August 4, 2005

Caring HEADLINES

Career exploration brings Bermuda high-school students to MGH

(See page 7)

Physical therapist, Ann Styers, PT (right), works with patient, Quynh Ton (center), in the physical therapy gym with a little help from a visiting Bermudian student

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MGH Patient Care Services
Working together to shape the future

Patients First: a comprehensive new quality and safety initiative

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

Putting patients first has always been the driving force behind clinical practice at MGH. Now, it is also a formal quality and safety initiative being launched in the state of Massachusetts. In January of this year, Massachusetts hospitals came together to introduce Patients First: Continuing the Commitment to Safe Care, a comprehensive plan to ensure that safe, high-quality patient care remains the healthcare standard in our state. To date, more than 80 individual hospitals, including MGH, have signed on to endorse the five-part safety agenda, which supports:

- staffing according to the individual needs of each patient
- educating the public to make informed healthcare decisions
- using hospital-based and community partnerships to re-build a shrinking workforce
- promoting safe, high-quality care for everyone by partnering with business, government, and consumer groups
- eliminating mandatory overtime

While this work is being advanced throughout the state, two competing bills have been put forth regarding patient safety. The first bill supports the state-wide initiative I just described. The second calls for government-mandated staffing ratios for nurses. At a recent hearing on Beacon Hill before the Committee on Public Health, several MGH nurses added their voice to the debate.

Staff nurse, Meg Soriano, RN, gave compelling testimony as a front-line caregiver saying, "As a nurse, I'm here today to support Senate Bill 1260, the Patients First bill, because it ensures that nurses and doctors have the flexibility we need to make patient-care decisions at the bedside. With due respect to legislators, caregivers are highly trained and skilled at making life-saving decisions, and not relying on government-mandated ratios to do so. We need nurse staffing practices that ensure patient safety, not meet government regulations.

"With the nursing shortage expected to reach a shortfall of 10,000 nurses by the end of the decade, this bill takes real steps to help relieve the shortage and put more nurses in Massachusetts hospitals by investing in nursing education and making it easier for universities to hire nursing faculty.

"Nurses take pride in providing holistic care to our patients, taking into account all factors that affect a person's health and wellness. The Patients First bill takes a holistic approach to the profession of nursing—it identifies the problems we're facing and the external influences that continue to challenge us. The bill offers a comprehensive approach to the issues without losing sight of basic nursing values: providing safe, compassionate, high-quality care."

Janet Madigan, RN, project manager, echoed Meg's sentiments. "The Patients First bill, is the proactive solution the legislature has been seeking. It addresses the nursing shortage and promotes safe patient care by creating public accountability and state oversight for the process of determining safe staffing patterns.

"This is the only bill before you that focuses on the most important issue of all—patient outcomes. It provides a process by which hospitals can identify, monitor, and publicly report staffing plans and nurse-sensitive outcomes."

At a time when health care is facing a dramatic shortage of nurses and other healthcare professionals, it's imperative that our solutions be thoughtful, coordinated, and far-reaching. The

continued on next page

Caring HEADLINES

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

For assistance in searching back issues, contact Jess Beaham, at 6-3193

MGH Institute of Health Professions Clinical Nurse Specialist Program

developed in collaboration with MGH Nursing

Information sessions:

Wednesday, August 17, 2005
11:00am–1:00pm and 6:30–8:00pm

Monday August 29, 2005
6:30–8:00am, 11:00–1:00pm and 6:30–8:00pm

Program begins in September, 2005
For more information, contact Miriam Greenspan or Pamela Senesac by e-mail

Pneumococcal Vaccine Program

On May 3, 2005, Phase II of the Pneumovax Program was rolled out in Provider Order Entry (POE). In this phase, a screen appears to the first provider who signs on to write orders for inpatients age 65 and older. The provider can select the default order for the Pneumovax, decline the order, or defer the decision for up to five days. An average of 175 vaccines per week have been ordered since implementation of Phase II

Question: What is the procedure for administering the vaccine after the order is received in POE?

Jeanette: The nurse will screen the patient for eligibility using the Pneumococcal Vaccination Screening and Eligibility Form (84592 rev. 2/05) and give the patient and/or family a copy of the Pneumococcal Polysaccharide Vaccine Statement (84492) to review. If the patient meets eligibility criteria, the nurse will administer the vaccine and complete the vaccine information at the bottom of the form. The form is filed in the Medication Section of the medical record.

Question: In the past, nurses weren't authorized to administer vaccines. Am I currently authorized to administer vaccines?

Jeanette: Yes, nurses are authorized to administer vaccines. You can refer to the Medication: Injections Procedure in the Nursing Procedure Manual for more information.

Question: Is the vaccine safe for immunocompromised patients?

Jeanette: Yes. According to Dr. David Hooper, chief of the MGH Infection Control Unit, the vaccine is a polysaccharide, not a live vaccine, and is safe for use with immunocompromised patients.

