September 23, 2004

# Caring HEADLINES

## Inside:



# Employee Recognition Program brings scads of 'Summer Fun'

Never let it be said that Patient Care Services doesn't know how to have *fun*!

Thanks to a special program under the auspices of the MGH Strategic Planning Committee's Workforce Task Force, managers and department heads were able to show their appreciation to hundreds of PCS employees through the MGH Summer Fun Program.

Some expressions of appreciation took the form of staff picnics, clam bakes, harbor cruises, Duck

*continued on page 8*

Nurse manager, Kathy Myers, RN (front row, second from left), associate chief nurse, Jackie Somerville, RN (second row, left), and staff of Ellison 6 and White 6 show off their new T-shirts compliments of the Summer Fun initiative

**MGH** Patient Care Services

Working together to shape the future

# High-quality patient care inexorably tied to mission, values

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

Health care is no different from other professions in its vulnerability to change. We all experience shifting trends, advances in technology, new ways of thinking about productivity. But unlike most other industries, health care is rooted in a fundamental desire to help people; to *care* for people. And therein lies a very big difference.

While some individuals may be drawn to a career by a desire to make money, succeed in business, or discover the new 'best thing,' a career in health-care is more than a job. Caring for people is a calling. And when we answer that call, we align ourselves with the core values we hold as individuals. When we come to work at a hospital, clinic, or health-care institution, we align ourselves with other individuals who share those core values. This is an important distinction because it means we have the privilege of working in an environment where our personal and professional values overlap.

It also means that when developments like capitation, new technology, or shifts in government policy create a climate of change, we are anchored to our mission by an innate sense of responsibility to our patients. Systems, personnel, the physical environment may change, but our commitment to deliver the best possible care to our patients remains the single most important priority. This strength of commitment comes from being part of a mission-driven organization.

**MGH Mission Statement**

**To provide the highest quality care to individuals and the local and distant communities we serve, to advance care through excellence in biomedical research, and to educate future academic and practice leaders in the health care professions.**

Some of you may be aware of the work of the Culture & Education Sub-Committee of the Quality & Safety Strategic Planning Committee, chaired by Susan Edgman-Levitan, executive director of the Stoeckle Center for Primary Care Innovation, and Georgia Peirce, director of PCS Promotional Communications and Publicity. The group is exploring a number of strategies and new approaches to providing high-quality, patient-centered care. One of those approaches is the Planetree philosophy. The Planetree philosophy came into being in the late 1970s. It encourages healing in all dimensions of the human experience—mental, emotional, spiritual, social, and physical. In addition to conventional treatments, the Planetree model embraces an approach to mind-body healing that encompasses complementary therapies, access to nature and art, pleasing architectural designs and facilities, and a belief that every person, regardless of role, plays an important part in patient care and has the ability to influence the hospital experience for patients and families.

What could be closer to our mission?

The Planetree model helps patients get well faster and stay well longer. It stresses the importance of patients reading and understanding their medical records, asking questions, and participating in the decisions that affect their care. Visiting hours are un-restricted, and children are encouraged to visit hospitalized loved ones. Family members are included in patient-education, physical care, and emotional support systems. The Planetree philosophy is a natural extension of our values and mission.

When we talk about health care, we're not talking about a static thing; we're not talking about an entity over which we have no control. We *are* health care. It is our commitment, both personal and professional, that drives change and evolution in the health-care arena. By simply being part of a mission-driven organization, along with others who share our passion, we have the power to shape the future. The culture we have created is a genuine reflection of our mission and values. And isn't that what every health-care professional wants—to be part of an organization that continually strives to find new and better ways to help people; that continually strives to find new and better ways to *care* for people.

## Clinical Recognition Program

**Clinicians recognized July 1–September 1, 2004**

Advanced Clinician

- Cheryl Lippi, RN, Blake 12
- Anne Coutinho, RN, Ellison 11
- Cheryl Brunelle, PT, Physical Therapy
- Marie Doucet, RN, Emergency Department
- Kristine Roy, RN, Blake 11
- Julianne Casieri, RN, Emergency Department
- Berney Graham, LICSW, Social Work
- Angela Altobell, RN, Main OR
- Fareeda Mahmoud, RN, Blake 11
- Anne MacMillan, RN, Ellison 7

# Magnet interim monitoring process

*On September 8, 2003, MGH received word from the commissioner of the American Nurses Association Magnet Recognition Program that MGH had been designated the 83rd Magnet Hospital in the world. Magnet recognition is granted for a four-year period, and hospitals are required to file interim monitoring reports annually demonstrating that they continue to meet the rigorous Magnet standards. Interim reports contain statistical information about nursing, patient satisfaction, and certain measures that demonstrate the relationship between nursing care and patient outcomes.*

*Question*: How many hospitals have received Magnet Recognition in the last year?

*Jeanette*: As of September 1, 2004, there are 119 Magnet Hospitals in the world, and many more are currently preparing for site visits in the United States and other countries. Though the number of Magnet hospitals continues to grow, it still represents less than 2% of all hospitals in the United States.

*Question*: What does our Magnet interim report show about the nursing staff?

