

# Caring

December 16, 2004

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## Partners in Excellence Awards showcase employee contributions

*Awards recognize contributions in: Leadership, Teamwork, Efficiency, Quality, and Community*



Jennifer Lassonde, staff assistant to associate chief nurse, Theresa Gallivan, RN, receives Partners in Excellence Award for Quality Treatment. Lassonde was nominated by Jeralyn Levasseur for her gracious efforts in orienting Levasseur to the MGH family and culture. Says Levasseur, "Every new employee should have their own Jennifer!"

Also pictured are (l-r): Peter Slavin, MD, president of MGH; James Mongan, MD, president and CEO of Partners HealthCare; and Jeff Davis, senior vice president for Human Resources

**MGH** Patient Care Services  
Working together to shape the future

## 2004: another chapter in an already rich history

As 2004 draws to a close, we look back on a year of optimism and achievement, a year of selflessness and humanitarianism, a year that should make every employee proud to work at MGH.

It began with an historic visit to Iran. When a 6.6-magnitude earthquake leveled the ancient city of Bam, killing more than 30,000 people, our International Medical-Surgical Response Team (IMSuRT) was deployed to care for survivors. Bringing much-needed medical aid to this se-

verely hard-hit, politically estranged part of the world gave our team an opportunity to be ambassadors of good will as well as highly skilled, healthcare professionals.

Iran was not the only country that benefited from the humanitarian efforts of MGH staff. Catherine Libberles, RN, embarked on a nine-day journey to Haiti, bringing her considerable nursing skills to the poorest country in the western hemisphere.

Several MGH employees joined forces

with ACCESO (Americans and Cubans building Community through Exchange, Support and Outreach) to deliver books, medical supplies, and specialized equipment for individuals with disabilities to healthcare facilities in Cuba.

And most recently, Grace Deveney, RN, and Kate Fallon, RN, became the first nurse recipients of the Thomas S. Durant, MD, Fellowship in Refugee Medicine and have been deployed to Sudan where they're working in collaboration with the Ire-



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

land-based humanitarian organization, Concern Worldwide.

This year saw the Democratic National Convention come and go with virtually no interruption to care or services at MGH.

Two new award programs were introduced in 2004. Jennifer Albert, RN, became the first recipient of the Norman Knight Preceptor of Distinction Award. Ann Kennedy, RN, and Joan Collins, RN, were honored with the first annual Brian M. McEachern Extraordinary Care Award, which was created in honor of much-loved Boston firefighter, Brian McEachern to recognize extraordinary care and patient advocacy. It was a special thrill for me to meet Mr. McEachern's family and

friends, especially his sisters, Diane and Geri.

MGH was one of several Massachusetts hospitals to host the first nursing-focused National Youth Leadership Forum. The Forum, designed to attract new nurses to the profession, offered unit-based job-shadowing, one-on-one learning opportunities, and panel discussions with nurses talking about why they decided to become a nurse, what they looked for in a nursing program, and what strategies were effective in ensuring they were on the right career path.

A milestone event during National Nurse Week this year, the MGH Nurses Alumnae Association presented a special gift to the MGH community, a bronze sundial depicting the past, present, and future of nursing. The sundial, created by local artist, Nancy Schön, sits on the lawn of the  
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### Clinical Recognition Program Clinicians recognized in 2004

#### Advanced Clinicians

- Theresa Adjan-Vallen, RN, Emergency Department
- Dana Allison, RN, Blake 13/14
- Angela Altobelli, RN, Main OR
- Elizabeth Andrews, RN, NICU
- Cheryl Brunelle, PT, Physical Therapy
- Diane Carter, RN, Bigelow 14
- Julianne Casieri, RN, Emergency Department
- Anne Coutinho, RN, Ellison 11
- Suzanne Danforth, SLP, Speech-Language Pathology
- Eleanora DiTocco, RN, Same Day Surgical Unit
- Marie Doucet, RN, Emergency Department
- Danielle Doucette, RRT, Respiratory Therapy
- Ann Eastman, RN, Bigelow 14
- Linda Gorham Ryan, RN, Phillips 22
- Berney Graham, LICSW, Social Work
- Beverly Hudson, RN, Cox 2

- Kathleen Larrivee, RN, Phillips 21
- Cheryl Lippi, RN, Blake 12
- Anne MacMillan, RN, Ellison 7
- Fareeda Mahmoud, RN, Blake 11
- Annette Mullen, RN, SICU
- Kristine Roy, RN, Blake 11
- Clare Swan, RN, Blake 2
- Elizabeth Viano, RN, Main OR
- Catherine Weaver, RN, Bigelow 14

#### Clinical Scholars

- Sharon Kelly-Sammon, RN, PACU
- Germaine Lamberg, RN, Blake 13/14
- Karen MacCormack, RN, NICU
- Mary Elizabeth McAuley, RN, Blake 4
- Dawn McLaughlin, RN, PICU
- Sandra McLaughlin, LICSW, Social Services
- Paula Nelson, RN, Blake 13/14
- Michelle O'Leary, RN, Ellison 8
- Patricia Owens, RN, Main OR
- Elena Pittel, RN, Blake 13/14
- Elizabeth P. West, RN, Blake 13/14

