I'm like a pit bull around this issue, but continued vigilance is the key to success.

A different approach to line-related bacteremias (LRBs) was needed. We adapted our experience with skin disinfection and 2% tincture of iodine to central-line skin preparation. The SICU prep procedure for central lines was changed to include a wide prep with povidone iodine and a narrow prep at the insertion site with 2% tincture of iodine. To aid in this methodology, we eliminated povidone swab sticks from our inventory.

We discussed central line catheters. The two central venous catheters used most in the SICU are the triple and quad lumens. The quad lumen is coated with silver sulfadiazine and chlorhexidine. The triple lumen offers no antibiotic coverage. We elected to trial an FDA-approved catheter made of Oligon. Oligon is polyurethane mixed with carbon, platinum, and silver. This material releases silver ions that repel bacteria and appear to prevent both internal and external colonization of catheters. We were able to determine that although the Oligon triple lumen was more expensive than our traditional catheter, we were actually saving money in terms of LRBs. The reward for this financial expenditure and change in skin preparation was achieving the lowest LRB rate of all ICUs within the Partners Healthcare System.

We have created a culture in the SICU where management of infection control is everyone's responsibility. We are always looking for ways to improve, and we strive daily to maintain our gains. I may have championed many of these initiatives, but the credit goes to the members of the SICU team, especially nurses and the Anesthesia/Critical Care staff. Patient-care outcomes are achieved by hard work and collaborative practice. I believe I work with the greatest team of healthcare professionals and non-professionals anywhere.

Call for Portfolios
PCS Clinical Recognition Program

The Patient Care Services Clinical Recognition Program is now accepting portfolios for advanced clinicians and clinical scholars.

Portfolios may be submitted at any time; determinations will be made within three months of submission.

Refer to the http://pcs.mgh.harvard.edu/ website for more details and application materials, or speak with your manager or director.

Completed portfolios should be submitted to The Center for Clinical & Professional Development on Founders 6.

For more information, call 6-3111.

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or by e-mail: ssabia@partners.org

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Blake 7 MICU has much to celebrate!

On Wednesday, June 17, 2002, the Blake 7 Medical Intensive Care Unit (MICU) held a special luncheon to celebrate the tremendous success they have experienced in the past year. And there was much to celebrate, including:

- the hiring of 25 registered nurses within the past year, eight of whom have already or will soon participate in the New Graduate Critical Care Nurse Program
- MICU staff were recipients of a Partners in Excellence Award
- two MICU nurses were nominated for the Stephanie Macaluso Excellence in Clinical Practice Award
- a MICU operations associate was nominated for the Pamela J. Ellis Award
- the unit developed inter-disciplinary evidence-based practice standards
- the unit developed inter-disciplinary protocols
- the unit established new inter-disciplinary MICU-based structures to continue to enhance nurse-physician collaboration and communication within the unit
- the unit established new structures to continue to enhance communication and flow of information as patients move between the MICU and general care units
- the 2002 Environment of Care report described Blake 7 as a 'model unit'

MICU clinical staff, support staff, and leadership attended the celebration as well as representatives from Respiratory Care, Physical Therapy, Radiology, clinical nurse supervisors, Pulmonary Medicine, and medical house staff.

The luncheon was intended to be a celebration of, and tribute to, the outstanding leadership of Adele Keeley, RN, nurse manager, Taylor Thompson, MD, medical director, and Efrat Miodovnik, operations coordinator, but the leadership triad shifted the focus of the celebration to the high level of commitment, enthusiasm, and professionalism exhibited by the MICU staff every day. They spoke about their own commitment to ensuring ongoing support for continued success.

At a time when patient care in ICUs has never been more complex, and the demand for MICU beds never greater, multi-disciplinary collaboration to ensure quality care is crucial. On Blake 7, creating a practice environment that is personally and professionally satisfying for every member of the team is the key to success.

Holding down the fort: Above, working, but celebrating in spirit, are (top to bottom): Kelly Connor, RN; Kerin Erickson, RN; and Cathy Beisheim, RN

Celebrating: At right (l-r) are: Adele Keeley, RN, nurse manager; Richard Lee, MD; Goyo Abel, MD; Deanna Nguyen, MD; Colleen Dunbar, RN (back); Nancy DiGrande, RN; Darcy Noonan, RN (back); Stacey Fabrizio, RN; C. Walter O'Donnell, MD (back); Kayla Zomlefer, MD; Joan Moriarty, RN; Patty McNamara, RN; Essie Hill, OA; Deborah Wexler, MD; Angela Smith, USA; Lucy Christmas, USA; Michael Tonelli, RN; and Efrat Miodovnik, OC (seated).

When/Where	Description	Contact Hours
August 1 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
August 1 7:30–11:30am, and 12:30–4:30pm	**Pediatric Trauma–Part III** Wellman Conference Room	---
August 1 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
August 6 8:00am–2:00pm	**CPR—American Heart Association BLS Certification for Healthcare Providers** VBK 601	- - -
August 8 8:00am–4:30pm	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Training Department, Charles River Plaza	7.2
August 14 8:00am–4:30pm	**Preceptor Development Program: Level I** Training Department, Charles River Plaza	7
August 14 8:00am–2:30pm	**Mentor/New Graduate RN Development Seminar I** Training Department, Charles River Plaza	6.0 (mentors only)
August 14 1:30–2:30pm	**OA/PCA/USA Connections** "Care of the Elderly." Bigelow 4 Amphitheater	- - -
August 15 1:00–2:30pm	**The Joint Commission Satellite Network presents:** "Preventing Medication Errors: What's New and What Works." Haber Conference Room	---
August 15 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK 401 (No BLS card given)	- - -
August 15 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
August 19 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
August 26 8:00–11:30am	**Intermediate Arrhythmias** Haber Conference Room	3.9
August 26 12:15–4:30pm	**Pacing : Advanced Concepts** Wellman Conference Room	5.1
August 27 (and September 19) 8:00am–4:15pm	**Neuroscience Nursing Review 2002 (Day 1)** BWH	TBA
August 28 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
September 3 8:00am–4:30pm	**Chemotherapy Consortium Core Program** Wolff Auditorium, NEMC	TBA
September 4 8:00am–4:00pm	**CVVH Core Program** VBK601	6.3
September 5 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
September 5 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2

For more information about any of the above-listed educational offerings, please call 726-3111.
For information about Risk Management Foundation educational programs, please check the Internet at http://www.hrm.harvard.edu

PCS Clinical Recognition Steering Committee celebrates: 'Mission accomplished!'

On Wednesday, June 19, 2002, The PCS Clinical Recognition Steering Committee officially met for the last time to acknowledge the end of their journey to create a clinical recognition program and to celebrate a job well done. Members of the committee pictured below are (l-r; back row): Steven Jurkowski, Jeanette Ives Erickson, Kristin Parlman, Jane Harker, Dawn Tenney, Evelyn Bonander, Andrea Beloff, Trish Gibbons, Susan Tully, Angie Mines, Ann Daniels, Michael Sullivan, Judy Newell, Deb Burke, Vicki Fung, Elizabeth Sullivan, (and seated): Carol Mahony, Carol Camooso Markus, Lillian Ananian, Carmen Vega-Barachowitz, and Ann Jampel. Also on the committee, but not pictured, are: Jackie Somerville, Theresa Gallivan, Lori Clark Carlson, Barbara Cashavelly, Marianne Ditomassi, Pat English, Chris Graf, Bob Kacmarek, Kathy Myers, Beth Nagle, Paige Nalipinski, and Cathy O'Malley.

Co-chairs, Vega-Barachowitz and Gibbons prepare to cut cake!

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