Question: Does the nurse have to obtain consent from the patient prior to administering the Pneumovax?

Jeanette: No, but the patient and/or family have the right to refuse the vaccine after reviewing the Pneumococcal Polysaccharide Vaccine Statement.

Question: Do I have to wait until the day of discharge to administer the vaccine?

Jeanette: No, but if the vaccine is given on the day of discharge, it must be given at least 20 minutes prior to discharge so the patient can be observed for a reaction. The vaccine is very safe with mild side-effects that may include redness or pain at the injection site. Severe reactions, such as hives, shock, or difficulty breathing occur rarely and should be reported immediately to the patient's physician.

Question: Do I need to document vaccine information in the Nursing Discharge Module?

Jeanette: Yes. The nurse discharging the patient must document the date the patient received the Pneumovax or the reason the patient didn't receive the Pneumovax. The POE screen will not appear during subsequent admissions if it's documented that the patient received the vaccine or had an allergy to the vaccine.

Question: Will this program expand to include other vaccines?

Jeanette: Yes. Soon providers will be prompted to order flu vaccine for patients 50 and older, from October through March, if there is adequate supply of vaccine.

Question: Can vaccine information be shared between the Nursing Discharge Screen and the On Call and LMR systems?

Jeanette: A two-way interface is being developed and will be implemented in the fall. For more information about the Pneumovax and Flu Vaccine Programs call Janet Madigan, RN, project manager at 6-3109.

Jeanette Ives Erickson

continued from previous page

projected shortage threatens every hospital's ability to recruit and retain competent staff, which in turn threatens our ability to provide safe, quality care. We need to address this challenge with the wisdom and experience we've gained as front-line caregivers.

We are fortunate to live in a state that boasts one of the most respected healthcare systems in the world. We need to preserve what is good about that system, and constantly be vigilant for ways to improve it. It is imperative for healthcare providers to have the flexibility to deliver individualized, high-quality care, and ensure that all healthcare decisions are based on the needs and best interests of our patients.

Patient safety is an issue of utmost importance to all of us in health care. If you have any questions or would like to discuss any of the bills or initiatives I've mentioned, I'd be more than happy to speak with you.

Update

It's my pleasure to announce that Lori Pugsley, RN, has accepted the position of nurse manager for the Blake/Ellison 13 Obstetrics Unit.

Obstetrics staff nurse, Brenda Pritchard, RN, has been selected as spiritual care fellow and will participate in the Clinical Pastoral Education Program for Healthcare Professionals, an interdisciplinary program offered by Chaplaincy.

NU at MGH

Are you interested in continuing your nursing education?

Are you interested in pursuing a master's degree in Nursing?

If you are, and you're currently a nurse working at MGH, Northeastern University is offering a program just for you.

Northeastern University is offering graduate programs in:
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mgreenspan@partners.org
telephone: 4-3506
pager: 3-0724

Me and My Baby: a valuable support group for new moms

—by Jodi Wolf, RN, and Maryann Corea-Carroll, RN

You can hear the Ellison elevator doors opening and closing as the moms and their babies get off on Ellison 15. They park their carriages outside the conference room, spread blankets on the floor, put their babies on their laps, and get ready to talk.

It's the beginning of Me and My Baby, a post-partum support group at MGH facilitated by OB nurses. The group meets once a week, and babies can be as young as two weeks old. There's a second group for 'older babies,' usually eight months old and older. These support groups were formed in response to a basic need identified by post-partum mothers to have a support group in the Boston area.

Sessions start with unstructured mingling, then eventually the facilitators, Maryann Corea-Carroll, RN, and Jodi Wolf, RN, staff nurses on the OB unit, are introduced. Then each of the moms introduces herself and her baby. The group varies in size depending on the day.

After introductions, a topic of interest is identified and discussed for about 20 minutes. Topics range from finding a baby-sitter for the first time to developmental milestones. Our lactation consultant is on hand to talk about any breast-feeding questions or concerns. During the rest of the session, moms get acquainted with one another, ask questions, share experiences and child-care tips, or talk about resources available in the Boston area. Many of the moms form play groups that meet outside the support group. The goal is to teach new moms to be resourceful and advocate for themselves as they transition into the role of mother.

There's a similar scenario at the Chelsea Health Center every week. Moms in this support group speak mostly Spanish. With the help of medical interpreter, Diana Maldonado, and OB outreach worker, Adela Marquez, communication among the moms goes smoothly. Originally, this group was intended to follow the same guidelines as the group at MGH. But interestingly, it developed into a combination support group for pregnant women as well as newly post-partum mothers. It evolved because pregnant women at the Chelsea Health Center identified a need for support both before and after giving birth. Women in the group have the opportunity to develop relationships before most of their babies are born.

This past May, we had a special Mothers Day Outing, a pot-luck picnic on the Charles, where we celebrated the hard work, devotion, and accomplishments of all the moms in the group. Photo albums were given to each mom so they could start chronicling their pictures and organizing memories of their babies.