## National Advance Practice Advisory Panel

*Sheila Kaiser, CRNA, chief nurse anesthetists, was recently appointed to the National Advance Practice Advisory Panel. I thought this would be a good opportunity for the MGH community to learn more about this panel; below are excerpts from a brief interview with Sheila*

**Jeanette:** Sheila, what is the National Advance Practice Advisory Panel?

**Sheila:** The Advance Practice Advisory Panel has been in place since 1995. Its primary function is to advise the National Council of State Boards of Nursing on the status of regulatory issues as they relate to advance practice nursing.

**Jeanette:** Who is on the panel?

**Sheila:** The panel is comprised of 15 members including clinical nurse specialists, nurse practitioners, nurse midwives, and certified registered nurse anesthetists. Right now, I am currently the only CRNA on the panel.

**Jeanette:** How did you become a member of this panel?

**Sheila:** I was nominated based on my work on the Massachusetts Board of Registration in Nursing, where I currently hold one of two advance practice seats. After being nominated by the Massachusetts BORN, I submitted an application, was inter-

viewed, and subsequently selected. The appointment is for two years, beginning in October, 2004. The panel meets quarterly in Chicago at the National Headquarters, and there is one annual meeting, as well. Our first goal is to revise the position paper issued in 2002 on Advance Practice Nursing. Our recommendations, or position papers, go to the National Council for consideration/adoption, then they are referred back to the state boards of Nursing for advisement related to the regulation of advance practice.

ment, is also a member of the board. I was appointed in January of 2003, so I'm just completing my second year. The board was recently reassigned to the Division of Professional Licensure under the Department of Public Health. The main focus of the board is to determine whether current regulations are adequate to ensure public safety?

**Jeanette:** Are there currently any vacancies on the board?

**Sheila:** Yes. There are currently four vacant seats awaiting appointments by the Governor.

### Jeanette Ives Erickson

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Treadwell Library honoring the nursing profession and the nurses of MGH.

Two cherished leaders retired from MGH this year after long and memorable careers. Carol Ghiloni, RN, nurse manager and 41-year veteran of MGH, retired on March 4th; and Evelyn Bonander, ACSW, long-time director of Social Services and 19-year veteran of MGH, retired on July 2nd. Both left a rich legacy and very big shoes to fill.

We welcomed Reverend Marcia Marino, who assumed her new role as director of the MGH Chaplaincy.

One year after becoming the first hospi-

tial in Massachusetts to earn Magnet-hospital designation, we received word from the American Nurses Credentialing Center that our interim monitoring report was accepted, ensuring our continued status as a Magnet hospital in good standing.

During the past (fiscal) year, Patient Care Services hired 503 new employees and enjoyed low vacancy and turnover rates in all departments.

2004 was indeed a year of great achievement, opportunity, and fulfillment. We continue to make quality and safety a top priority. We continue to support important programs such as hand hygiene, pain-management, pa-

tient education, student outreach, community-service, emergency preparedness, and care of the elderly. We continue to see positive outcomes from the work of our collaborative governance committees. We continue to address issues of diversity, disparities in health care, and making our services more accessible to individuals with disabilities.

As I wish you all a safe and happy holiday, I thank you for the exceptional work you do and the selfless commitment you make on behalf of our patients and our hospital. May 2005 be as rewarding and full of promise as this past year.

**Jeanette:** When you say regulatory issues, can you be more specific?

**Sheila:** The primary goal of the National Council of State Boards of Nursing is to ensure public safety. This is accomplished through regulations related to the education, accreditation, and certification of advance practice nurses across the country.

**Jeanette:** You mentioned your work with the Massachusetts BORN. Can you tell us more about that?

**Sheila:** There are 17 seats on the board, two advance practice seats of which I hold one as a CRNA. The other was recently filled by a nurse practitioner. Phil Waithe, RN, clinical educator in the Knight Center for Clinical & Professional Develop-

**Jeanette:** What are some of the areas of focus of the BORN?

**Sheila:** We look at nursing education, regulation, discipline issues, and the nursing and nursing-faculty shortages.

**Jeanette:** Is there anything else you'd like to tell us related to your participation on the panel or your work with the BORN?

**Sheila:** I'm very excited to represent MGH on both the state and national levels on issues related to advance practice nursing. It is truly an extraordinary opportunity. I encourage all nurses to get involved with professional organizations to help ensure public safety and influence the direction of nursing in the future.

## ‘Bearing witness’ in the classroom: sharing my vision of nursing

—by Kathryn J. Pazola, RN, pediatric staff nurse

I didn't want to do it. When I was first asked to speak to a class of high-school juniors about nursing, I resisted. I wasn't sure teen-agers would be interested. How could I engage them about such a straight-forward topic? How could I (older than many of their parents) bring *my* world to them? And could I give a positive, yet honest, account of nursing knowing there are frustrations that can challenge even the most enthusiastic and committed nurses?

