August 21, 2003

Caring HEADLINES

Inside:

SummerWorks Recognition Luncheon

Some extraordinary young people spent the summer at MGH this year as part of the SummerWorks career exploration program, a component of the Youth Enrichment Program under MGH Community Benefits. To paraphrase Oz Mondejar, Human Resources manager and SummerWorks supervisor, "These are remarkable kids. These are the kids we should be seeing in the news. These are the shining stars of our future."

SummerWorks is a seven-week, supervised employment program for graduating Timilty students that combines interactive workshops with hands-on

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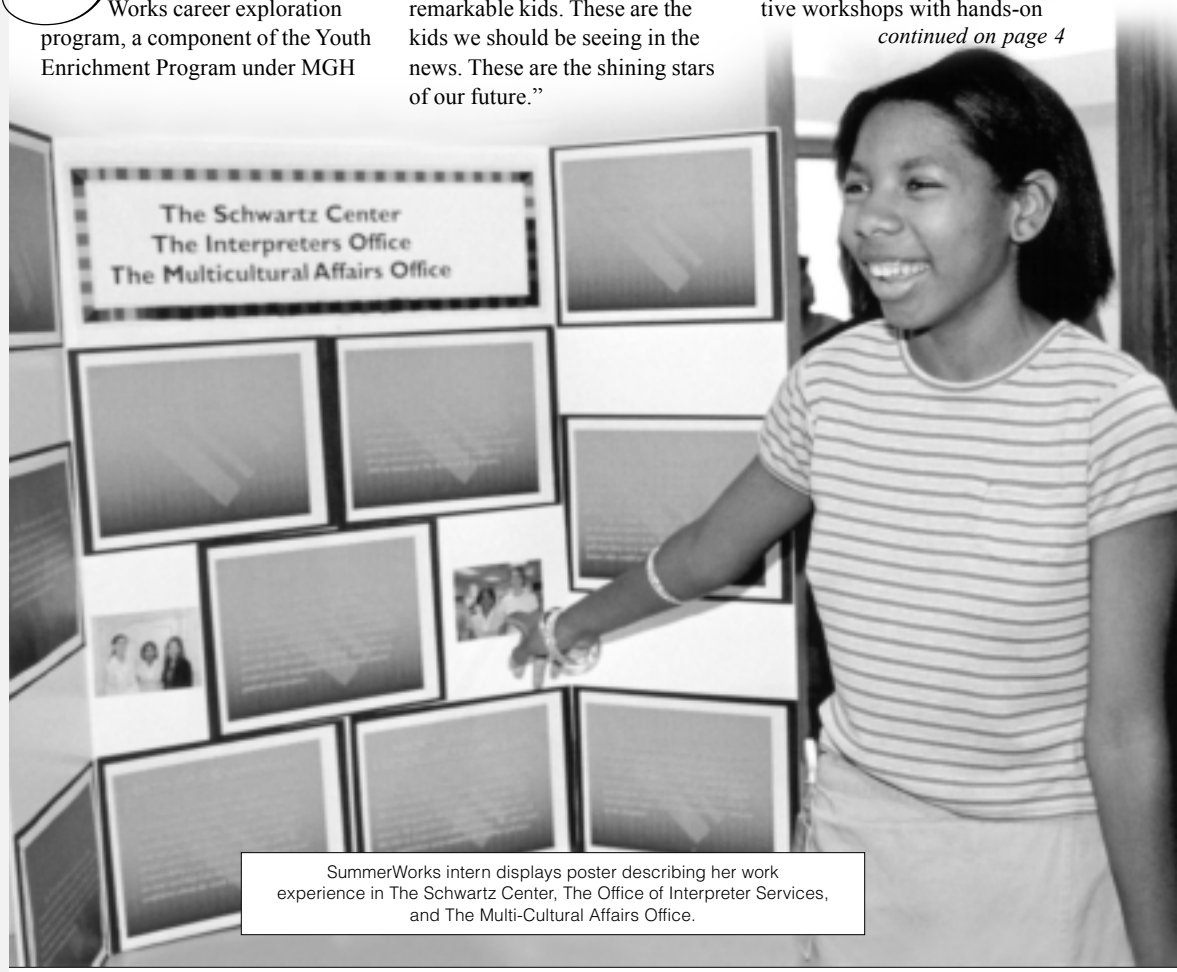

SummerWorks intern displays poster describing her work experience in The Schwartz Center, The Office of Interpreter Services, and The Multi-Cultural Affairs Office.

MGH Patient Care Services

Working together to shape the future

Safety never goes out of style!

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

Safety is more than a priority at MGH—it is a factor in every decision we make, every initiative we implement, and every patient-care situation we encounter. The importance we ascribe to safety is reflected in our strategic planning at the Partners' level, the hospital level, and throughout every department in Patient Care Services.