Response to these groups has been very positive. Moms love having a forum for sharing information and garnering support.

One participant says, "I was such a wreck after my mom left. I didn't know what to do with this new baby. I was used to living a selfish life with my husband. This group helped me feel normal and validated all my feelings and anxiety."

This is just one example of the positive feedback we've received about the Me and My Baby support groups. We tell all our patients about the group and stress that it's not a support group for post-partum depression. (Although, if a woman is depressed we direct her to the appropriate resources at MGH.) It's been wonderful getting to know the moms, watching their babies grow, and more importantly, seeing the moms grow. We hope word continues to spread and new moms continue to seek support and companionship in the Me and My Baby support groups.

For more information on the Me and My Baby support groups, call 617-726-4312, or visit: www.massgeneral.org/familyeducation, on-line.

Me and My Baby Support Group

(Photo provided by staff)

Carol A. Ghiloni Oncology Nursing Fellowship

—by Amanda Coakley, RN, staff specialist

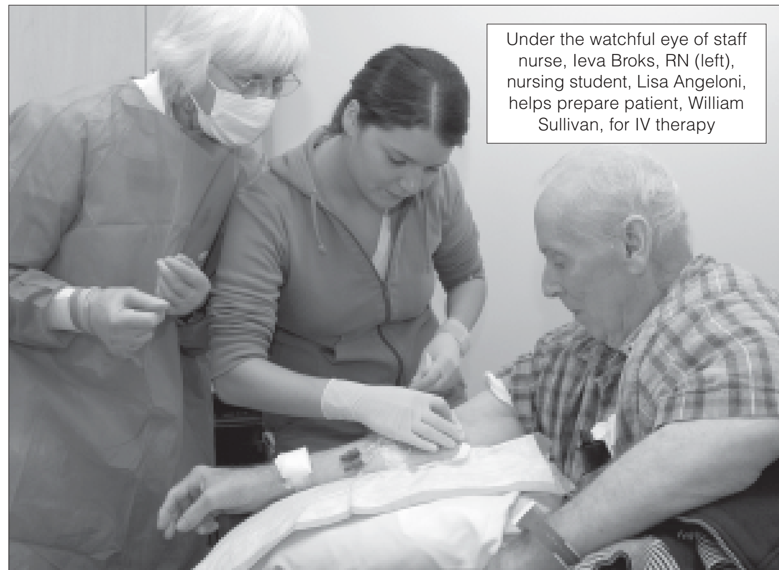
Lisa Angeloni, a nursing student at Boston College, and Peg Baldwin, a student at the University of Massachusetts, Lowell, are currently participating in the ten-week Carol A. Ghiloni Oncology Nursing Fellowship program, which was created in 2001. The fellowship provides students with a hands-on opportunity to learn about the specialty of oncology nursing. Angeloni and Baldwin have been learning about the various roles nurses play and the many different career opportunities available to them upon graduation. Both Angeloni and Baldwin began their fellowship with a five-week rotation on an inpatient oncology unit, Baldwin on Bigelow 7, and Angeloni on Ellison 14. The fellows have had an opportunity to observe in Radiation Oncology, the Infusion Unit, and in outpatient cancer centers in the Yawkey Building. They attended Schwartz Center Rounds, a variety of HOPES programs, and other educational programs offered within the Cancer Center.

This year, Margie Laccetti, RN, was the faculty oncology fellow. Laccetti is currently an associate professor at Boston College where she teaches Adult Health. She spent the past ten weeks rotating through many of the specialty areas in our Oncology Service observing some of the newest techniques and procedures that she talks about in the classroom.

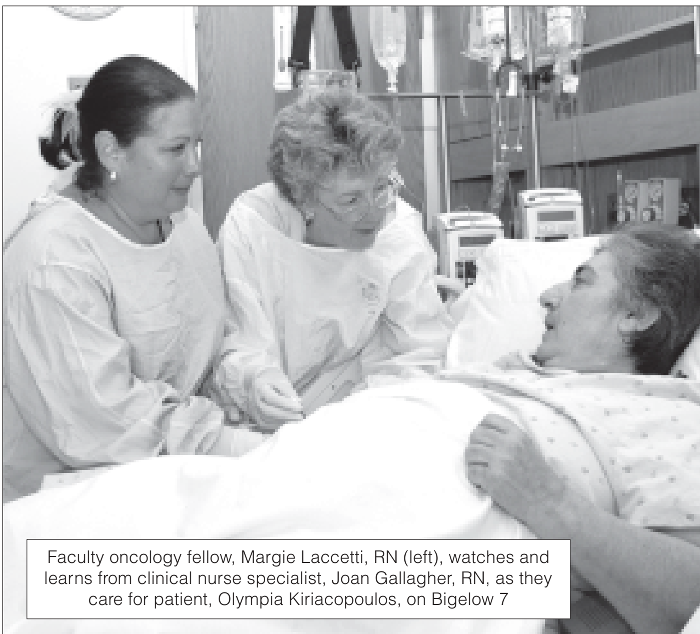
The Oncology Fellowship is partially funded by Johnson & Johnson and has been an excellent learning opportunity for students and faculty alike. The program has been a valuable recruitment tool as well, with six of the past eight fellows accepting employment with the Oncology Nursing Service at MGH.