*Jeanette*: Magnet hospitals have a more educated and experienced nursing staff and a higher percentage of nurses certified in specialty areas. The number of MGH nurses who have degrees in Nursing is above the national and Magnet average, and it continues to increase as nurses continue their education. The number of nurses who have successfully completed certification exams in their area of practice has also increased.

For the purposes of the Magnet interim report, nurse staffing is reviewed and the vacancy and turnover rates on each unit are reported. MGH continues to have lower vacancy and turnover rates than the state, the nation, and other Magnet hospitals.

Educational resources provided for staff are also reported, and MGH continues to invest more resources than the national average.

*Question*: What does our interim report show about nursing- and patient-satisfaction?

*Jeanette*: Every year nurses participate in the Staff Perceptions of the Professional Practice Environment Survey, which is sent to all clinical staff within Patient Care Services. Three key elements are essential to all Magnet hospitals: autonomy, control over the practice setting, and relationships with physicians. Every year, the Magnet-related scores at MGH have increased and are well above average. Also, the number of nurses who report that they're 'very satisfied' with the practice environment continues to increase. Routine hospital surveys of patients show a similar picture. Patients are satisfied with the care they receive at MGH, especially the nursing care. Scores are consistently above the national average.

*Question*: What do these ratings have to do with patients?

*Jeanette*: There is a growing body of research that shows a strong relationship between nursing care and positive patient outcomes. The nursing interventions that most affect patient outcomes are routinely monitored. This data is analyzed and compared to benchmarked standards to ensure that we continuously improve our performance. For every nursing-sensitive indicator at MGH, the news is good. The report includes information on pressure ulcers, patient slips and falls, infections, and length of stay.

## Call for Nominations

### Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

Nominations are now being accepted for The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award. The award was created to recognize clinicians within Patient Care Services whose practice exemplifies the expert application of values reflected in our vision. Staff nurses, occupational therapists, physical therapists, respiratory therapists, speech and language pathologists, social workers and chaplains are eligible.

The nomination process:

- Direct-care providers can nominate one another. Nurse managers, directors, clinical leaders, health professionals, patients and families can nominate direct-care provider.
- Those nominating can do so by completing a brief form, which will be available in each patient care area, in department offices, and at the Gray information desk.
- Nominations are due by October 4, 2004. Recipients will be selected in November.
- Nominees will receive a letter informing them of their nomination and requesting they submit a professional portfolio. Written materials on resume-writing, writing a clinical narrative, and securing endorsement letters will be enclosed.
- A review board including previous award recipients, administrators, and MGH volunteers will review the portfolios and select award recipients. The board will be chaired by Trish Gibbons, RN, director of The Center for Clinical & Professional Development.
- The award ceremony will be held on December 9, 2004.

**Award and award-related activities**

Award recipients will receive $1,500 to attend a professional conference or course of their choosing. They will be acknowledged at a reception of their peers and family members, and their names will be added to the plaque honoring previous Macaluso award recipients. Recipients will receive a crystal award from Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse.

For more information or assistance with the nomination process, please contact Mary Ellin Smith, RN, professional development coordinator, at 4-5801.

# Ensuring important information isn't 'lost in translation'

*—by Mary Elizabeth McAuley, RN, and Donna Slicis, RN, of the Patient Education Committee*

Effective patient-education materials are a key factor in our ability to meet the needs of our patients and achieve the best possible clinical outcomes. Karin Hobrecker, translation specialist, is one resource available to clinicians who want to make their patient-education materials available in other languages. Karin draws on years of experience in interpreting (spoken language) and translating (written language) in a variety of settings. Prior to coming to MGH, Karin worked as a US certified court interpreter, a medical interpreter, and as a marketing representative for foreign-language products. At MGH, she has translated for many administrative and clinical departments including Patient Care Services, the Avon Breast Center, the Pre-Admission Testing Area, the Cancer Center, the Planning Office, and other services to help meet the needs of our diverse patient population. Recently, the Patient Education Committee asked Karin to discuss the steps involved in translating a written work from English into another language.

*Question*: Karin, can you describe the process of translating patient-teaching materials from English into another language?

*Karin*: The goal is not just changing the language but conveying the message clearly in a way that reaches the intended audience. To accomplish this, I work with the 'owner' of the material to learn about the piece and its purpose. How will it be used? Who will be reading it? When? Why? I like to think of the process as a partnership between the clinical team, the audience, and the translator. In the end, you want to ensure that the needs of the message-giver and the message-receiver are being met.

*Question*: How do you do that?

*Karin*: I meet with the owner of the piece. We review it for clarity and to determine if it meets the literacy needs of the intended audience. I make sure we have a shared understanding of the audience, the purpose, and have clarified all terms that may need explanation. Sometimes this is a process of discovery. The clinician has 'inherited' the piece, or it's outdated and needs to be updated before it can be translated. Sometimes we find references to other materials so we need to translate those documents, as well. Ideally, a thorough review ensures that the end product meets the needs of both patients and clinicians.

*Question*: Can you give an example of how you strive to meet the needs of patients and providers?

*Karin*: The forms that patients fill out are one example. When translating a form for patients to record their weight, for instance, I want to ensure that patients understand what is being asked. I also want the provider reviewing the form to be able to understand what's been written in another language.

