December 21, 2006

Caring HEADLINES

Everyone's enjoying the new playroom on Ellison 18!

Thanks to a special grant from Toys 'R' Us and the Starlight Starbright Children's Foundation, the Ellison 18 playroom received a spiffy new make-over, re-opening on Wednesday, December 6, 2006, after almost 18 months of planning, designing, and construction.

Complete with a 55-gallon aquarium, flat-screen plasma television, DVD, VCR, and stereo CD player, built-in interactive games, and a host of new toys (compliments of Toys 'R' Us and Angels Above), the new playroom is a bright, fun, relaxing space for pediatric patients and their families.

The grant request was submitted by child life specialists who heard about the multi-year, multi-million-dollar, joint project between Toys 'R' Us and the Starlight Starbright Children's Foundation to renovate playrooms in hospitals across the country.

Says child life specialist, Anne Bouchard, CCLS, "This project truly was a collaborative effort between so many wonderful people and departments. It was a joy to work with them all every day."

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Toys 'R' Us mascott, Geoffrey the Giraffe, celebrates the opening of the new playroom along with a couple of happy playroom visitors, Nicholas DeFelice and his mom, Denise.

(Photo by Michelle Rose)

Inside:

MGH Patient Care Services
Working together to shape the future

2006 a banner year for Patient Care Services here and abroad

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

Seeing all the wonderful, culturally diverse displays in the Main Corridor always reminds me how much I love the holiday season—spending time with loved ones, sharing in family traditions, and reflecting back on the events of the past year.

I feel fortunate to be part of an organization whose work and mission make such an important contribution to health care, the communities we serve, and indeed, the world. Every year, it seems our influence spreads further and further to bring aid and services to those in need.

In 2006, building on a strong foundation of humanitarian aid and concern, a number of Patient Care Services staff members travelled to foreign lands to bring care and expertise to areas that, in many cases, have no viable healthcare system. Lucinda Langencamp, RN, of the MassGeneral Hospital *for* Children, and Chanda Plong, RN, of the Bigelow 11 Medical Unit, were recipients of the Thomas S. Durant, MD, Fellowship in Refugee Medicine. Lucinda worked in an under-served area of Rwanda, while Chanda served in southeast Asia, including Cambodia, the country from which her parents escaped before she was born.

Karen Holland, RN, and Joy Williams, RN, served aboard the USNS Mercy in Indonesia for three months under the auspices of the Durant Fellowship Program.

I had the privilege of working with Project HOPE and the US Agency for International Development as senior nurse consultant on a project to build a children's hospital in southern Iraq. In my role as consultant, I mentored the person chosen by the Iraqi Ministry of Health to be chief nurse at the Basrah Children's Hospital and flew to Jordan and Oman to meet with the first class of Iraqi nurses being trained to work at the hospital. I continue to be involved with this project and plan to return to Jordan and Oman to meet with future training classes.

To support our growing interest in providing international, humanitarian aid, this year we launched the new MGH Center for Global Health and Disaster Response under the leadership of Thomas Burke, MD. The mission of the center is to, "improve the health of the world's most vulnerable and crisis-affected populations through care-delivery, education, and research."

We launched The Institute for Patient Care, which encompasses The Knight Nursing Center for Clinical & Professional Development; The Maxwell & Eleanor Blum Patient & Family Learning Center; The Yvonne L. Munn Center for Nursing Research; the new Center for Innovations in Care Delivery; and a number of other programs and initiatives geared toward advancing clinical excellence, inter-disciplinary collaboration, education, and research. I'll share more about the vision and other details of the Institute in future issues of *Caring Headlines*.

I feel fortunate to be part of an organization whose work and mission make such an important contribution to health care, the communities we serve, and indeed, the world. Every year, it seems our influence spreads further and further to bring aid and services to those in need.

Excellence in patient care continues to be our highest priority, which is why we supported the Patients First legislation, an historic initiative designed to reduce medical errors, promote supportive work environments, and provide the general public with key information to make informed decisions about healthcare institutions. MGH and 67 other acute-care hospitals in Massachusetts were the first in the nation to voluntarily enact a policy that publicly reports unit-by-unit staffing plans and other key quality measures.

Some new faces joined the Patient Care Services leadership team in 2006. Mike McElhinny, MDiv, became the new director of the Chaplaincy; Eileen Flaherty, RN, assumed the role of director for PCS Financial Management Systems; and Barbara Blakeney, RN, the immediate past-president of the American Nurses Association, became the first innovations specialist in The Center for Innovations in Care Delivery.