The fellowship program was named for Carol Ghiloni in 2004 upon her retirement from MGH where she worked for more than 40 years. At the time of her retirement, Ghiloni was nurse manager of Ellison 14. She is currently involved with the ongoing development of the fellowship program.

For more information about the Carol A. Ghiloni Oncology Nursing Fellowship program, contact Mandi Coakley, RN, at 6-5334.



Under the watchful eye of staff nurse, Ieva Broks, RN (left), nursing student, Lisa Angeloni, helps prepare patient, William Sullivan, for IV therapy



Faculty oncology fellow, Margie Laccetti, RN (left), watches and learns from clinical nurse specialist, Joan Gallagher, RN, as they care for patient, Olympia Kiriacopoulos, on Bigelow 7

Staff nurse, Dana Villeneuve, RN (left) shows nursing student, Peg Baldwin, how to verify chemotherapy orders on the computer

Pain-management, a pivotal part of patient care on White 6

Jean Stewart, RN, staff nurse, advanced clinician, White 6

My name is Jean Stewart, and I am a nurse on the White 6 Orthopaedics Unit. It was a typical day on White 6, that is to say, it was a typically busy day, when one of my colleagues approached and asked for help with one of her patients.

Mr. J was a middle-aged man who had undergone total knee-replacement surgery the day before and was now experiencing a great deal of pain. The nurse informed me that the patient was restless, had not slept, and was using a patient-controlled analgesic (PCA) device to administer morphine every six minutes. The nurse added that the orthopaedic team was planning to consult the Pain Service, but she wanted me to assess Mr. J before that happened. I agreed, and we went together to the patient's room.

When we got there, I stopped in the doorway and observed the patient. He appeared to be sleeping. My colleague turned to me and said she'd come get me when Mr. J woke up.

"He's not sleeping," I said.

It's not unusual for patients in pain to lie still in bed with their eyes closed. To the inexperienced eye, it may seem like they're sleeping and pain-free. One of the first things I teach staff is to take the time to wait and watch. Taking a closer look at Mr. J, we could see that he was fidgeting slightly and his eyes flickered. From the look of his bed, it appeared he hadn't slept all night.

I went to the bedside, and Mr. J's eyes opened. I introduced myself and explained that his nurse had asked me to help control his pain. I assured him we were going to do everything possible to make him comfortable.

Mr. J told me he 'wasn't a wimp' and didn't like to take medication. He didn't want to be seen by the Pain Service because he was afraid they'd give him even more medication. I asked if I could ask him some questions to help me understand the nature of his pain, and that would help us decide if we needed to call the Pain Service. I reiterated that our goal was to make him comfortable.

I asked Mr. J to tell me about his pain. He described, 'hitting the PCA button' then dozing off and waking up later in pain.

"When you fall asleep, does it feel like you've been sleeping for days?" I asked. "Or do you wake up in pain, hit the button, and feel surprised when no medicine comes because it's only been a few minutes?"

His eyes opened wide as if he knew exactly what I was talking about.

"Yes," he said.

I asked if he felt he was getting *any* relief, and he said he couldn't tell because he kept falling asleep and waking up in pain. He said he just kept hitting the button hoping it would relieve his pain and let him get some rest.

This is a common cycle for patients to experience post-operatively. The PCA device can be very effective for some patients on the first day after surgery, but may not meet pain and rehabilitative needs on subsequent days.

I asked Mr. J if he had been able to tolerate any breakfast. He said he'd had a few sips of juice and kept it down, so I suggested he have some toast and crackers and take two Percocet. I walked Mr. J and his nurse through my thinking—he was tolerating food, and the Percocet would prevent the waves of pain he'd been experiencing. But I recommended keeping Mr. J on the PCA until we all felt comfortable that his pain was under control.

I cleared the PCA device (so we would be able to track how often Mr. J used it), and his nurse administered the Percocet.

I asked the nurse to continue to monitor his use of the PCA, and I let her know I'd consult with her later to decide whether it should be discontinued or if the dose should be decreased. I also mentioned that even when the PCA is discontinued, many patients like to keep it in their room for a few hours until they're sure they really won't need it.

Within a half hour, the nurse and I looked in on Mr. J to find him resting peacefully. After a few hours, he awoke to eat lunch, sit in his chair, and begin physical therapy.

The next day, when I saw him walking with his nurse in the hall, I overheard the nurse say, "There goes your savior." Mr. J stopped and thanked me for my help. He said he felt much more comfortable and that the fog in his head had lifted.