I get many requests to translate forms containing open-ended questions where patients have to write out answers. Many of these questions could be presented with 'check-box' answers labelled in both English and another language so the record can be understood by patients and caregivers.

*Question*: What are some other challenges to translating documents?

*Karin*: Documents that have multiple purposes or contain too much information can be confusing in any language. Vague terms are not helpful. Terms like 'limit,' 'plenty,' or 'avoid' are confusing. The message needs to be clear. Instead of: "Avoid driving when taking this medication," say, "Do not drive while taking this medication."

*Question*: What is the best way to check for understanding or clarity?

*Karin*: The best way is to review the document repeatedly as it's being created. It's always a good idea to have more

*continued on next page*

(L-r): Donna Slicis, Karin Hobrecker, and Mary McAuley

Karin Hobrecker, translation specialist (left), and Connie Roche, RN, nurse practitioner in the Avon Breast Center, review patient-education materials

## Translation

*continued from page 4*

than one person review your work. If it's clinical in nature, review it with non-clinical staff from another area. Encourage questions and comments. Don't take criticism personally. The goal is to meet the needs of your audience, and critical review is a necessary part of the process.

Testing your work with a pilot audience is another way to check for clarity and to see if you're meeting the needs of your audience. It's a good idea to pilot test with people who share the same demographics and experience of your target audience. To avoid bias, the owner of the piece should not pilot test the document directly.

*Question*: How do you take into consideration the cultural needs of your audience?

*Karin*: It's important to keep in mind that there is diversity even within language groups. Patients who speak Spanish or Arabic, for instance, may come from any number of countries, cultures, and life experiences. Similarly, English-speaking patients are the product of different cultures, life experiences, and lifestyles.

The same approach that works for English works for other languages—and that is using plain, simple language and having clarity in your purpose. It is important to be inclusive in your documents. For instance, instructions on exercise and activities should include references to a variety of occupations and sports; dietary instructions should recognize the wide variety of foods patients eat. Some topics should be more specifically tailored to the audience, referring to the customs, traditions, or lifestyle of a given group.

*Question*: What should providers know about written teaching tools?

*Karin*: Written materials support face-to-face patient-teaching. Although learning preferences may vary, interactive teaching that engages the patient works best for most patients regardless of language. Learning and retention increase when we follow the 'hear, see, do' rule. In addition to hearing, reading, or watching a demonstration, patients should have the opportunity to perform the action being taught or rephrase and confirm their understanding orally.

When caring for patients who speak languages other than English, clinicians work with medical interpreters to ensure understanding. Written materials complement and support clinicians' work and give patients a way to take the teaching home with them.

*Question*: What resources are available at MGH for clinicians who want to learn how to write clearly?

*Karin*: The Blum Patient & Family Learning Center has a number of resources. The Cancer Center Patient Education Steering Committee has a system in place for producing teaching materials in plain language. Treadwell Library hosts a monthly plain language lunch group where staff can bring materials for comments and discussion. Treadwell Library also hosts a 2-day plain language workshop dedicated to producing materials for patients and consumers. The workshop is led by a consultant and is a great way to quickly gain an understanding of how to write simply, plainly, and clearly. I have taken the workshop, and even with all my years of experience in writing and translating, I learned a lot and gained new insight into this aspect of communication. Writing is a process, and writing in a way that can be understood by all MGH patients is a team effort.

For more information about plain writing or how to create easy-to-read patient-education materials, contact Donna Slicis, RN (4-1668), Mary McAuley, RN (6-3732), Beth Schneider at Treadwell Library, or any member of the Patient Education Committee.

### 2-Day Plain Language Writing Workshop

Learn how to write easy-to-read materials that patients can and will want to read.

Clinicians and non-clinicians, learn how to use plain language in your memos, newsletters, articles, reports and teaching materials.

Plain Language Writing Workshop (Level I) sponsored by Treadwell Library.

**September 30 and October 1, 2004**
**Charles River Park, Room 225**
**Fee: $225**

Register at http://massgeneral.org/library/registration.asp.

For more information, contact Beth Schneider, director of Treadwell Library at eschneider1@partners.org

### Clinicians participate in translation initiative

The MGH Translation Initiative was launched in October, 2003, as a pilot to develop high-quality, culturally appropriate materials and test their impact on patient satisfaction. A multidisciplinary team of clinicians and staff from the Avon Breast Center and the Gillette Center for Women's Cancers collaborated. Using plain-language techniques, they created a seamless pathway of orientation and education materials at appropriate literacy levels. Karin Hobrecker, translation specialist, is now applying this model to other medical services.

### Translating a document: a team effort!

by Karin Hobrecker

Before translating, review with writer and owner of the piece to be translated:

- What is the purpose of the piece?
- What is the context for how the piece will be used?
- What is the key information?
- Who is the target audience and what are the literacy issues?
- Clarify the writing and define technical terms
- Organize key information; put it into logical order

While translating, write, rewrite, and test:

- Keep the purpose of the piece in mind
- Adapt the translation to audience needs
- Test with an audience (small focus groups)
- Review suggested changes with the original writer
- Finalize document and proof read

After translating, create, print, and distribute document. Track its use and solicit feedback

- Select color
- Finalize format (break long text blocks into smaller sections)
- Create draft

# Physical therapist tailors treatment to meet specialized needs of cancer patient

Cheryl Brunelle, PT
physical therapist

My name is Cheryl Brunelle, and I have been a physical therapist for five years, the last 18 months here at MGH. I currently see patients on Bigelow 7, the Gynecology-Oncology Unit. I met 'Lynn' earlier this year when an intern I was supervising was treating her. Lynn is still an inpatient at MGH, and I continue to see her every day.