Many of our safety policies and initiatives are on-going, having been in place for many years. Others are new and build on the knowledge and insight we've gained from past experience. All are geared to ensure that patients receive the highest quality care in a safe and secure environment.

You're all familiar with our annual fire-safety re-training; the work of The Needlestick Reduction Task Force; The TB Task Force; our on-going hand-hygiene improvements; and the work of the multi-disciplinary MGH Ethics Task Force and the PCS Ethics in Clinical Practice Committee. All of these groups make a significant contribution to patient safety.

Some of our more recent initiatives include Quality and Safety Unit Rounds, which began last September. Cy Hopkins, MD, and Joan Fitzmaurice, RN, directors of The Office of Quality & Safety, visit a different patient-care unit every week to talk with staff about patient-safety issues and brainstorm about ways to improve current systems. Quality and Safety Unit Rounds have resulted in some important discussions and triggered valuable changes on individual units, such as:

- weekly multi-disciplinary rounds
- a bi-lingual discharge teaching sheet for all unit-specific procedures
- installing whiteboards in patients' rooms to improve staff communication
- conducting a unit-based survey of patients and families to learn how we can improve their hospital experience
- suggesting labeling changes to Pharmacy to ensure proper identification of IV bags

This past year, The Safety in Motion Committee was formed to examine and improve patient transportation throughout the hospital. Their work is centered around:

- creating a safe and efficient system for transporting acutely ill patients to and from internal diagnostic testing sites
- developing and implementing standards, protocols, and training to support this system
- designing systems to measure the work associated with internal patient-transport
- monitoring the effectiveness of new systems

Our new Anticoagulation Management Service provides comprehensive monitoring, management, and education for patients requiring anticoagulation therapy. The program is co-directed by a nurse and a physician, and is staffed by nurses who have extensive knowledge and experience in anticoagulation.

We have instituted a Fall Prevention Program whereby we identify patients at high risk for falling and place appropriate signage in their rooms and in their medical records to alert staff (at test sites) of the patient's risk for falling. Feedback from families about this program has been very positive.

The Patient at Risk for Injury Committee is revisiting our restraint policies to ensure they preserve and protect patients' rights and autonomy. The group is examining The Patient Observer Program to assess its feasibility as an alternative to physical restraints. And a pilot program involving The Psychiatric Clinical Nurse Specialist Consultation Service is being explored as a way to further reduce the need for restraints.

In April of this year, an important change was made to our documentation process. Physical and Occupational Therapy documentation now appears in the Progress-Notes Section in the main body of the patient's medical record to ensure informed communication among disciplines.

I, along with Brit Nicholson, MD, and Gregg Meyer, MD, co-chair The Quality and Patient Safety Task Force, one of seven sub-groups of the hospital's Strategic Planning Steering Committee. Our task force will be developing initiatives that:

- distinguish MGH on the basis of quality and safety
- update priorities for The Office of Quality & Safety
- set clear quality and safety goals for MGH and the MGPO
- identify 'quick hits' and plans to implement them
- determine how to measure quality

In an effort to improve and streamline communication among PCS staff, I've instituted an e-mail newsletter to disseminate important, time-sensitive information. Quality and safety issues will be regular topics in these electronic communications.

The programs and initiatives I've mentioned here are only a few of the measures we take to ensure a safe and secure environment for our patients. At MGH, safety never goes out of style; it drives our practice at every level, in every setting, for every patient who seeks our care.

Update

We have received notification from the American College of Surgeons apprising us of our re-verification as a Level 1 Pediatric Trauma Center. Congratulations to the Massachusetts General Hospital *for* Children for continuing to deliver the highest quality of care to pediatric trauma patients.

Preparing for the JCAHO: some helpful reminders

Question: When is the JCAHO scheduled to visit MGH?

Jeanette: The JCAHO will be conducting its survey of MGH the week of September 15–19, 2003. This year, the laboratory survey and the full hospital survey will take place at the same time.

Question: At what point are patients assessed when they're admitted to MGH?

Jeanette: All patients are assessed for appropriate unit placement and appropriate level of care prior to, or at the time of, admission. Initial assessments are conducted and documented by both nurses and physicians within 24 hours of admission. Discharge planning needs are identified at the time of initial assessment.

Question: Are there special assessment requirements for different patient populations?

Jeanette: Specific assessment requirements exist for patients with special needs due to age, ability, or condition. For example, infants, children, and adolescents are assessed in an age-appropriate manner for: emotional, cognitive, educational, social and daily-activity needs, as well as developmental level, height, weight, head circumference, and immunization status.