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

Jean's narrative beautifully describes two important areas of clinical practice—one is keeping patients free of pain, the other is educating staff and co-workers on how to recognize, assess, and effectively manage pain. By sharing her insights and the observations she's accrued over many years as an orthopaedic nurse, Jean helped Mr. J achieve a level of comfort. And just as important, she imparted knowledge to her colleague—knowledge her colleague can use when caring for patients in the future.

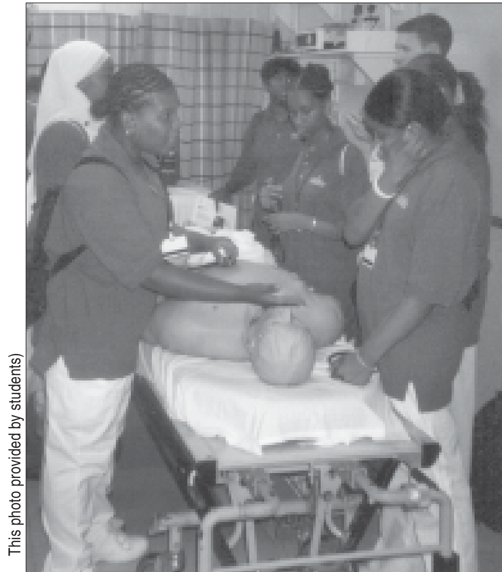
This narrative reminds us that every clinical situation is an opportunity to teach and to learn.

Thank-you, Jean.

Career exploration brings Bermuda high-school students to MGH

On July 28, 2005, ten high-school students from the self-governed British territory of Bermuda visited MGH as part of a career pathway initiative sponsored by MGH, the ACE Foundation, the Bermuda Ministry of Education, and the Bermuda Hospital Board. During their week-long visit, students between the ages of 16 and 19 participated in a number of on- and off-site activities to learn about the array of opportunities available in healthcare professions. All students who participated expressed an interest in pursuing a career in health care and had taken part in the King Edward VII Memorial Hospital Volunteer Programme. After visiting Harvard Medical School, the MGH Institute of Health Professions, and other local points of interest, students spent their last full day shadowing MGH clinicians in on-the-job learning situations. Some of the areas of interest identified by students were Nursing, Physical Therapy, Geriatrics, and Pharmacy.

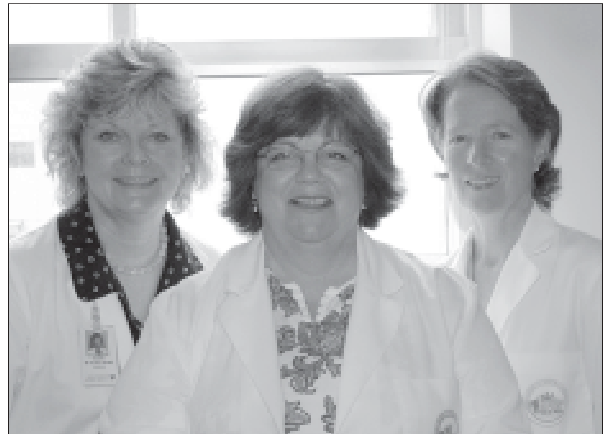
For more information about the Bermuda visit and other student outreach programs, contact Candace Burns at 4-2950.


(This photo provided by students)

Above: Group of visiting Bermudian students learn how to check vital signs at Harvard Medical School's Human Simulation Lab. Above right: Neila Altobelli, RRT, respiratory therapist, explains how a ventilator works to student in the Medical Intensive Care Unit. At right: Students attend an informational session in the MGH Etherdome.

Simulation: bringing hands-on experience to educational programs

—by clinical nurse specialists, Susan Kilroy, RN; Jeanne McHale, RN; and Beth Nagle, RN



Susan Kilroy, RN (left); Jeanne McHale, RN (center); and Beth Nagle, RN

The patient is a 52-year-old male with cellulitis in his right thigh and end-stage renal disease. While awaiting hemodialysis he goes into a wide complex tachycardia. He is apneic and has no pulse. His team of nurses springs into action. They quickly call a code and apply AED pads. Three shocks are delivered without converting the rhythm. They begin ventilation with a manual resuscitator bag, quickly slide the board under his back, and start chest compressions while awaiting the arrival of the code team.

Does this sound like a medical emergency on a general care unit? Actually, it's a group of MGH nurses participating in a simulation exercise with a life-sized, computer-driven mannequin named, SimMan.

Simulation is not a new concept in education. Basic anatomical simulators were used to practice clinical skills as early as the 17th century. Healthcare educators have always valued the 'real-life experience' of learning at the bedside. This can be an effective way to learn, but a balance between the learning needs of the student and the clinical needs of the patient must be maintained. With this in mind, healthcare educators explored the training and education strategies used in other industries. Simulation is widely accepted as an effective learning method in the military, in the field of aviation, and in the nuclear power industry.