Lynn is a highly motivated, intelligent, articulate 52-year-old woman who worked as a nurse until her illness curtailed her career. She is married, but her husband is not involved in her care; her mother and sister are Lynn's primary sources of support. She adores her three dogs, and her room is plastered with their pictures. She loves music, and always has a stack of CDs at her bedside.

Lynn was diagnosed with a very serious cancer of the ovary in 1999. She achieved complete clinical remission after an initial course of chemotherapy, then later experienced recurrences, resections, debulking, and has undergone various chemotherapeutic and experimental regimens. In January, 2004, she was enrolled in an immunotherapy study, which resulted in a number of side-effects including colitis, a papular rash, and complications including positive blood cultures, brachial plexus neuropathy, and a small bowel obstruction. Since being diagnosed, she has had many highs and lows. She admits that each low has been progressively harder for her to overcome.

My choice of physical-therapy intervention was the result of a combination of information including the complex patho-physiology of Lynn's many side effects, her medications, complications, and disease process. I wondered if Lynn's decreased strength was a result of her disease, long-term steroid use, deconditioning, or repeated abdominal surgery, which can result in a loss of core stability. The parameters of my program were determined by the effect of Lynn's fatigue on her abdominal muscles and the amount of pain she was in. The program used low reps, high sets, splinting with arm exercises over her G-tube site, boluses prior to physical therapy, increasing her core stability with bed exercises and standing exercises. Providing effective intervention for Lynn involved daily challenges depending on her highs and lows. I always scheduled a co-treatment with a physical therapy aide, and called the unit to ensure the time was suitable for Lynn, her mom, and the nursing and medical staff. We had to reschedule a number of times due to tests, unexpected bowel issues, pain, a poor night's sleep, or those all-important visits from friends, family members, and dogs.

Instilling confidence in Lynn that physical therapy would always happen was sometimes difficult. Knowing that she relied heavily on her physical-therapy treatment as a motivator, I tried everything in my power to make sure it did happen. On more than one occasion when Lynn's physical therapy aide was unavailable, I called upon nurses to help me. We would arrange Lynn's physical therapy to coincide with a bed change or transfer to a chair. Sometimes, nurses would ask me to help weigh Lynn by helping her to stand on and use the scale. Until two weeks ago, Lynn was mobilizing in the corridor with her mother, and actively participating in an exercise program every day. Her mother had learned the program and would help her through it. Lynn was counting on her physical-therapy program to get her strong enough to be able to go home. Unfortunately, she developed a small bowel obstruction and became extremely nauseous. She declined a nasogastric or G-tube placement for more than a week. Eventually, she did agree to have a G-tube placed. During that week, she was too nauseous to participate in physical therapy, and in fact, declined for the entire week. She was unable to get out of bed. I suggested some exercises she could do in bed, gave Lynn's mom ideas about positioning, and educated Lynn on the likely effects of missing a week of physical therapy.

I stopped by every day to see how Lynn and her mom were doing, only to find both of them becoming more and more discouraged. I assured them that when medical management determined that Lynn was ready, we would pick up where we left off with the goal of getting Lynn ready to go home. I made sure they knew about our Chaplaincy, Social Services, and the Pet Therapy program in case they needed more support.

At the end of the week, I re-evaluated Lynn. She had lost a lot of strength and was feeling very discouraged. Due to Lynn's time in bed and the resulting deconditioning, I felt an increased initial frequency of physical therapy was warranted. I asked a physical therapist to see her over the weekend, emphasizing Lynn's recent setback and her need to continue with therapy. Lynn worked with a physical therapist over the weekend. On Sunday, she was successful in transferring to a chair, but unfortunately stayed in the chair too long and was unable to stand to transfer back to bed. The therapist called for assistance and together they helped Lynn transfer safely back to bed. As I could well understand, this had a negative effect on Lynn's confidence, increased her fear of falling, and hurt her pride.

When I entered Lynn's room on Monday I could see her complete discouragement and diminished morale. I asked myself, 'How can I give her what

*continued on next page*

## Exemplar

*continued from page 6*

she needs today and still achieve what I know she can accomplish today?' I immediately addressed the events of the weekend with Lynn and her mom. I suggested we use a stretcher chair for transfers until Lynn's strength returned (that way we could 'slide transfer' her back to bed if she was unable to stand). I asked Lynn how long she felt she could realistically sit in the chair. She said one hour. So that became our goal.

I had become keenly aware of Lynn and her mother's mutually dependent relationship. Her mother didn't accept the word 'can't' from Lynn, and Lynn would never say, 'I can't' unless she really meant it. Lynn, would always say, "Don't ask me. Just do it, and it will get done." I reminded Lynn of our goal to get her home. I told her we'd been in this place of decreased strength and mobility before and had worked our way out of it. We could do it again. This inspired her mom to say, "Come on, let's try. All of us together."