I shared my trepidations with my niece, who is also a nurse. Her encouragement and enthusiasm convinced me to do the lecture. She ‘surf-ed the Net’ and found a lot of helpful background information for my presentation. She suggested I contact the Johnson & Johnson Company, who is sponsoring a national campaign to promote nursing. They sent posters and pamphlets and a video on nursing that I could show in class. I put together a slide show of my own to help demonstrate the important points I wanted to make.

Feeling more prepared with my collection of audio-visual aids, I was on my way...

My goal was to present a positive vision of nursing; to portray today's nurse as educated, professional, and caring; to discuss the many roles and career opportunities available to nurses; and to share my personal ‘vision’ as a pediatric nurse.

I began by asking if anyone in the class had ever been a patient in a hospital, or knew anyone who had. And based on that experience, how did they perceive the nurse's role? This was a good springboard for conversation and discussion, and it was a good opportunity to clarify some misconceptions.

Before sharing what ‘a day in the life of a nurse’ is like, I wanted to educate them on how nursing became a profession. Showing a slide of Florence Nightingale, I talked about the evolution of nursing from the battlefield to the hospital to the community. I described how Nightingale set standards for nursing practice and education. I discussed the various educational paths that can lead to a career in nursing today. We talked about how the image of nursing has changed since the early days of the profession. I stressed that despite how nurses may be portrayed

on television and in the movies, nurses are respected men and women who are ‘thinkers’ and ‘doers.’

A slide showing a nurse holding a patient's hand in an equipment-laden ICU setting paved the way for a discussion of the ‘high-tech, high-touch’ work nurses do every day.

A slide showing multi-disciplinary rounds spurred a discussion about teamwork and collegiality. I stressed the importance of teamwork in caring for patients and families. Students had questions about how the healthcare team operates—Who leads the team? Do nurses make their own decisions? How does the team coordinate the care of a patient? I was encouraged by their questions—it meant they were listening!

I felt it was important to discuss nursing education, advanced degrees, certification, specialization, and life-long learning. A slide showing a nurse at a professional workshop was the backdrop for this topic. Students seemed surprised to learn that I was studying for my recertification exam in Pediatric Oncology Nursing, my area of expertise.



Kathryn Pazola, RN  
pediatric staff nurse

The easiest part of my presentation was sharing what I do in my day-to-day practice. I described a ‘typical’ day touching on many facets of my work: planning and giving care; advocating for patients and families; teaching; comforting; and collaborating with the team.

As an example, I shared an instance where I cared for an adolescent who had been newly diagnosed with diabetes. I talked about how I taught the patient about the disease and how to manage glucose testing and insulin injections. I talked about the need to comfort patients who may be sad or anxious as they adjust to their new diagnosis. I talked about educating, supporting, and reassuring parents so they can help manage their child's care at home. I talked about how we communicate with the school nurse to ensure continuity of care and support when the child returns to school.

I wanted to show the transformative power of nursing, because I truly believe we help restore patients with our caring; we make them feel whole and capable again. As I neared the end of my presentation, one student asked how I stayed so enthusiastic about nursing after such a long time. I said that being involved in a patient's recovery is a challenge and a privilege. Patients teach us about courage. To be part of their lives is an honor.

Thinking back, I didn't want to do the lecture. Had I achieved my goal? Did I succeed in recruiting anyone into the nursing profession? I may never know. I do know that visiting this school gave me a sense of re-dedication. Talking to those students, ‘bearing witness’ to the profession, confirmed for me that nursing is noble work. And nursing does make a difference.

## Evidence-based nursing practice: what's the story?

—by Elizabeth Johnson, RN

On Thursday, October 28, 2004, 65 MGH nurses from a variety of roles and specialties explored the principles

of evidence-based nursing practice at a special workshop called, "Evidence-Based Nursing Practice: What's the Story?" After introduc-

tory remarks by associate chief nurse, Trish Gibbons, RN, Dr. Dorothy Jones, RN, senior nurse scientist, delivered the keynote address,

discussing the history, guiding concepts, and current trends in evidence-based nursing practice. Jones talked about the relevance of evidence to best nursing practices and how it makes the contributions of nursing more visible to the multi-disciplinary team, the public, and third-party payers.

Dr. Anne-Marie Bar-ron, RN, followed with a presentation on the principles of reflective nursing practice and its relevance to evidenced-based nursing practice. She discussed qualitative research, evidence-based practice, and the usefulness of clinical narratives.

Lynda Tyer-Viola, RN, spoke about the integration of reflective practice and evidence-based practice. Carolyn

Paul, MSLS, senior librarian at Treadwell Library, shared techniques on how to conduct a literature search.

The workshop included a presentation and unbundling of clinical narratives, a panel discussion of evidence as defined and used by nurses in different specialty areas, and a discussion of potential research questions related to the clinical practice of many of the participants.