In health care, simulation-based education has been widely used in anesthesia training programs for 35 years. As technology became more sophisticated, and life-like synthetic simulators like SimMan were developed, opportunities to offer more dynamic patient-care learning situations became possible. Today, simulation provides an educational experience that allows learners to utilize their clinical knowledge, develop critical-thinking skills, and gain confidence in their clinical abilities.

The department of Nursing's Simulation Program provides opportunities to acquire knowledge and skills in a risk-free, experiential learning environment to improve quality of care and promote safety for patients and clinicians. Simulation occurs in concert with other teaching modalities to enhance the delivery of safe, efficient, competent care. Clinical nurse specialists and educators from The Knight Center for Clinical & Professional Development partnered with clinical nurse specialists from other settings to design and implement some of the initial nursing programs. Members of this group include: Gail Alexander, RN; Patricia Connors, RN; Brian French, RN; Catherine Griffith, RN; Susan Kilroy, RN; Cynthia LaSala, RN; Ann Martin, RN; Jeanne McHale, RN; and Beth Nagle, RN.

Bedside Emergencies for the New Nurse is a program geared toward general-care staff nurses who have less than one year of acute-care experience. The objective is to enhance the nurse's ability to care for patients experiencing bedside emergencies and further develop critical thinking, communication, and teamwork. The course combines hands-on and didactic sessions covering code-cart contents, AED, defibrillators, the role of code team members, how to use the cardiopulmonary arrest flow sheet, and simulation scenarios involving patients with tachyarrhythmias, desaturation, hypotension, and cardiac arrest. Participants have commented on how the program increased their awareness of the 'big picture' in emergency situations and helped them prepare and organize their thoughts and actions during a code.

Michael Bierier, MD; Susan Kilroy, RN; Martha Kane; Monique Mitchell, RN; Ted Stern, MD; Leslie Wlodyka, RN; and Knight Center simulation staff were part of a collaborative effort among Nursing, Psychiatry, Medicine, and Addictions to develop an interdisciplinary program to enhance the ability of nurses and physicians to identify, assess, diagnose, and treat patients with alcohol withdrawal and delirium. This program has been piloted on a number of units and will become a monthly offering in the fall. Based on feedback from participants, the program will expand its focus to include the care of patients with acute mental status change.

Another program was developed to meet the needs of nurses participating in the New Graduate Critical Care Program. These nurses attend a series of simulation sessions covering respiratory emergencies, intubation, shock, and cardiac arrest. Simulations enhance the development of critical thinking, communication, and teamwork as participants apply in practice what they've learned in the classroom. Feedback indicates that participants feel more confident about participating in emergency situations after attending the class.

Code Team Training has been the focus of another program offered in collaboration with the Center for Medical Simulation in Cambridge. Code team members from Nursing, Medicine, Anesthesia, Pharmacy and Respiratory Care participate in simulated cardiac arrests. The goal of the program is to enhance the ability of the interdisciplinary team to optimize the management of pa-

continued on next page

Simulation

continued from previous page

tients in cardiac arrest and introduce principles of critical event-management.

An influx of new graduate nurses on White 8 and White 10 led to the pilot on those units of what would evolve into the Bedside Emergencies program. A similar program was developed for nurses on White 7 and Ellison 7 who would be working in the new Trauma Rapid Admission Care Unit. These programs combined didactic and practical content with simulated patient emergencies to enhance nurses' ability to care for patients in emergent clinical situations.

The newest program, which was piloted in July and is slated for roll-out in the fall is Code Blue: Simulated Codes for the Experienced Nurse. It is geared for general care staff nurses who have more than a year of acute-care experience. Nurses receive didactic code-related information, participate in simulated cardiac arrests, and are introduced to the principles of crisis resource-management. Participants strongly endorsed the program, reporting that it made them feel more comfortable with emergency equipment and the role they play in a code.

Berney Graham, MSW; David Greer, MD; Mary Guanci, RN; and Reverend Linda Knight, along with New England Organ Bank staff, Partners Telemedicine and Knight Center simulation staff are currently working to develop an instructional video demonstrating best practices for approaching families about end-of-life decisions and organ donation.

Interdisciplinary collaboration and partnership with clinical nurse specialists and staff nurses throughout the organization have helped launch the MGH Nursing Simulation program. We look forward to incorporating this exciting teaching modality into new and existing educational programs.

For more information about simulation programs at MGH, contact Gail Alexander, Jeanne McHale, or Beth Nagle at 6-3111.

MGH is committed to improving hand hygiene

MGH follows the CDC guidelines for:

- Hand-hygiene practice
- Hand-hygiene education
- Monitoring for improvement
- Selection of hand-hygiene products
- Providing feedback to the workforce
- Established fingernail policy
- Focused assessment of hand hygiene when outbreaks occur

Stop the Transmission of Pathogens

What is hand hygiene?