There are also special assessment requirements for patients receiving treatment for behavioral or emotional disorders and victims of substance abuse.

Question: What is a clinician's responsibility in assessing and reporting suspected abuse?

Jeanette: Abuse includes physical assault, rape (or any other sexual molestation), domestic violence, child- and elder-abuse. Nurses, physicians, and social workers are *required by law* to report suspicions regarding abuse, however all caregivers should report potential abuse. If abuse is suspected, concerns should be discussed with the patient's physician, an immediate supervisor, or the social worker assigned to the unit.

Question: Who is responsible for infection control?

Jeanette: Infection control is considered an organizational responsibility that falls to every employee of MGH, not just a single individual or department.

Question: What is the process for reporting information related to infections?

Jeanette: Employees should consult the Infection Control Unit regarding precautions or potential infection-control issues.

Question: What happens when/if there is an outbreak of an identified infection?

Jeanette: If an outbreak or cluster of infections is suspected, a member of the Infection Control Unit will work with staff to identify the problem, make appropriate plans to solve the problem, and assess the effectiveness of the solution. Infection-control measures include staff education, improved hand-hygiene techniques, and higher precaution levels.

Back issues of the JCAHO Talking Papers are available on-line and are updated regularly.

For more information about the JCAHO survey, contact the MGH Compliance Office at 6-5109.

JCAHO Pain Standards: incorporating pain into other standards

This is the third in a series of articles on the new JCAHO pain-related standards. In this article, we discuss incorporating pain into other standards.

JCAHO standards are directed at clinical and organizational preparedness to deliver high-quality care. Awareness of, and interventions related to, pain have now been incorporated into some pre-existing JCAHO standards, such as:

- the goals of care include not only treating a disease or condition, but also treating pain and other symptoms of that disease
- procedures address and support safe medication prescribing, including PCA and other pain-management techniques
- post-procedure monitoring includes pain severity and quality and responses to treatment
- pain that interferes with rehabilitation is identified and addressed
- the organization collects data to monitor its performance, including "the appropriateness and effectiveness of pain-management"
- planning for the continuum of care includes management of pain and other symptoms
- patient pain-education is coordinated and multi-disciplinary
- when pain is an anticipated component of treatment, patients are informed of the risk, "the importance of effective pain-management, the pain assessment process, and methods for pain-management"
- in regard to professional preparation for pain-management, the standards require the organization to:
  - educate relevant providers in pain-assessment and pain-management
  - determine and assure staff competency in pain-assessment and management
  - address pain-assessment and management in the orientation of all new staff

Clearly, the intent of incorporating pain into other JCAHO standards is to call attention to the importance of pain-management at every stage and every level of patient care. By routinely incorporating pain-assessment and pain-management into our practice, and addressing pain-related issues in orientation and continuing education, we expect the quality of pain-management to improve significantly throughout the entire healthcare system.

SummerWorks Program

continued from front cover

work experience at MGH. The program helps instill professionalism and a positive work ethic while exposing students to a variety of healthcare career opportunities.

At the SummerWorks Graduation and Recognition Ceremony on Friday, August 8, 2003, program coordinator, Wanda Velazquez, addressed the gathering, saying, "The application process was not simple. The program requirements were not lax. But

continued on next page

Shining Stars
(clockwise from top right)

1) SummerWorks intern gives farewell address at SummerWorks graduation ceremony.
2) SummerWorks intern and supervisor, Bridget Manley, RN (right), are congratulated by Wanda Velazquez and Candace Burns (back left).
3) SummerWorks intern with her Photo Lab supervisor, Sam Riley.
4) SummerWorks intern listens intently during ceremony
5) SummerWorks intern gives poster presentation.

I, too, remember Ruth Sleeper

—submitted by Dr. K. Anne Phipps, former student of Ruth Sleeper

When Anne Phipps read about the Ruth Sleeper family's visit to MGH in the July 3, 2003, issue of *Caring Headlines*, it triggered some fond memories. Phipps wanted to share those memories with nurses and others at MGH, so she put her thoughts on paper. These are some of Anne Phipps' recollections of Ruth Sleeper, director of Nursing and director of the School of Nursing at MGH from 1946–1966:

What a colorful, memorable person she was! I entered the MGH School of Nursing in 1949. Miss Sleeper was the director of the Nursing School. Perhaps the school didn't quite know what to do with me. I came with a BA from Barnard College. The joint program between Radcliff and the School of Nursing had just begun. A program with Boston College and the Nursing School was in progress. Yale offered a master's degree, but I had my sights set on MGH.

We stood when Miss Sleeper came into the classroom. She commanded respect with her presence.