The Evidence-Based Nursing Practice Resource Group that organized the workshop is in the process of establishing a network of nurses interested in evidence-based practice. The group is also developing follow-up programs.

For more information about the work of the Evidence-Based Nursing Practice Resource Group, contact Elizabeth Johnson or Deborah Jameson by e-mail.



**Above:** MGH nurses attend Evidence-Based Nursing Practice workshop.

**At left:** Members of the Evidence-Based Nursing Practice Resource Group who planned the October 28th workshop are (l-r): Deborah Jameson, RN, and Elizabeth Johnson, RN (seated); and Kathleen Grinke, RN; Carolyn Paul, MSLS; Lynda Tyer-Viola, RN; Catherine Griffith, RN; and Ed Coakley, RN.

## Vigilance, empathy and advocacy contribute to positive outcome on Bigelow 11

*M*y name is Donna Lawson, and I am a staff nurse on Bigelow 11.

Recently, I had the rewarding experience of caring for Mr. T, a 72-year-old man who lives in the western part of the state. Mr. T was admitted to MGH due to increasing shortness of breath, abdominal discomfort, fever, and fatigue. His condition was complicated by several pre-existing medical conditions including chronic lymphocytic leukemia (CLL), anemia, coronary artery disease, and hypertension. Mr. T was being followed at MGH for his CLL by an oncologist.

Mr. T was admitted to our general medical unit for a work-up of his symptoms. I was assigned to him early in his admission. From our very first meeting, I was impressed by him. I remember going into his room for the first time and seeing a very neatly groomed gentleman with a great smile and a firm handshake. I introduced myself and explained my role as his nurse. I did a thorough assessment and asked him some questions related to his symptoms. When I finished, I asked if he had any questions. He asked, "When can I go home?" That's

when I first got to know and understand where Mr. T was coming from. He explained that he and his wife had driven for four hours to get to MGH, that they'd gotten stuck in rush-hour traffic, and gotten lost after getting off the highway because of the Big Dig. I pulled up a chair and listened. I asked questions about his family and discovered that his wife worked full time as a pharmacy technician and wouldn't be able to stay in Boston while Mr. T was hospitalized. This raised a red flag for me. Here was this man with an underlying cancer diagnosis experiencing these new, vague symptoms without any of his usual support systems nearby. I couldn't help think how I would feel in his situation, or my dad, who's also 72 years old. I knew Mr. T was going to need some extra support.

When I completed Mr. T's nursing admission assessment form, he explained that he'd been feeling sick for about two weeks but had decided to go on a previously scheduled vacation despite his symptoms. It was while on vacation that the symptoms became too much, and he went to a nearby hospital to be evaluated. Because of

his complex history, Mrs. T felt Mr. T would be better off at MGH because we knew him and were familiar with his care. I could tell Mr. T felt badly about 'ruining' their vacation. I sat beside him and said, "Honestly, Mr. T, if it had been your wife who was sick, wouldn't you have done the same for her?" There it was again—that great smile of his. I reassured him that he was in the best possible place, and we were going to take great care of him.

I came to know Mr. T well. He told me all about his rural town, his beloved pets, and most importantly, his family. I made sure his phone was always within reach so he wouldn't miss their daily calls. I made a point of stopping by his room frequently, not just for clinical reasons, but just to say 'Hi' or chat for a few minutes. I noticed that whenever we talked about his animals, his face would light up. I told Mr. T about our Pet Therapy program and he was delighted. He faithfully signed up for visits from a pet-therapy team every Tuesday and Thursday. He seemed to feel better on those days despite the fact that his hospital course was becoming more complicated. Mr.



Donna Lawson, RN  
staff nurse, Bigelow 11

T's fevers at admission had revealed a blood infection that was requiring antibiotics and a pleural effusion that needed to be tapped. His abdominal pain had been attributed to ascites with an unknown etiology. About a week into Mr. T's hospitalization, I noticed he was becoming distressed over his lack of progress. We'd start our shift together with a firm handshake and an update of the 'goings-on' back home. And he would always ask about my husband and children. Typically, during my assessment, we would discuss his concerns and our plan for the day.

Over time, I began to notice that Mr. T's food intake was diminishing. His trays appeared almost untouched and he seemed to be getting weaker. I began to ask more probing questions about his symptoms. He had begun to develop nausea, persistent vomiting, and abdominal

pain, but would always down-play the severity of his symptoms.

I reported Mr. T's symptoms to the medical team. I suggested we might want to consider a work-up for pancreatitis. Mr. T didn't have a history of pancreatitis, but I thought his symptoms were leaning toward that diagnosis. The team agreed. I asked if they would reconsult the GI team because of his pre-existing ascites, and wondered if there might be a connection. I had cared for patients in the past who'd had similar presentations, and I thought, since he wasn't improving, we should investigate every option. Unfortunately, Mr. T's tests revealed that he did have pancreatitis, which would further prolong his hospitalization.