Disinfecting hands *plus* washing hands *plus* performing proper skin care constitutes good hand hygiene.

Hand-washing is one of the most important actions you can take to clean your hands and reduce the spread of germs... but healthcare workers must do even more.

Healthcare workers must disinfect hands to stop the spread of pathogens (germs that cause disease), and moisturize hands to help keep their skin healthy and intact.

For more information about hand hygiene, contact your nurse manager, operations coordinator, or infection control practitioner, or call Infection Control directly at 6-2036

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Publisher

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

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Susan Sabia

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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:
August 18, 2005

Stephanie M. Macaluso, RN Excellence in Clinical Practice Award: 'it's an honor just to be nominated'

—by Mary Ellin Smith, RN, professional development coordinator

Every day, clinicians touch the lives of patients, families, and colleagues. The Stephanie M. Macaluso Excellence in Clinical Practice Award is an opportunity to acknowledge and make visible the practice of individual clinicians. The award was created in 1996 to recognize direct-care providers whose practice is caring, innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of leadership and entrepreneurial teamwork

Nominations are now being accepted for the Macaluso Excellence in Clinical Practice Award. Nomination forms are available on patient-care units, in departmental offices, and in The Knight Center for Clinical & Professional Development (6-3111).

Previous recipients of the Macaluso Award acknowledge that it is an important professional accomplishment. Tom Lynch, RN, 2001 recipient, says, "Receiving the award gave me a new and better validation of my professional self."

Anita Carew, RN, says, "It is wonderful to be recognized for strong bedside nursing."

For many, just being nominated by a peer is the most meaningful part of the process. Tessa Goldsmith, SLP, 1998 recipient, says, "It was wonderful to be recognized for my work by the community at large… I was especially moved by the letters of recommendation I received from my colleagues."

The Macaluso Award is an opportunity for patients, families, managers, colleagues, peers, and directors to express their pride in, and appreciation for, clinicians they work with every day.

Once nominated, clinicians submit a portfolio for review by the Selection Committee. Rochelle Butler, LPN, 1999 recipient, described the idea of putting her portfolio together as initially daunting but ultimately allowed her to reflect on her personal journey. Says Butler, "It made me realize that the same interests that made me choose nursing thirty years ago still motivate and influence my practice today."

Recipients of the Macaluso Award receive $1,500 toward attendance at an educational conference of their choosing. Alison Squadrito, PT, 2004 recipient, plans to use her award to attend a national conference. Judy Lynch, RN, 2002 recipient, added to her professional library by purchasing reference books and materials.

For more information, to nominate a clinicians, or for assistance in developing a portfolio, contact professional development coordinator, Mary Ellin Smith, RN, at 4-5801.

August Vacation Club

August 22–September 2, 2005
MGH Backup Child Care Center
Camp Hours: 7:30am–5:45pm

Camp cost: $275 for 5 days; individual days, $60 per child
The program is geared toward 6-12-year-olds.

Activities may include:
Aquarium IMAX, Faneuil Hall Performers, Franklin Park Zoo, Ferry to George's Island, Swimming, Quincy Birthplace Tour, "Boston by Little Feet," Curious Creatures, Cookout at the Center

The Backup Child Care Center is also available to provide care for younger children, aged 15 months–5 years old. Call 617-724-7100, or stop by to make a reservation.

SummerWorks Showcase

Thursday, August 4, 2005
11:30am to 1:00pm
Main Corridor

SummerWorks is a seven-week career exploration/summer employment program offering graduating Timilty School 8th graders paid internships at MGH during their summer vacation. Please stop by the SummerWorks Showcase as interns present the skills, experience, and lessons they learned.

SummerWorks is a school partnership initiative through the MGH Community Benefit Program.

Clinical Pastoral Education Fellowship for Healthcare Providers

The department of Nursing and the Kenneth B. Schwartz Center are offering fellowships for the 2006 MGH Clinical Pastoral Education Program for Healthcare Providers

The Clinical Pastoral Education Program for Healthcare Providers is a part-time program with group sessions meeting on Mondays from 9:00am–5:00pm. Hours for the clinical component are negotiated separately. Deadline for applications is September 1, 2005.

Two spiritual caregiver fellowships are available for the winter 2006 Clinical Pastoral Education Program. Applicants must be registered nurses in the department of Nursing who are in direct-caregiver roles and who have a minimum of 2 years nursing experience.

Six Kenneth B. Schwartz fellowships will be awarded to caregivers from Medicine, Nursing, Social Work, or other disciplines who interact directly with patients and families.