I needed to be careful to choose interventions that instilled confidence in Lynn. When she lost confidence it took her a long while to get it back. I needed a selective treatment approach. Keeping in mind Lynn's disappointment at not being able to get out of bed for a week, her intense fear of trying again, and her ultimate goal of going home, I had to ask myself: What could I do to meet Lynn's needs and still provide attainable goals?

I reviewed her impairments from her recent re-evaluation, which I had completed four days before. I started by prioritizing Lynn's exercise program. I explained why we were doing each exercise—elbow flexion to help her use her Balkan frame and bed rails for bed mobility and repositioning; shoulder flexion to help her reach the Balkan frame with her right hand; elbow extension, knee extension, and bridging to help increase strength in the muscles that would help her to stand. I chose each level of resistance based on Lynn's manual muscle test grade. For example, her elbow extensor grade was 4+/5, meaning she was able to provide maximal resistance through more than 1/2 of her range of movement. I chose a Theraband to provide resistance. I didn't feel free weights were appropriate at this time due to her fatigue level and fear that she could drop a weight. I chose active shoulder flexion only, because Lynn's grade on the manual muscle test was 2+/5, which meant she could lift her arm through less than 1/2 of her range against gravity. I manually guided Lynn's arm during right-shoulder flexion, as she responded well to tactile cues. When I removed my hand, she'd stop lifting her arm, feeling 'it was too weak.' I offered guidance without actual assistance to help her move through her whole range. Lynn got through all the exercises by doing a few reps (5-10) and a few sets (2-3). She would have been unable to do more reps of any particular exercise due to her quick muscle fatigue. I revised the written exercise program that Lynn's mom had been doing with her and asked her to start doing the exercises we had done that day. She was glad to get back to their program and feel like she was making a contribution to getting Lynn home.

**I needed to be careful to choose interventions that instilled confidence in Lynn. When she lost confidence it took her a long while to get it back... I had to ask myself: What could I do to meet Lynn's needs and still provide attainable goals?**

Next came trying to convince Lynn to think about getting out of bed. I didn't think that getting up to a standing position would instill confidence in her. She was too fearful after the weekend. I asked if she could sit on the edge of the bed if we all helped. She said she would try. I talked her through each step, including body positions, hand placement, IV lines (Lynn was very fearful of pulling out an IV line, as her venous access was extremely difficult). She asked me to repeat the explanation, which I did. When helping Lynn to mobilize, I stood very close to her, closer than I would have stood to other patients. She had said that made her feel safe. It took us about ten minutes to get her to the edge of the bed. We did several exercises while she was sitting. I tried to make the time go by faster by talking about the new pictures of Lynn's dogs that her mother had brought in. Lynn said her anxiety level decreased significantly.

We worked on weight-bearing exercises using her feet and bringing her shoulders forward as she would have to do to initiate a stand. I wanted her to practice individual components of the functional movement so she could incorporate them into a whole during the next treatment. Lynn said she was feeling better about working toward her goal of going home, but that it would likely take some time before she was ready to stand. Lynn's mom said, 'One step at a time,' and I reiterated that we had been here before and we could do it again. I asked her to help me understand how I could better meet her needs. She felt that this intervention had been a good start and that she'd like to continue with it. She added that she appreciated the explanations I provided about why we did each intervention. When I stepped out of the room, Lynn's mom came out and hugged me. She thanked me for my patience and for giving them hope that they could do this again.

I still see Lynn. She is working on standing and starting to mobilize. Her strength continues to improve slowly. I think we've 'almost' made our way out of one of Lynn's lows.

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

Patience, understanding, perseverance, and an impressive application of knowledge and skill make this clinical experience a learning tool for all. Cheryl understood the importance that physical therapy held for Lynn over and above physical improvement. It represented hope for Lynn and her mom. Cheryl created opportunities for Lynn to achieve small successes and enjoy some control over her treatment at a time when hope was in short supply. She found the delicate balance between pushing Lynn to improve and allowing her to succeed, all the while educating her about why each intervention was necessary.

This is a wonderful narrative. Thank-you, Cheryl.

## Summer Fun

*continued from front cover*

Tours, and personalized T-shirts and baseball caps. On Bigelow 11, day- and evening-shift staff enjoyed relaxing massages. Says nurse manager, Eileen Flaherty, RN, "It was a great way to acknowledge the hard work, commitment, and compassion of the Bigelow 11 team who work so hard every day to provide exceptional care to patients and families."

Kathleen Myers, RN, nurse manager of White 6 and Ellison 6 used her Summer Fun funding to throw a pizza party for staff and purchase shirts with the names of each unit imprinted on the sleeve or back (Orthopedics, Orthopedics/Urology).

In the PACU, when nurse manager, Kathy Cullen, RN, told staff about her plan to have an ice cream social, they offered to forfeit their summer fun in order to recognize the staff of Ellison 6 for their "consistently exemplary, cooperative, and cheerful efforts in helping the PACU achieve positive patient outcomes and ensure quality care across the continuum." (The PACU had their ice cream social, and a thank-you cake was sent to Ellison 6.)