Once we were able to manage Mr. T's symptoms, he gradually began to improve. I helped him recognize the

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## Exemplar

*continued from page 6*

good progress he was making despite how frustrating it sometimes seemed to him. I know how a long hospitalization can wear someone down, both physically and emotionally. Even though Mr. T could independently manage his activities of daily living, I asked the medical team for a Physical Therapy consult to help him focus on getting his strength back. When he started to improve, we started to discuss discharge planning and the need for him to finish his antibiotic course.

I spoke to our case manager to see if we could arrange for Mr. T to finish his treatment at home with support from the Visiting Nurses Association (VNA). We discussed discharge options with the medical team and with Mr. T. All agreed that this was a reasonable plan and that shortening his length of stay would be good for Mr. T.

Mr. T asked if I would speak to his wife. He didn't want to overwhelm her as she would be working and feel responsible for his care. I was able to speak to Mrs. T on her next visit to the hospital. She seemed comfortable with the idea but was nervous about what her role would be as far as administering medications. I assured her that a medication vendor would

deliver the drugs and any necessary supplies, and that the VNA nurse would administer the medications. I explained that we could talk to the case manager to arrange the timing where they had to travel several hours to get home. Before long, all was arranged, and Mr. T was ready to go home.

Our parting words were full of emotion. He was very excited about being reunited with his family, his pets, and his home, but was very nervous about the prospect of managing all his care needs. I prepared him to expect that he would probably tire easily at home and that simple, everyday activities might exhaust him. I explained that his endurance would improve a little every day; he just needed to pace himself and listen to his body.

We discussed his home-care regimen and his follow-up care both locally and here at MGH. I asked if he'd try to make his follow-up appointments at MGH on Mondays, Tuesdays, or Wednesdays, as those are the days I work, and I really wanted to see him again. He promised he'd try. With one last handshake that turned into a hug, we said goodbye.

The next day, I asked the case manager if she'd spoken to Mr. T and if all had gone well with the VNA and drug vendor on his first night back home. She said

everything had gone as planned. Knowing that Mr. T was home safely gave me peace of mind.

A month passed quickly. One day after returning to the unit after lunch, a co-worker informed me that a visitor had stopped by to see me. She said he would try to come back after his doctor appointment. I smiled to myself thinking it might be Mr. T. At 3:00 that afternoon Mr. T came back to the unit with his wife. I was paged to the front desk. When Mr. T and I saw each other, we both smiled with tears in our eyes. He looked wonderful!

"It's so good to see you," he said.

He laughed when I said, "It's so funny to

see you with real clothes on!"

I was amazed at how healthy he looked. And it was great to see that familiar smile of his again. Both Mr. T and his wife were grateful for the care they had received. Mr. T had made a full recovery and was back to enjoying life again. He promised to stay in touch and stop by whenever he came to MGH. I'm already looking forward to our next visit.

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

Donna's extensive clinical knowledge, compassion, and presence to the patient are vividly portrayed in this ac-

count of her care of Mr. T and his family. Donna says she, "came to know Mr. T well." It was that intimate knowledge of her patient that drove every decision and intervention of his care. It was that knowledge that caused her to ask the team to consider a new diagnosis. And it was that knowledge that informed every aspect of the holistic care she provided.

Donna intuitively tended to Mr. T's physical, spiritual, and emotional needs, enlisting the services of the Pet Therapy Program, working closely with the case manager to arrange VNA assistance, and providing constant encouragement and reassurance.

Thank-you, Donna.

### Call for Abstracts Nursing Research Day May 4, 2005

The Nursing Research Committee is calling for poster abstracts for Nursing Research Day 2005.

This is an opportunity to share nursing research, evidence-based practice models, and creative approaches used to improve the nursing care of patients and their families

To submit an abstract, go to the Nursing Research Committee website at: [www.mghnursingresearchcommittee.org](http://www.mghnursingresearchcommittee.org) (no spaces), select "Abstract Submission" and follow the submission guidelines.

For more information contact: [www.mghnursingresearchcommittee.org](http://www.mghnursingresearchcommittee.org)

Submissions are due by January 31, 2005

### Call for Proposals The Yvonne L. Munn, RN, Nursing Research Awards

Staff are invited to submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Week in May of 2005.

Proposals are due by March 1, 2005. Guidelines to assist in developing proposals are available at: [http://pcs.mgh.harvard.edu/CCPD/cpd\\_award\\_munn.asp](http://pcs.mgh.harvard.edu/CCPD/cpd_award_munn.asp) (no spaces)

For more information, contact Virginia Capasso, RN, at 726-3836 or by e-mail at [vcapasso@partners.org](mailto:vcapasso@partners.org)

**Nurse Week 2005 will  
be celebrated at MGH  
May 1-6, 2005**

## PDCA: a multi-disciplinary approach to quality

—by Scott M. Dickinson, operations coordinator, White 8 and 10, and member of PCS Quality Committee

If you drove to MGH today, you probably used the gauges on your dashboard to monitor your speed, fuel consumption, and engine temperature. You may even have used navigational tools. The reliability of these instruments is extremely important in ensuring that you make it to your destination safely. Staff at MGH use similar indicators to ensure the highest level of quality and safety for our patients and their families.