Student outreach remains a key component of our recruitment strategy. This year, we hosted students through a variety of programs, including the National Youth Leadership Forum; Job Shadow Day; The Carol A. Ghiloni Oncology Nursing Fellowship; the Pro-Tech Program; and our partnership with the Timilty Middle School in Roxbury, to name only a few.

We were honored to have renowned author and lecturer, Patricia Benner, RN, return as a guest for Nursing Grand Rounds. Benner had a chance to hear a number of clinical narratives, dialogue with staff, and speak about the importance of reflective practice.

Courtney Lyder, RN, doctorally-prepared geriatric nurse practitioner and professor of Nursing

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Ives Erickson

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and Medicine at the University of Virginia, gave the inaugural Knight Visiting Professor in Wound Healing Lecture. Lyder's extensive research includes groundbreaking studies on characteristics of Stage I pressure ulcers in people of color.

Research is a critical component of Patient Care Services' Professional Practice Model. This year, we developed a formal program of nursing research that offers opportunities to nurses at all educational levels and a Nurse Scientist Advancement Model for doctorally prepared nurses. And we will continue to look for opportunities to engage in scientific inquiry as a means of improving patient care.

Quality and safety have always been a top priority at MGH. Among many other initiatives this year, we introduced the web-based safety-reporting system. The online safety-reporting system streamlines the way employees report incidents, speeds communication, and reduces delays in follow-up and improvement measures.

To help eliminate or reduce injuries to caregivers, we have trialed a number of assistive devices. The ceiling lift pilot program was very well received and helped raise awareness about the need for this important technology at MGH.

Because smoking presents such an overarching health risk, we have embarked on an initiative to help identify smokers among our inpatient population and provide them with help and advice on how to quit smoking.

Through the efforts of many people and committees throughout Patient Care Services, we continue to advance our work around capacity-management, advance directives, health literacy, hand hygiene, documentation, fall-reduction, care for the elderly, medication administration, and so many other important initiatives.

We continue to work closely with state legislators and representatives to ensure that important healthcare issues such as staffing, disparities in care, and care for the uninsured are understood and addressed.

During the past (fiscal) year, Patient Care Services continued to grow, welcoming 849 new employees among the various disciplines.

And even as 2006 draws to a close, we continue to explore new ways to improve patient care. It's a privilege to engage in this important work with you. I hope your holiday reflections are as meaningful, rewarding, and inspiring as mine most certainly are.

Thank-you for the contributions you make to patient care at MGH every day. I wish you all a safe and happy holiday.

Updates

I'm pleased to announce that Lin-Ti Chang, RN, has accepted the position of staff specialist providing project-management and support to initiatives in Medicine and the Emergency Department with an emphasis on the MGH Heart Center.

Sara Macchiano, RN, has assumed the position of nurse manager for the White 9 General Medical Unit.

Clinical nurse specialist, Connie Cruz, RN, has joined the Psychiatric Nursing Consultation Service, and Sara Fisher, RN, will come on board in January.

Maria Winne, RN, has accepted the position of nurse manager for the Bigelow 9 Respiratory Acute Care Unit.

Clinical Recognition Program

Advanced clinicians and clinical scholars recognized in 2006

Advanced Clinicians:

- Kelly Macauley, PT, Physical Therapy
- Janet Doherty, RN, Same Day Surgical Unit
- Ellen Silvius, RN, Endoscopy Unit
- Jennifer Mathisen, RN, Medical Intensive Care Unit
- Brenda Pignone, RN, Surgery
- Lori Darragh, RN, Cardiac Surgery
- Rachel Bolton, RN, Radiation Oncology
- Denise Dreher, RN, IV Therapy
- Mary Louisa Zwirner, LICSW, Social Services
- Amy McCarthy, RN, Orthopaedics
- Charlene Gorden, RN, Respiratory Acute Care Unit
- Marilyn Healey, RN, Surgical Unit
- Elizabeth Cole, PT, Physical Therapy
- Jennifer McGaffigan, RN, Obstetrics
- Susan LaGambina, RRT, Respiratory Therapy
- Patrick Birkemose, RN, Cardiology
- Linda Cahoon, RN, Medical Unit
- Marjorie Voltero, RN, Endoscopy Unit
- Carole-Ann Sheridan, RN, Neurology
- Karen Ward, RN, Oncology
- Kelly Macauley, PT, Physical Therapy
- Janet Doherty, RN, Same Day Surgical Unit
- Ellen Silvius, RN, Endoscopy Unit
- Jennifer Mathisen, RN, Medical Intensive Care Unit
- Brenda Pignone, RN, Surgery
- Maryalyce Romano, RN, Surgery
- Christine Perino, RRT, Respiratory Care
- Eileen Collins, PT, Physical Therapy
- Melanie Struzzi, PT, Physical Therapy
- Jennifer Hovsepian, RN, Cardiac Surgery
- Marissa Legare, RN, Transplant Unit
- Tracey Zachary, RN, Emergency Department
- Noel DuPlessis, RN, Neurology
- Katherine O'Meara, RN, Medicical Unit
- Cheryl Hersh, SLP, Speech, Language & Swallowing Disorders
- Kathleen Mortimer, RN, Surgery

Clinical Scholars:

- Sheila Brown, RN, Radiation Therapy
- Kathleen Carr, RN, Coronary Care
- Elyse Levin-Russman, LICSW, Social Services
- Janet Kimbrough, RN, PACU
- Kelley Grealish-Kelly, RN, Same Day Surgical Unit
- Barbara Levin, RN, Orthopaedics
- Corrina Lee, RN, GYN-Oncology
- Cynthia Finn, RN, Cardiac Surgery
- Robert Larocque, RN, Radiology
- Ann Hession, RN, Obstetrics
- Sheila Brown, RN, Radiation Therapy
- Kathleen Carr, RN, Coronary Care
- Elyse Levin-Russman, LICSW, Social Services

Patient-education expert, Fran London, visits MGH

—by Cheryl Brunelle, PT; Kathleen Reilly Lopez, RN; and Taryn Pittman RN, for the Patient Education Committee

In 2005, the Patient Education Committee conducted a staff-needs assessment survey of patient-education practices. The results of the survey gave us insight into staff perceptions of their practice around patient-education assessment, access to resources, teaching skills, evaluation of teaching, and documentation. The survey helped guide the committee in developing its goals for 2006. One goal was to communicate and disseminate patient-education information to the larger MGH community.

Toward that end, the committee organized a patient-education conference with a nationally renowned expert in patient education. Fran London, RN, is a health education specialist at Phoenix Children's Hospital. She has written numerous books on patient education, including, *No Time to Teach?: A Nurse's Guide to Patient and Family Education.* In a recent interview, London said, "I wrote it for nurses who are rushed, but want to improve their skills. I wrote it for real people dealing with real-life issues."

In the preface, London says, "...Nurses can let the state of health care today frustrate us. We can blame the system, say it's not our fault, we have no time to teach, despair the human condition and be miserable. Or we can accept the reality, [and] change perspective."

London brought this perspective to MGH on November 13, 2006, for an interactive, multi-disciplinary, patient-education conference. Conference attendees spent the morning exploring patient education in an interactive, energetic exchange of ideas. London challenged us to think outside the box and find new ways to identify 'teachable moments.' London encouraged clinicians to teach as we go about our every-day, patient-care activities, weaving information into every aspect of care. Feedback from patients and families is essential, she said, to ensure the message is getting through.

London suggested ways of making sure patients being discharged can identify important information. She suggested using a highlighter to distinguish key information on discharge forms, such as how to know when there's a problem, whom to call, and when to see the doctor again.

"I liked the way Fran said to individualize the teaching, involve patients, and evaluate their understanding," said one nurse from the Obstetrics Unit. "It makes sense. Patients and families feel more comfortable if they have a chance to ask questions before they leave." These concepts were the basis of London's presentation: any time you can involve your patient in the education process, your chances of success are improved.

Another nurse said, "Fran helped me realize I have to slow down and think about what I'm doing when I teach my patients. Discharges can

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Author and educator, Fran London, RN, speaks at recent patient-education conference, sponsored by the PCS Patient Education Committee

Patient Education Conference

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be so rushed on my unit." London suggested sitting with patients to 'slow down' the process. This allows patients to ask questions and helps clinicians evaluate the effectiveness of their learning.