It's safe to say that the Summer Fun Program was a huge success and a good time was had by all.

**At right**: Staff of Bigelow 11 enjoy relaxing massages as part of the Summer Fun Program. **Far right**: Staff from both the PACU (Post Anesthesia Care Unit) and Ellison 6 celebrate collaborative practice and the cooperative spirit they share that contributes to enhanced patient outcomes.

(Photo by Sam Riley)

(Photo provided by PACU)

# Networking to Improve Care of Health System Elders (NICHE)

*—submitted by staff specialists, Jan Duffy, RN, and Mary Ellen Heike, RN*

Over the next few months, staff will be learning about NICHE, *Networking to Improve the Care of Health System Elders,* a model of care designed to address the needs of older patients. The complexities of geriatric care are well documented. Falls, pressure ulcers, disruption in sleep and eating patterns, urinary incontinence, delirium, and medication reactions can lead to increased lengths of stay and increased hospital costs. Nurses play a key role in preventing and managing conditions that can reduce negative outcomes.

As the population ages, more than 40% of our patients are over the age of 65. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, and associate chief nurses, Theresa Gallivan, RN, and Debra Burke, RN, identified the need for a comprehensive elder care program at MGH. After attending a Leadership Conference sponsored by NICHE, the decision was made to implement this program at MGH. A NICHE Core Planning Team was established to examine our practice models.

NICHE, a program of the John A. Hartford Foundation Institute for Geriatric Nursing at New York University, focuses on nursing practices to improve care to hospitalized elders. It has been implemented at more than 110 hospitals nationwide. At MGH, the program will be expanded to reflect our interdisciplinary approach to patient- and family-centered care.

The NICHE program offers materials and services designed to cultivate a new way of thinking and caring for hospitalized elders. The three-phase approach includes:

- assessing gaps and needs in geriatric nursing care
- modifying nursing care to address these gaps
- evaluating the effectiveness of modifications.

Outcomes at NICHE hospitals include:

- enhanced nursing knowledge and skills regarding the treatment of common geriatric syndromes
- greater patient-satisfaction
- eliminated or reduced use of restraints
- decreased length of stay and re-admission rates for elderly patients

*continued on next page*

# 2005 National Patient Safety Goals

Quality and safety go hand-in-hand, particularly when we're talking about health care. We constantly strive to create the safest possible environment in which to deliver quality care. Much is done inside our walls to ensure the safety of our practice environment, and we benefit from the guidance and direction of outside agencies, as well.

Promoting specific improvements in patient safety, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently introduced its National Patient Safety Goals for 2005. The aim is to focus attention on problem areas within health care, while offering "evidence and expert-based solutions." The goals, in large part, are a by-product of JCAHO's sentinel-event database, which includes blinded, aggregate data that has been reported to JCAHO. Based on emerging patterns, each year an advisory committee recommends specific goals to JCAHO's Board of Commissioners for approval.

During the hospital's next on-site survey—which will occur without advance notice—JCAHO representatives will assess our performance in these areas. Several of the 2004 Goals are being carried over, including:

- Improving the accuracy of patient identification
- Improving the effectiveness of communication among caregivers
- Improving the safety of using medications
- Improving the safety of using infusion pumps
- Reducing the risk of health-care-associated infections

The following Goals will be introduced in 2005:

- Accurately and completely reconciling medications across the continuum of care
- Reducing the risk of patient harm resulting from falls

In the coming months, more information about each goal, along with suggested evidence-based solutions, will be presented in *Caring Headlines*. Additional reference materials (handouts, checklists, websites) will be recommended to help clinicians address these issues at the unit level.

For more information about the 2005 National Patient Safety Goals, log on to the JCAHO website at www.jcaho.org (no spaces) or contact the MGH Office of Quality and Safety at 6-9282.

*This article constitutes a new column in* Caring Headlines. *Because quality and safety are such a vital focus of our daily work,* Caring Headlines *will carry a regular column offering insight into patient-safety issues, trends, research, and stories in the news. Please read and share this information with your colleagues, and feel free to suggest ideas for future topics. For more information about this new column, contact Georgia Peirce at 4-9865.*

## NICHE

*continued from previous page*

- improvements in the physical environment, equipment, and supplies needed to support geriatric care
- an increase in the length of time between re-admissions
- reduction in costs associated with hospital care of the elderly.

The NICHE Core Planning Team is currently assessing MGH policies and procedures, investigating geriatric certification for nurses and physical therapists, and planning for the assessment phase of the program. Look for more on the NICHE implementation process in future issues of *Caring Headlines*. For more information, contact Jan Duffy, RN, at 6-3201.