One of my objectives in choosing MGH was to learn a skill to support myself while reaching my goal of becoming a singer. I had studied in New York with Frank LaForge and Joseph Regneas while completing a degree in Sociology at Barnard. I practiced wherever and whenever I could. Soon word got around and I was asked to sing for special occasions.

Perhaps I knew Miss Sleeper in a way no other student did. Miss Sleeper belonged to a group of bell-ringers. (The bells came from The Old South Church.) The group met weekly in Miss Sleeper's apartment. It was a Wednesday evening, if I recall correctly, when I was asked to join as a solo vocalist.

Dr. K. Anne Battley Phipps
MGH School of Nursing, class of 1953

Every week after having sandwiches and coffee, the group practiced. And there was always a sandwich for me. Mainly, I listened until it was time for my solo. We performed at several events in Boston. Miss Sleeper often talked of her family during this time.

After a trip to Switzerland, Miss Sleeper brought back blue flower pins for every member of the group. I still have mine, a wonderful reminder of an extraordinary lady.

I graduated with the March, 1953, nursing class. Did I become an opera singer? No. A funny thing happened on the way to New York and fame—the psychiatric rotation at McClean Hospital changed my direction. The lure of New York was tarnished forever. There was something else in life that was more important. I became a psychiatric nurse.

I taught at the Indiana University School of Nursing for many years. Building on a BA in Sociology, a diploma in Nursing, and an MA in Nursing Education, I eventually received a PhD in Folklore at the age of 64. With complementary medicine and alternative healing practices on the rise, I hope I've helped forge a place for nursing on that new horizon.

It would be interesting to know how Miss Sleeper would feel about those she nurtured and what they went on to do.

SummerWorks Program

continued from previous page

these students persevered. While other kids their age were out playing or sitting at home in front of their televisions, these students came to work every day with a positive attitude, determined to succeed. They were exposed to real-life work situations, glitches and all, and they excelled. It proves to me once again that when you give students an opportunity to perform, they'll perform. And these interns performed well!"

Candace Burns, director of the MGH BPS School Partnerships Program, added, "We wish our students luck as they pursue their dreams to become pediatricians, scientists, biomedical engineers, and as one student told me, the director of the Schwartz Center. As you go forward, continue to believe in yourselves as we all believe in you."

One intern was asked to speak on behalf of the group to summarize the SummerWorks experience. A poised and articulate, 14-year-old, Arenthia Kelley, who did her internship in The Center for Clinical & Professional Development, rose to the occasion. "This has been an amazing experience," she said. "SummerWorks taught us reliability and responsibility. It taught us to have pride in our appearance and to act in a way that will inspire people to take us seriously. We learned to be trustworthy and professional. Through our responsibilities and the workshops we attended, we were challenged to consider our personal goals and life choices." She closed by quoting friend and fellow intern, Vivian Santiago. "It's been great," she said. "I hope we can do it all again some time."

NICU nurse is 'instrument' of compassion at life-altering time

Peggy Nelson, RN, staff nurse, NICU

My name is Peggy Nelson, and I have been a nurse in the Neonatal Intensive Care Unit for 22 years. I have seen primary nursing at its absolute best.

Over the years, I've had the good fortune to be involved with many wonderful families, all extremely dedicated to their babies and their babies' care. Families are really the primary caregivers; we are their instruments. Primary nursing is a unique tool, and positive outcomes are its greatest reward.

I can't begin to understand what these families feel—the twists and turns their everyday lives go through so they can be here for their babies. They have other children, jobs, a house, bills, and any number of other commitments, and here they are facing the greatest challenge of their lives... a sick newborn. This is a baby they don't even know yet. They haven't had a chance to incorporate this new family member into their lives yet, and this tiny baby has totally superseded all other commitments they might have. This is unconditional love for a child.

'Mary's' parents had an almost 2-year-old son. Mary's birth was totally unexpected at just under 27 weeks gestation. There had been no complications during the pregnancy, but after giving birth, mom had numerous complications and was hospitalized twice. Twenty-seven weeks is considered very premature—not without complications—but certainly survivable.

Mary's first few days were routine. Then, as expected, she began to get sicker. We explained to the parents that this was not unusual in babies of Mary's size and prematurity. We assured them that we would follow her closely and adapt our management as her illness dictated.

Mary was a fighter. She would open her eyes, even at her sickest, to let us know she was there. On one of Mary's quieter nights, her dad arrived unexpectedly around 9:00pm. He had just brought his wife in to be admitted for the second time with complications. Mary was wide awake. He talked to her for a while, then became silent. What must be going through his mind, I thought. His wife is back in the hospital. His daughter is right in front of him. He still can't believe this is happening. He's scrambling for babysitters for his son. His head must be spinning.