For more information, contact the Chaplaincy at 726-4774, or call Reverend Angelika Zollfrank at 724-43227

Educational Offerings

When/Where	Description	Contact Hours
August 18 1:30–2:30pm	**Nursing Grand Rounds** “Warming up to Legal Issues.” O’Keeffe Auditorium	1.2
August 18 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
August 24 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
August 25 1:30–2:30pm	**Nursing Grand Rounds** “Caring for Patients with Dementia.” O’Keeffe Auditorium	1.2
August 26 12:00–3:30pm	**Basic Respiratory Nursing Care** Ellison 19 Conference Room (1919)	- - -
September 1 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
September 8 1:30–2:30pm	**Nursing Grand Rounds** “Conversations with Patricia Benner.” O’Keeffe Auditorium	1.2
September 9 and 12 8:00am–4:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room	16.8 for completing both days
September 12 and 30 8:00am–4:15pm	**Neuroscience Nursing Review Course** O’Keeffe Auditorium	TBA
September 12 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK401 (No BLS card given)	- - -
September 13 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
September 14 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
September 14 1:30–2:30pm	**OA/PCA/USA Connections** “Superior Service Skills.” Bigelow 4 Amphitheater	- - -
September 14 7:00am–12:00pm	**CVVH Core Program** VBK601	6.3
September 14 11:00am–12:00pm	**Nursing Grand Rounds** “Respiratory Nursing Update.” Sweet Conference Room GRB 432	1.2
September 14 4:00–5:00pm	**More than Just a Journal Club** Thier Conference Room	1.2
September 15 8:00am–4:30pm	**Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other** Training Department, Charles River Plaza	7.2
September 15 1:30–2:30pm	**Nursing Grand Rounds** “Illuminating Practice through Nursing Narratives.” O’Keeffe Auditorium	1.2
September 19 8:00am–4:30pm	**Intermediate Respiratory Care** Thier Conference Room	TBA
September 21 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
September 22 8:00am–4:30pm	**Workforce Dynamics: Skills for Success** Training Department, Charles River Plaza	TBA
September 22 1:30–2:30pm	**Nursing Grand Rounds** “Quality & Safety Update.” O’Keeffe Auditorium	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.

Match it, catch it, attach it

—*by Katie Farraher and Mary Ann Walsh, RN, Office of Quality & Safety*

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) lab survey has been scheduled for September 19–October 3, 2005. The survey of our clinical testing sites occurs every two years, as oppsed to the hospital-wide survey that occurs every three years.

This year, JCAHO's National Patient Safety Goals will be a major focus of the survey, with particular attention to the goal of improving the accuracy of patient identification. It's likely that surveyors will be checking to see that two patient identifiers are used in the specimen-collection process. The expectation is that every clinician, "use at least two patient identifiers (neither of which is to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing; or providing any other treatments or procedures." Patient Care Services has elected to use the patient's name and medical-record number as the two identifiers on all inpatient care units.

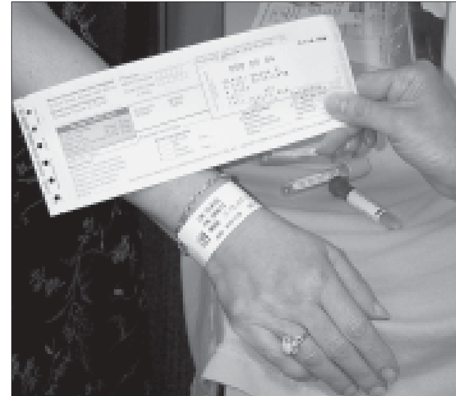
The new campaign, *Match it, Catch it, Attach it*, describes the process clinicians should use when performing lab-related procedures. Clinicians should *match* the name and unit number on the patient's ID band to the name and unit number on the lab requisition and labels on specimen containers. If there's not an exact match, they should *catch it*, correct the mistake, and *attach* the correct label and requisition to the correct specimen.

JCAHO surveyors may go anywhere in the hospital where lab procedures are performed, such as the OR, the Cath lab, or patient care units. They'll ask staff about their practice and may want to observe a blood draw.

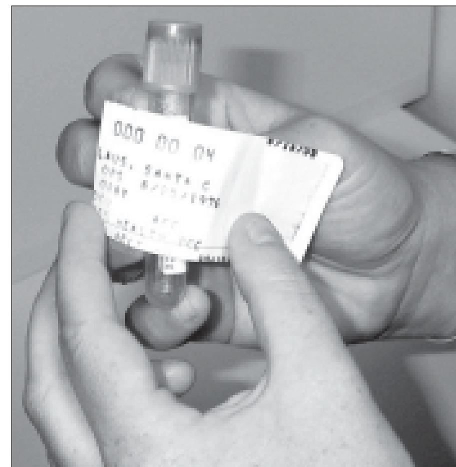
Other aspects of the survey may include hand hygiene, reading back of critical test results, and point-of-care testing. These topics will be addressed in upcoming issues of *Caring Headlines* and in other educational forums.

For more information about the upcoming lab survey, contact Mary Ann Walsh or Katie Farraher in the Office of Quality and Safety at 6-9282.

Match it



Catch it



Attach it

(Photos by Jess Beaham)

Caring HEADLINES

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