Invisible to most patients, there are numerous systems and processes in place throughout the hospital to ensure seamless, efficient operation at every stage of a patient's care. Maintaining adequate linen and medical supplies, meal service, building repairs and maintenance, the delivery of inpatient mail, the availability of televisions in patients' rooms, and the delivery of medications throughout the hospital are just a few of the many services that require ongoing, behind-the-scenes, quality-assurance monitoring.

Processes are evaluated for effectiveness

and to determine where there may be opportunities for improvement. Staff in various settings and departments adhere to a pre-established set of quality checks. At MGH, the PDCA model is used. PDCA stands for Plan, Do, Check, Act. Before implementing a new process, whether it's designing a patient room or initiating a new treatment plan, the four steps of the PDCA model are employed:

- 1) *Plan* how the system should be designed using tools such as flow-charting, brainstorming, patient focus groups, or customer mapping
- 2) *Do* refers to 'trying' the system out, or piloting it, on a small scale to see how it works and to resolve any unexpected glitches or problems before it is implemented on a larger scale

- 3) *Check* the plan by examining data checklists, control charts, and measuring key performance indicators

- 4) *Act* involves providing formal training for staff and standardizing the process

The PDCA model is an on-going process that constantly looks for ways to improve performance and reduce errors.

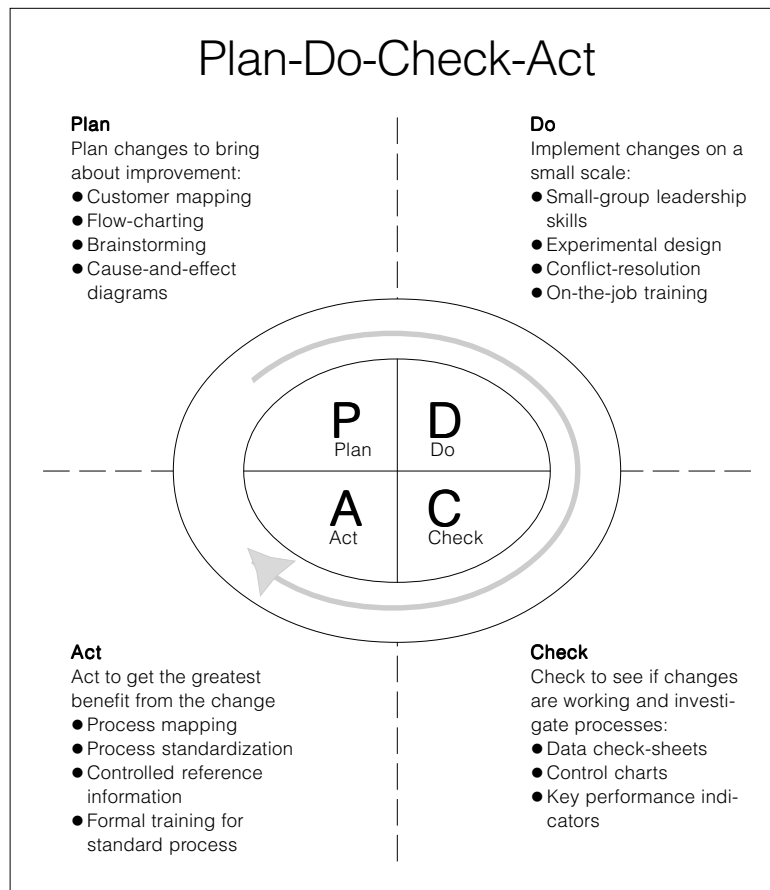
Look for PDCA posters throughout the hospital as part of a campaign to inform staff, patients, families, and visitors about our quality model.

On February 7, 2005, the PCS Quality Committee will present a special conference entitled, "The Different Faces of Quality Improvement: Creating an Environment of Quality and Safe Practice." PDCA will be one of many topics discussed (see shaded box on opposite page).

For more information about the work of the Quality Committee or the Plan-Do-Check-Act model, contact Scott Dickinson at 4-2354.



Scott Dickinson  
operations coordinator





## Pneumococcal Vaccination Program

—by Janet M. Madigan, RN  
project manager, Patient Care Services Information Systems

**O**n November 30, 2004, a program was launched to help educate physicians, nurses, and the general public about the benefits of receiving the pneumococcal vaccine. With this year's shortage of flu vaccine, preventing complications from the flu is imperative. The pneumococcal vaccine protects patients against 23 types of pneumococcal bacteria.

Posters and fliers have been placed in lobbies and other public areas at MGH and the health centers to help educate the public about the benefits of receiving the vaccine. People at risk (including those 65 years old or older, and those aged 2–64 who have chronic medical conditions) are encouraged to talk to their

healthcare providers about the vaccine.