He asked me how I thought Mary was doing. Trying to be positive, but not give him false hope, I told him I thought she looked very content listening to him talk to her. His voice was the best medicine. A little grin came over his face and he agreed. He left feeling he'd done something positive for his daughter.

In the days that followed Mary did not take the usual path of premature infants of her size and gestation. Her parents became increasingly concerned and looked to us, not necessarily for answers, but for information that would help them make decisions down the road. We had many family meetings and answered all their questions openly and honestly. Difficult options were addressed. The bottom line was always what was best for Mary. They weren't ready to let go, but Mary wasn't getting better and she was beginning to show signs that she may not recover.

At every critical juncture, the primary care team met with Mary's parents. On her final night, I sensed Mary was getting tired. Her tiny lungs didn't have the capacity to overcome the level of prematurity though her heart and soul seemed willing.

Her parents came for one last family meeting. They brought their son and took what would be their only family picture with Mary. Mary was baptized. They all seemed at peace.

The dynamics of that day were greatly influenced by the primary care team. An incredible team of compassionate professionals had embraced Mary's parents, and an integral part of that team is the primary nurse. As one of Mary's primary nurses, I felt we were able to support these parents and help them cope at this difficult, life-altering time.

They had trusted us to take care of their baby, and now they were trusting us to help them let go.

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

At those times when the overwhelming circumstances of life become almost too much to bear, meaningful little things take on so much more importance. When Peggy told dad she thought Mary was very content listening to the sound of his voice, that was a little thing. But it made a world of difference to Mary's dad. And you know it's a memory he will carry with him for a very long time.

This is a wonderful story of primary nursing, teamwork, and compassionate end-of-life care.

Thank-you, Peggy.

CORRECTION

An article in the August 7, 2003, *Caring Headlines* stated that the MGH Family Care Program was seeking 'volunteer' families to provide care for disabled adults and frail elders. In fact, families who participate in the program receive a monthly stipend for their participation.

Nelson receives 2003 Ben Corrao Clanon Memorial Scholarship

The 17th annual Ben Corrao Clanon Memorial Scholarship was established in 1987 by Ben's parents, Regina Corrao and Jeff Clanon, as a way to honor their son Ben's memory and formally recognize the exemplary practice, commitment, and advocacy of NICU nurses. This year, the award went to NICU staff nurse, Peggy Nelson, RN (see narrative on opposite page).

Nurse manager, Peggy Settles, RN, introduced Nelson, saying, "Peggy was selected by her peers for her unwavering ability to balance professional collaborative practice with her commitment to support patients and families at the most difficult times. Peggy is able to maintain objectivity in the face of great adversity."

Corrao commented that 17 years seemed to have passed in the blink of an eye! "When I remember the conversations and experiences we had while Ben was a patient here, I realize that I've carried many of those lessons forward in the parenting our other children. I am a fierce advocate for my children; I always think outside the box; and that all began here seventeen years ago."

Clanon observed that many nurses were present who had been there during Ben's hospitalization. "You people never leave," he joked. "But I think that speaks to the genuine care and compassion you provide to patients and families who come here. It's not about the money for you. It's not just a job. And that's what we remember."

Said Nelson, "I'm honored to work with an incredible team of nurses on this unit. Helping to incorporate the family's desires into our plan of care, making sure there is a consistent philosophy, that's what primary nursing is all about."

NICU staff nurse, Peggy Nelson, RN (second from left), receives Ben Corrao Clanon Award from (l-r) Peggy Settles, RN, nurse manager, and Ben's parents, Regina Corrao and Jeff Clanon.

Call for nominations

The Anthony Kirvilaitis Jr. Partnership in Caring Award

The Anthony Kirvilaitis Jr. Partnership in Caring Award recognizes non-clinical staff within the department of Nursing who exemplify the qualities that made Tony Kirvilaitis so valued in his role as training development specialist in the Center for Clinical & Professional Development. These qualities include *reliability, responsiveness, creativity, assurance, collaboration, and flexibility.*

The award is given to two individuals annually. Operations associates, unit service associates, operating room assistants, unit assistants, patient care service coordinators, ED admitting assistants and patient care information associates are eligible for the reward.

Nominations are due by August 29, 2003.

Each recipient receives an award of $1,500.00. Recipients will be recognized at a ceremony in November, and their names will be added to the plaque honoring all Anthony Kirvilaitis Jr. Partnership in Caring Award recipients.

For information about the nomination process, please contact Nancy DeCoste, training specialist, at 4-7841; or Carolyn Washington, operations coordinator, at 4-7275.

Caring for delirious elders: it takes a village

Susan M. Kilroy, RN, MS,
clinical nurse specialist

—by Susan M. Kilroy, RN, MS, clinical nurse specialist, White 10

Patients admitted to general medical units present with a wide variety of diagnoses and conditions. Acute confusion, or delirium, is a condition that arises frequently in elderly medical patients. It may be precipitated by infection, toxic metabolic states, hypoxia, or nervous-system pathology.