**NICHE Core Planning Team**

Sponsors:
Debra Burke, RN; and Theresa Gallivan, RN

Alison Bates, PT
Andrea Bonanno, PT
Theresa Cantanno, RN
Scott Ciesielski, RN
Grace Good, RN, CS
Barbara Guire, RN
Keith Perleberg, RN
Jennifer Repper-Delisi, RN
Kate Barba, RN
Sharon Bouvier, RN
Diane Carroll, RN
Joanne Empoliti, RN
Sheila Golden-Baker, RN
Mary Ellen Heike, RN
Marion Phipps, RN
Barbara Roberge, NP



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

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

**Managing Editor**
Susan Sabia



**Distribution**
Please contact Ursula Hoehl at 726-9057 for all issues related to distribution

**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
For more information, call: 617-724-1746.

**Next Publication Date:**
October 7, 2004

# Applying for Accreditation for Partners Human Research Protection Program

*—submitted by Partners Research Management*

In clinical research we strive to meet the highest ethical and professional standards to protect all individuals who participate in human-research studies. Compliance with these standards requires the attention and commitment of many professionals, including clinical researchers, research nurses, our Institutional Review Board (IRB) and its staff, grant and contract negotiators, as well as hospital administrators. Together, all these participants constitute our Human Research Protection Program (HRPP).

Recent review of the conduct and oversight of clinical research has resulted in the development of HRPP accreditation programs to ensure that standards are being met. Although accreditation is voluntary, the process of applying for accreditation affords organizations an opportunity to assess and strengthen their research programs.

MGH and BWH are applying jointly for accreditation as the Partners Human Research Protection Program. The application is being submitted to the Association for the Accreditation of Human Research Protection Programs (AAHRPP) which was incorporated in April, 2001.

The AAHRPP accreditation program uses a voluntary, peer-driven, educational model that is a two-step process. The first step is a rigorous self-assessment, which we have already completed and submitted to the AAHRPP. The second step is a site visit, which is scheduled for Tuesday through Thursday, October 5–7, 2004. During the site visit, AAHRPP evaluators will meet with representatives from all facets of the HRPP, including investigators, IRB members and staff, research administrators, grant and contract personnel, and Partners administration and leadership. In many ways, it will be similar to a JCAHO site visit.

In preparation for the visit, the Partners Human Research Committee will send frequent, brief, educational bulletins reminding staff of certain policies (policies are also posted on the Partners Human Research Committee website: http://healthcare.partners.org/phsirb/home.htm. Please take a moment to read these notices. This is also an excellent opportunity to consult with the Partners Human Research Quality Improvement Program to assess compliance with relevant regulations and policies.

For more information about this new accreditation, please contact Rosalyn Gray or P. Pearl O'Rourke, MD, via e-mail. For information on AAHRPP, visit their website at http://www.aahrpp.org (no spaces).

## Call for Nominations

### Norman Knight Preceptor of Distinction Award

Nominations are now being accepted for the Norman Knight Preceptor of Distinction Award, which recognizes clinical staff nurses who consistently demonstrate excellence in educating, precepting, mentoring and coaching fellow nurses. Candidates are nurses who demonstrate commitment to the preceptor role, seek opportunities as life-long learners to enhance their own knowledge and skills, and work to create a responsive and respectful practice environment.

Nurses may nominate colleagues whom they know to be strong educators, preceptors, mentors and coaches. Nomination forms are available on all inpatient units and in The Center for Clinical & Professional Development on Founders 6.

**Nominations are due by October 25, 2004**

The second Norman Knight Preceptor of Distinction Award will be presented on February 10, 2005. Recipient will receive a professional development award in the form of tuition for a nursing course or a program of study with a clinical nurse specialist.

For more information, please call Rosalie Tyrrell, RN, at 724-3019.

**The Employee Assistance Program**
Work-Life Seminar and Educational Series
presents

### The Elder Care Monthly Series

Presented by Barbara Moscowitz, LICSW, geriatric social worker

Series will address: care coordination; legal, estate, and medical issues; grieving; and caring for yourself while caring for elder loved ones.

**Starts Tuesday, September 28, 2004**
**12:00–1:00pm**
**VBK401**

For more information, call 726-6976.

## Jewish Holiday Schedule 2004/5765

Friday, September 24, 2004
2:00pm
Erev Yom Kippur Service
Eve of the Day of Atonement

Wednesday, September 29, 2004
2:00pm
Erev Sukkot Service
Eve of the Holiday of Sukkot

Wednesday, October 6, 2004
2:00pm
Hoshanah Rabbah Service
Service for the Seventh Day of Sukkot