Physicians have been encouraged to order the vaccine for all inpatients aged 65 and older who:

- have not received the pneumococcal vaccine since turning 65
- were vaccinated before they turned 65, but more than five years ago
- have not had an allergic reaction to the vaccine

Stickers have been placed on the outside of medical records to remind physicians to consider ordering the vaccine for patients meeting this criteria.

### *Nursing Procedure*

When an order for the vaccine is received in POE, the operations

associate will transcribe the order onto the green medication sheet and place a copy of the Pneumococcal Vaccine Screening and Administration Form (form #84502) with the medication sheets. Prior to administering the vaccine, the nurse will give the patient (or legal representative) a copy of the Pneumococcal Polysaccharide Vaccine CDC Information Sheet (English: form # 84492; Spanish: form # 84493) for review and answer any questions.

The patient is then screened for eligibility using the Vaccine Screening and Administration Form. If the patient does not have a fever higher than 100°F (or 38°C) at the time the vaccine is to be administered, and the patient or legal representative does not refuse the vaccine, the pneumococcal vaccine can be administered and documented on the green medication sheet. The nurse will then complete the documentation requirements on the form, file the original in the medical record, and give the copy to the patient or legal representative so it can be brought to the primary care physician for documentation in his/her records.

For more information, contact Janet Madigan, RN, project manager, at 6-3109, or by e-mail at: [jmadigan@partners.org](mailto:jmadigan@partners.org).

### The Different Faces of Quality Improvement: Creating an Environment of Quality and Safe Practice

All members of the MGH community are invited to attend this full-day educational offering to learn how to create and maintain the safest possible environment for patients, families, visitors, and employees.

Topics will include:

- Strategic Planning
- Patient Safety Goals for 2005
- The Role of Patient Safety Rounds
- Planning a Project Improvement Initiative
- Hand Hygiene

Keynote speaker, Anita Tucker, DBA, will speak on, "The Impact of Operational Failures on Nurses and their Patients"

**Monday, February 7, 2005**  
**8:00am–4:30pm**  
**O'Keeffe Auditorium**

CEUs available  
For more information, call The Center for Clinical & Professional Development at 6-3111



Back issues of *Caring Headlines* are available on-line from the Patient Care Services website at: <http://pcs.mgh.harvard.edu/>  
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### Published by:

*Caring Headlines* is published twice each month by the department of Patient Care Services at Massachusetts General Hospital.

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### Submission of Articles

Written contributions should be submitted directly to Susan Sabia **as far in advance as possible**. *Caring Headlines* cannot guarantee the inclusion of any article.

Articles/ideas should be submitted in writing by fax: 617-726-8594 or e-mail: [ssabia@partners.org](mailto:ssabia@partners.org)  
For more information, call: 617-724-1746.

### Next Publication Date:

January 6, 2005



## Sharing Muslim traditions and hospitality: the annual Eid-ul-Fitr celebration

—by Firdosh Pathan, RPh, member of the Diversity Steering Committee

In the spirit of unity and community-building, the PCS Diversity Steering Committee, Chaplaincy, and Muslim staff from throughout the hospital helped coordinate the annual Iftar celebration (breaking of the fast during the Holy month of Ramadan). On October 27, 2004, the MGH community joined Muslim patients, family members, staff, and visitors in the Wellman Conference Room to share food, friendship, cultural traditions, and hospitality. Jeanette Ives Erickson, RN, senior vice president for Patient Care, and Peter Slavin, MD, president of MGH, were among the many guests.

Ramadan is the ninth month of the Islamic lunar calendar. During

Ramadan, which began at sundown on October 15th this year, healthy Muslim adults and many children fast from dawn until sunset. They do not eat or drink during daylight hours. Smoking and sexual relations are forbidden during fasting. And at the end of each day, the fast is broken with prayer and

a meal called the Iftar.

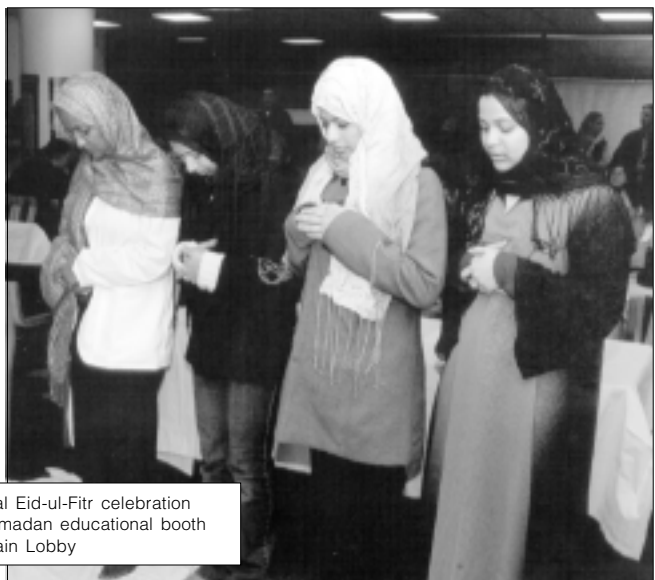
During Ramadan, Muslims perform good deeds such as offering more prayers, giving more to charity, abstaining from bad habits, improving family relations, visiting one another, and helping the poor and sick. Rama-

dan is a 'training month' for Muslims to try to be better people. Elderly people and expectant mothers are allowed to abstain from rituals that may be harmful for them. Elderly Muslims can observe the holiday by feeding a person in need every day. Expectant mothers can observe the fasting tradition at another time of the year after giving birth. The purpose of

Ramadan and the fasting tradition is to give Muslims an opportunity to practice self-control, discipline, generosity, and God-consciousness by eliminating impurities from the body.