Delirium occurs in approximately 30% of hospitalized elders. Unfortunately, it's sometimes viewed as a chronic condition that is routinely experienced by elders. Since the inception of the Psychiatric Clinical Nurse Specialist Consultation Program, many incidences of delirium have been recognized and treated effectively on general medical units.

Noting that a significant percentage of their consults were for patients experiencing delirium, the psychiatric CNS group developed a one-hour in-service to help educate nurses in early recognition of delirium, prompt treatment, underlying causes, and rapid return to a functional state.

Shortly after the in-services, Mr. T, an elderly man, was admitted to White 10 with confusion, visual hallucinations, and a low sodium level. When I arrived on the unit the next morning, I was greeted by one of the night nurses who told me that Mr. T had fallen during the night. When he arrived on the unit at 7:00pm the night before, the nurse assessed that Mr. T was alert and oriented to person, place, and time, but he asked questions that didn't make sense. During the night he vacillated between being alert and oriented, and confused. Twice he attempted to get out of bed without assistance. A roll belt (an assistive device that allows patients freedom of movement while preventing them from getting out of bed) was placed to ensure Mr. T's safety, and he received some intravenous haldol, a medication to help restore mental processes.

Even after these interventions, Mr. T continued to be unsettled. He removed his roll belt, so as a last resort, wrist restraints were applied in an effort to keep him safe. Staff checked on him regularly and frequently throughout the night. But despite these measures, Mr. T managed to untie his restraints, and was found on the floor. He wasn't injured, but safety was the overriding concern. Mr. T was placed on three-point restraints, and received a dose of an antipsychotic medication. He finally fell asleep at 5:00am.

Our goal for the day was to perform an objective assessment of Mr. T's mental status and formulate a plan to keep him safe. I administered the Folstein Mini-Mental State Examination, a tool that measures cognitive ability, and he scored 13 out of a possible 30. He experienced particular difficulty with attention, calculation, and recall. He was unable to verbalize what he would do if he needed help, and he couldn't demonstrate how to use the call bell.

All this information led to a diagnosis of delirium. Knowing that staff nurses had recently received education on delirium, my role was to help them apply this new information, develop a plan of care, and evaluate the effectiveness of their interventions. A key element of my role is coaching: supporting nurses as they try new approaches, assisting them in critical thinking, providing feedback, and being available to work with them directly.

What was learned in our delirium education is that early recognition is key. We have to mobilize these patients, provide toileting, food and fluid, and decrease any unnecessary stimulation. The first step was to remove the restraints and have Mr. T eat breakfast under supervision. Second, was a consult to Physical Therapy, which happened that morning. Molly McCormick was Mr. T's nurse that day. This is her perspective:

When I first met Mr. T, he was in a very confused state, although he was alert enough to know he was in restraints. We decided it would be a good idea to give him freedom from the restraints while in a supervised setting. We began by sitting him up in bed and encouraging him to feed himself. With someone at the bedside keeping close watch, Mr. T was able to accomplish this almost entirely on his own.

After breakfast, Mr. T was seen by the physical therapist who recommended he be frequently ambulated in the hallway and escorted to the bathroom. What I realized at this point, was that normalizing his routine was making a difference. Although he was intermittently confused, our quick response to his delirium helped us better control his environment, and minimize the need for restraints. I felt I had the tools and resources necessary not only to recognize delirium, but to treat it accordingly.

In addition to being followed by the medical team, Mr. T was seen by a psychiatrist who made medication recommendations to treat his delirium. Mr. T's haldol dosage was changed to allow for regular administration, three times a day. The plan called for treatment of his hyponatremia with intravenous fluid.

Nurses rounded with the physician team exchanging information and modifying the plan as necessary. Mr. T had a good day. Though he did experience some confusion overnight requiring restraints, frequent re-orientation, and safety checks, by the next morning he was alert, pleasant, and oriented only to person. Restraints were remov-

continued on next page

Clinical Nurse Specialist

continued from previous page

ed, and he was able to use the bathroom, perform his morning toiletries, and feed himself. We felt good about our ability to minimize the use of restraints, and continued to work to eliminate them entirely.