All services held in the MGH Chapel
Light refreshments will be served

For more information, call Rabbi Ben Lanckton, Jewish chaplain, at 4-3228

Shanah tovah u'metukah
A new year of goodness and sweetness

| When/Where | Description | Contact Hours |
|---|---|---|
| October 5<br>7:30–11:00am/12:00–3:30pm | **CPR—American Heart Association BLS Re-Certification**<br>VBK 401 | - - - |
| October 6<br>8:00–11:30am | **Intermediate Arrhythmias**<br>Haber Conference Room | 3.9 |
| October 6<br>12:15–4:30pm | **Pacing: Advanced Concepts**<br>Haber Conference Room | 4.5 |
| October 13<br>8:00am–2:30pm | **New Graduate Nurse Development Seminar I**<br>Training Department, Charles River Plaza | 6.0<br>(for mentors only) |
| October 13<br>1:30–2:30pm | **OA/PCA/USA Connections**<br>"Skin Care and Prevention of Pressure Ulcers." Bigelow 4 Amphitheater | - - - |
| October 13<br>11:00am–12:00pm | **Nursing Grand Rounds**<br>"The Respiratory-Compromised Patient." Sweet Conference Room GRB 432 | 1.2 |
| October 13<br>8:00am–4:30pm | **Advances in Anti-Coagulation**<br>Shriners Auditorium | 8.1 |
| October 15 and 18<br>8:00am–5:00pm | **Advanced Cardiac Life Support (ACLS)—Provider Course**<br>Day 1: O'Keeffe Auditorium. Day 2: Wellman Conference Room | 16.8<br>for completing both days |
| October 15 and 20<br>8:00am–4:15pm | **Neuroscience Nursing Review Course**<br>Day 1: Walcott Conference Rooms. Day 2: Wellman Conference Room | TBA |
| October 18<br>8:00am–4:30pm | **A Diabetic Odyssey**<br>O'Keeffe Auditorium | TBA |
| October 20<br>1:30–2:30pm | **USA Educational Series**<br>Bigelow 4 Amphitheater | - - - |
| October 21<br>8:00am–2:00pm | **BLS Certification for Healthcare Providers**<br>VBK601 | - - - |
| October 21<br>8:00am–4:30pm | **Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other**<br>Training Department, Charles River Plaza | 7.2 |
| October 22<br>7:30–11:30am and 12:30–4:30pm | **Congenital Heart Disease**<br>Burr 3 Conference Room | 4.5 |
| October 25<br>7:30–11:00am/12:00–3:30pm | **CPR—American Heart Association BLS Re-Certification**<br>VBK 401 | - - - |
| October 25 and 26<br>7:30am–4:30pm | **Intra-Aortic Balloon Pump Workshop**<br>Day 1: Wellman Conference Room. Day 2: VBK601 | 14.4<br>for completing both days |
| October 26<br>8:00am and 12:00pm (Adult)<br>10:00am and 2:00pm (Pediatric) | **CPR—Age-Specific Mannequin Demonstration of BLS Skills**<br>VBK 401 (No BLS card given) | - - - |
| October 27<br>8:00am–2:30pm | **New Graduate Nurse Development Seminar II**<br>Training Department, Charles River Plaza | 5.4 (for mentors only) |
| October 28<br>8:00am–4:30pm | **Evidence-Based Nursing Practice**<br>Morning: Haber Conference Room. Afternoon: Charles River Plaza | 7.8 |
| October 28<br>1:30–2:30pm | **Nursing Grand Rounds**<br>"Focus on Patient Safety." O'Keeffe Auditorium | 1.2 |
| October 29<br>8:00am–4:30pm | **Workforce Dynamics: Skills for Success**<br>Training Department, Charles River Plaza | 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.

# Kidney Care Day

The Renal Unit is pleased to announce the first-ever MGH Kidney Care Day

**Thursday, September 30, 2004**
**8:00am–4:00pm**
**O'Keeffe Auditorium and the Main Corridor**

Educational programs, medical grand rounds, blood pressure screenings, and discipline-specific information on kidney disease.

8:00am
Medical Grand Rounds
with Dr. Robert Toto
"Improving Outcomes in Diabetic Nephropathy"
O'Keeffe Auditorium

9:00am–1:00pm
Educational tables in the Main Corridor staffed by kidney care providers at MGH and throughout the area (including representatives from: The Center for Renal Education, Hemodialysis, Peritoneal Dialysis, Pediatric Nephrology, Food & Nutrition Services, and the Transplant Unit)

2:15pm
Special guest speaker
"The Humorous Side of Coping with Chronic Illness"
O'Keeffe Auditorium

For more information, call 617-720-2774

# On-site BSN and master's degrees in Nursing

Registered nurses at MGH seeking a baccalaureate (BSN) or master's degree in Nursing, come learn more about opportunities to earn degrees through on-site programs.

On-site program offered by Northeastern University

Distance Learning program offered by St. Joseph's College of Maine

**Information Sessions**
**Tuesday, September 28, 2004**
**6:30am–7:00pm**

Information tables in the White Lobby will direct you to sessions being held at times convenient for you.

For more information, contact: Miriam Greenspan, RN, on-site education coordinator in The Center for Clinical & Professional Development at: 724-3506
pager: 3-0724
or by e-mail

First classes to begin in January, 2005

# De-coding professional ethics:

## how does your code guide your practice?

The Ethics In Clinical Practice Committee invites you to attend a special program focusing on codes of ethics employed by various healthcare disciplines. We will discuss how codes of ethics guide interdisciplinary, clinical decision-making in resolving ethical dilemmas and the legal implications for use.

Presenters:
Christine Mitchell, Marilyn McMahon, and Regina Holdstock
Panel discussion to follow

**September 29, 2004**
**8:30am–12:00pm**
**Haber Conference Room**
**(across from O'Keeffe Auditorium)**

Limited to 45 participants

Refreshments will be available

Nursing CEUs available

For more information or to register, call The Center for Clinical & Professional Development at 6-3111 (include your name, discipline, hospital location and contact information)

Caring HEADLINES

Send returns only to Bigelow 10
Nursing Office, MGH
55 Fruit Street
Boston, MA 02114-2696

First Class
US Postage Paid
Permit #57416
Boston MA