Because Ramadan is a lunar month, it begins approximately 11 days earlier every year. At the end of the Holy month, Muslims celebrate Eid-ul-Fitr, the festival of fast-breaking, which took place this year on November 12th (or 13th). Muslims celebrate Eid-ul-Fitr by visiting each other and performing charitable acts. Eid-ul-Fitr is a time for Muslim children to have fun.

Muslims follow the religion of Islam. At MGH, the Muslim prayer room, or Masjid, is located in Founders 109. For more information about Ramadan or the Muslim faith, e-mail [teid@partners.org](mailto:teid@partners.org), or [fpathan@partners.org](mailto:fpathan@partners.org) (no spaces, no hyphens).



Scenes from the annual Eid-ul-Fitr celebration and (upper right) the Ramadan educational booth in the Main Lobby

# Educational Offerings

December 16, 2004

When/Where	Description	Contact Hours
January 3, 4, 10, 11, 24, 25 7:30am–4:30pm	<b>Greater Boston ICU Consortium CORE Program</b> BIDMC	44.8 for completing all six days
January 4 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK 401 (No BLS card given)	---
January 6 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
January 10 8:00am–3:00pm	<b>Advanced Cardiac Life Support (ACLS)—One-Day Re-Certification Provider Course</b> Wellman Conference Room	---
January 12 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
January 12 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
January 12 7:00am–12:00pm	<b>CVVH Core Program</b> Haber Conference Room	6.3
January 12 11:00am–12:00pm	<b>Nursing Grand Rounds</b> Sweet Conference Room GRB 432	1.2
September 8 4:00–5:00pm	<b>More than Just a Journal Club</b> Walcott Conference Room	---
January 13 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
January 13 7:30am–12:30pm	<b>Pediatric Advanced Life Support (PALS) Re-Certification Program</b> Wellman Conference Room	---
January 20 8:00am–4:30pm	<b>Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other</b> Training Department, Charles River Plaza	7.2
January 20 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
January 24 and 25 7:30am–4:30pm	<b>Intra-Aortic Balloon Pump Workshop</b> Day 1: NEMC; Day 2: VBK601	14.4 for completing both days
January 26 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
January 26 4:00–5:30pm	<b>Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements</b> FND626	1.8
January 27 8:00am–4:30pm	<b>Workforce Dynamics: Skills for Success</b> Training Department, Charles River Plaza	TBA
January 27 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
January 27 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Management of Difficult Patients.” O’Keeffe Auditorium	1.2
January 28 12:00–4:00pm	<b>Basic Respiratory Nursing Care</b> Ellison 19 Conference Room (1919)	---
January 28 9:30–11:30am	<b>CINAHL: Cumulative Index to Nursing and Allied Health</b> FND626	1.2

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>.

## Hansen participates in ONS Leadership Development Institute

Andrea Hansen, RN, staff nurse on Phillips House 21, was selected to participate in the Oncology Nursing Society's Leadership Development Institute. Hansen was chosen from a national pool of candidates to be paired with a mentor in Oncology Nursing to design and implement a leadership project.

## Nurses co-present at wound-management workshop

On Wednesday, July 14, 2004, Virginia Capasso, RN; Joanne Empoliti, RN; Joan Gallagher, RN; Ann Martin, RN; and Amanda Savage, RN, co-presented a wound-management workshop in Hyannis, Massachusetts, at the Primary Care of Older Adults/Complementary Health Care conference sponsored by the Nurse Practitioner Associates for Continuing Education.

## Tyrrell presents at Staff Development forum

Professional development coordinator, Rosalie, Tyrrell, RN, presented, "Understanding and Leading a Multi-Generational Workforce," at the western Massachusetts Nursing Staff Development Organization in Springfield, Massachusetts, on October 15, 2004.

## Ciano named AMMP Member of the Year

Charles Ciano, operations coordinator for Ellison 14 and 16, was recognized by the Association of Multi-cultural Members of Partners (AMMP) as Member of the Year on September 16, 2004. Ciano is instrumental in managing the portion of new-employee orientation that describes the AMMP program.

## Amaya, Myers and Niles present in Las Vegas

Staff nurses, Claribell Amaya, RN, and Ivonny Niles, RN, and nurse manager, Kathleen Myers, RN, presented their poster, "Addressing the Nursing Shortage and Health Disparities: Clinical and Mentoring Support for Foreign-Born Nurses," at the National Association of Hispanic Nurses' annual meeting in Las Vegas.

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