On day three, we reviewed Mr. T's care at weekly nursing rounds. It was an excellent opportunity to review both his medical and nursing care. Becky Dobbyn, a new graduate nurse, had cared for him that day. This is Becky's perspective:

We talked about hyponatremia, the symptoms and treatment. It was important for me to clarify exactly what measures would be appropriate to keep Mr. T calm and safe. We had a good discussion about dementia and delirium and the role of the nurse in managing behaviors. Every time I entered Mr. T's room, I made a point of re-orienting him, offering him fluids and toileting. He remained confused at times and needed re-orientation with each encounter. I made sure he ambulated, with assistance, as a means of providing physical activity and decreasing agitation. I encouraged him to sit in the chair at his bedside with his wife. At the end of the day, I felt really comfortable about the care I provided because I had the information I needed regarding his condition.

Mr. T continued to progress. He engaged in daily activities. He was soon able to identify how to use the nurse call bell. We put signs in his room to remind him to call for help before attempting to get out of bed. He remained on fall precautions and frequent safety checks. He was ambulated several times a day. He still became confused at night, and occasionally attempted to get out of bed without calling for help, but he was easily re-directed.

One week after admission, I re-administered the Mini-Mental State Examination. This time he scored 26 out of a possible 30, a major improvement. Shortly thereafter, he was transferred to a rehabilitation facility, with a plan for him to return home with his wife after that.

Lessons learned from this patient situation are many. One of the most important lessons is the benefit of a collaborative care-planning process. Interdisciplinary input was key, and kept us focused on maintaining Mr. T's function. We learned that objective measures of mental status are helpful in the initial assessment, and also as a measure of progress. We learned that focusing on returning to normal function and constant re-assessment helped us be creative about ways to minimize the use of restraints. We learned to use each other for validation of behaviors and clarification of the plan as we introduced new interventions. And best of all, it was gratifying to see Mr. T leave MGH greatly improved, both medically and functionally. It took a 'village' of caregivers.

Substance abuse and withdrawal in the acute-care setting

September 22, 2003
8:00am–4:30pm
O'Keeffe Auditorium

Program will include information on the new **Alcohol Withdrawal Clinical Pathway**

This program will help clinicians develop skills in assessing and caring for adult patients withdrawing from drugs and alcohol in the acute-care setting. All clinicians are welcome.

For more information or to register, call The Center for Clinical & Professional Development at 726-3111.

Contact hours will be awarded to nurses

Advanced Pharmacology

Nurses! Register for fall non-degree courses at the IHP

Advanced Pharmacology will be available on-line, starting September 3, 2003.

Commonly used drugs, drug interactions, and pharmacotherapeutics will be explored building on a basic knowledge of pharmacology. The course is designed to meet requirements for prescription-writing by advanced practice nurses.

For more information, call 726-3164 or visit www.mghihp.edu and click on: "Take or Audit a Course."

Register by August 15th for a 10% tuition discount. Full-time Partners employees may take their first 3-credit class for half-price.

35 CE hours or 3 academic credit hours. Pass/Fail option available.

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HealthWISE lecture series helps keep older adults informed

On July 28, 2003, the MGH Senior HealthWISE Lecture Series featured a panel presentation entitled, "Can you hear me now? How to keep your voice in healthcare decision-making."

Panelists were introduced by Barbara Moscowitz, LICSW, director of the HealthWise Program. Marilyn Wise, LICSW; Theresa Cantanno, RN; Sharon Brackett, RN; and Gayle Peterson, RN, all members of the PCS Ethics in Clinical Practice Committee, focused on the importance of advance directives and healthcare proxies. The presentation was followed by small group discussions and individual consultations.

The MGH Senior HealthWISE Lecture Series was created to promote health and wellness among older adults in the local community. HealthWISE staff conduct weekly health and wellness clinics for residents of The Amy Lowell House, The Blackstone House, and The Beacon House as well as sponsoring health screenings and educational programs, free of charge, for all older adults in the community.

For information on the HealthWISE program and upcoming presentations, contact Lindy Wilks at 724-6756 or send e-mail to: lwilks@partners.org.

Above: panelists (l-r): Theresa Cantanno, RN; Marilyn Wise, LICSW; Sharon Brackett, RN; and Gayle Peterson, RN, share information on advance directives and healthcare proxies at recent HealthWISE lecture-series presentation.

At left: Cantanno leads small-group discussion with local community members.

(Photos provided by Marilyn Wise)

When/Where	Description	Contact Hours
September 2 8:00am–4:30pm	**Chemotherapy Consortium Core Program** Wolff Auditorium, NEMC	TBA
September 4 7:30–11:00am and 12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
September 4 1:30–2:30pm	**Nursing Grand Rounds** "Issues related to Disaster Mental Health." O'Keeffe Auditorium	1.2
September 8, 9, 15, 16, 22, 23 7:30am–4:00pm	**Greater Boston ICU Consortium CORE Program** SEMC	44.8 for completing all six days
September 8 8:00–4:30pm	**Cancer Nursing Concepts: Building Blocks of Practice** O'Keeffe Auditorium	TBA
September 10 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
September 10 1:30–2:30pm	**OA/PCA/USA Connections** "Preventing Violence in the Workplace." Bigelow 4 Amphitheater	- - -
September 11 8:00am–4:30pm	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Training Department, Charles River Plaza	7.2
September 12 and 18 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
September 15 7:30–11:00am and 12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
September 15 and 16 8:00–4:15pm	**Neuroscience Nursing Review** Day 1: O'Keeffe Auditorium. Day 2: Walcott Conference Room	- - -
September 17 1:30–2:30pm	**USA Educational Series** "Work-Related Injuries." Bigelow 4 Amphitheater	- - -
September 18 1:30–2:30pm	**Nursing Grand Rounds** "Organ and Tissue Donation." O'Keeffe Auditorium	1.2
September 18 1:00–2:30pm	**The Joint Commission Satellite Network presents:** "Putting the Pieces Together: Self Assessment, Priority, Focus, Process, and Methodology" Haber Conference Room	- - -
September 22 8:00am–4:30pm	**Substance Abuse and Withdrawal in the Acute-Care Setting** O'Keeffe Auditorium	TBA
September 23 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK 401 (No BLS card given)	- - -
September 24 4:00–5:30pm	**Using On-Line Resources to Research Herbs and Dietary Supplements** Clinics 262	1.8
September 24 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
September 24 8:00am–4:30pm	**Preceptor Development Program** Training Department, Charles River Plaza	7
September 26 8:00am–4:30pm	**MGH School of Nursing Alumni Homecoming Program** O'Keeffe Auditorium	TBA

For detailed information about educational offerings, visit our web calendar at http://pcs.mgh.harvard.edu. To register, call (617)726-3111.
For information about Risk Management Foundation programs, check the Internet at http://www.hrm.harvard.edu.

STOP Task Force: improving patient care by preventing hospital-acquired infections

The MGH Hand Hygiene Task Force, which was responsible for introducing CalStat, the alcohol-based hand disinfectant, has changed its name to better reflect the full scope of its mission. The task force is now called STOP (Stop Transmission Of Pathogens). The group expanded its focus to include, not just hand hygiene, but all aspects of infection-prevention, including the transmission of pathogens (viruses, fungi, and bacteria).

STOP Task Force members are broadening their activities to raise awareness about how pathogens are transmitted, giving special attention to the cleanliness of equipment and the patient care environment.

The group is developing strategies to increase staff compliance with precaution techniques. Members of the task force will monitor

practice on units and provide feedback to staff on precaution-compliance issues. A key focus of their efforts will be to raise awareness about the red 'P' icon that appears in the Clinical Applications Suite (CAS) when a patient is on precautions.

The STOP Task Force is developing educational initiatives on hand-hygiene techniques and general infection-control practices for clinical and non-clinical employees. The goal is to improve the quality of patient care by preventing hospital-acquired infections.

Several representatives from Patient Care Services are members of the STOP Task Force. They are: professional development coordinator, Brian French, RN; staff specialist, Rosemary O'Malley, RN; and associate chief nurses, Trish Gibbons, RN; Jackie Somerville, RN; and Dawn Tenney, RN.

For more information about the work of the STOP Task Force, call Infection Control at: 726-2036.

Golden Pen Award recipients

The following staff nurses received Golden Pens in the new program that acknowledges staff nurses for exemplary documentation:

Ellison 8: KeriAnn Giglio
Ellison 12: Theresa Murphy
Ellison 16: Karen Booker-Ciampa, Barbara Doherty, Susan Gage and Claire MacIsaac
Ellison19: Alicia Rounds, David Miller, and Stacey Margardo
Phillips 21: Gayle Peterson and Claire Seguin
White 8: Amy Sozanski
White 12: Beth Fortini and Coleen Comerford
CSICU: Darleen Crisileo
Blake 11: Dan Lonergan, Joanne Parhiala, Martha Root, and Trish Zielinska
Blake 13: Mary Gilbert
Dialysis: Nyla Shellito
Bigelow 11: Ana Gomes, Ed Newbert, and Meg Soriano
MICU: Nasha Watler, Barb Sprole, and Breda Naughton
PICU: Heidi Simpson, Linda Hirota, Beth Robbins, Cheri Boulanger and Kathleen Pease
SDSU: Karen J. Kelley, Suzanne McCarthy, Eleanora DiTocco, Cesareo Villa, Patricia A. Lynch, Sandy Taylor, Kristen Frazier, Sandy Greene, and Kellie Mitchell

Once a month, one Golden Pen recipient is randomly selected to receive a $50 American Express gift certificate. This month, the gift certificate went to Michelle Robertson of the NICU.

Caring HEADLINES

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