Sometimes, patients' priorities are different from ours, and we need to be sensitive to that. We have to allow patients to tell us when it's a good time for new information. Maybe we need to re-frame the idea of 'non-compliance.' "Maybe it's just bad timing, or they just didn't understand it at that moment," said London. "We need to empower families. Clinicians are only with patients for a brief time; family members are with them all the time. We need to work closely with families as they take on some of the healthcare teaching responsibilities."

London advised us to keep three questions in mind when we teach our patients:

- Why does this information matter?
- What is the point of what I'm teaching?
- Why is this important?

She stressed that by keeping these simple questions in mind when we teach our patients, we can really impact their outcomes and care.

During the afternoon session, London held small-group consultative sessions with clinical nurse specialists and the Patient Education Committee. The CNS group brought up several patient-education issues, including how to cover a lot of material in a short amount of time; how to prioritize teaching; how to prepare patients to learn once they're ready for discharge; and how to deal with non-compliant patients. London shared that there are four basic objectives to patient education:

- help patients and families get their questions answered
- help patients and families make informed decisions
- help patients develop basic self-care skills
- help patients recognize problems and know how to respond

Clinicians should focus on these areas when teaching. To ensure success, it is essential to: involve patients and families; individualize teaching to make it more meaningful; and evaluate understanding to ensure that learning has occurred. Clinicians should integrate patient education into their care and use every opportunity to teach. Informal teaching sessions with patients and families can convey important information, reinforce learning, and save time.

London acknowledged that working with non-compliant patients who are frequently readmitted can be frustrating. In such cases, it's important to go back to the assessment and ask additional questions to try to shed light on the patient's behavior. She cited the Kleinman, Eisenberg, and Good assessment as a good tool as it incorporates questions such as: What concerns you most about this illness? What kind of treatment do you think you should get? This type of conversational approach helps alleviate patients' fears and opens up an interactive dialogue.

The Patient Education Committee met with London after the conference to discuss ways the committee could have more organizational impact. London suggested actively looking for best patient-education practices throughout the hospital and sharing those practices at committee meetings and in *Caring Headlines*. We talked about strategies such as informing individual clinical areas about patient-education resources instead of trying to inform everyone at once; making patient education a more prominent part of nursing orientation and precepting programs; training 'super users' in how to access and use patient-education resources and providing incentives for sharing that knowledge with others.

We talked about how to improve the documentation of patient education. London observed that hospital leadership can support the documentation of patient education through performance reviews that validate clinicians' competence. Improved patient-education practices ultimately improve patient outcomes and decrease the number of return visits.

For more information about patient education or the work of the Patient Education Committee, contact Taryn Pittman, RN, at 4-3822.

Caring HEADLINES

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

The MGH Tobacco Treatment Service

Under the current standard, all patients should be asked if they've used tobacco products in the past 12 months. If they have, the Tobacco Treatment Service should be notified (6-7443) for a consult

In the smoke-free environment of the hospital, The Tobacco Treatment Service can help patients avoid nicotine withdrawal

Every patient who has smoked in the past 12 months should be given a copy of the *Guide for Hospital Patients Who Smoke* (Standard Register form #84772). A copy of the guide is placed at every patient's bedside when the room is cleaned

Helping patients to quit smoking is part of the excellent care all clinicians provide at MGH

Make your practice visible Document your work

For more information, or to request a quit-smoking consult, call 6-7443

The administrative fellow experience: Patient Care Services—more than just another rotation

—by Angela Marquez, MPH, (UCLA '06); and David Reisman, MHA, (Ohio State '06)

The Administrative Fellowship Program at MGH is well known and respected among master's prepared professionals interested in pursuing a career in Hospital Administration. Because a hospital administrator needs to have a deep and clear understanding of patient- and family-centered care, Patient Care Services (PCS) is one of the first areas administrative fellows are assigned. During the PCS rotation, fellows complete Operations Associate (OA) training and work in that capacity for several weeks. The experience helps fellows appreciate the challenges associated with the daily operations of a clinical unit.

Fellows are encouraged to shadow members of the clinical staff to develop a sense of how care is delivered and to see the kinds of issues that arise during a patient's hospital stay. During their recent rotation, administrative fellow, Angela Marquez, was assigned to the Medical Intensive Care Unit (MICU) under the preceptorship of nurse manager, Adele Keeley, RN; and David Reisman was assigned to Phillips House 20 and 21 under the preceptorship of nurse manager, Keith Perleberg, RN. All found the experience productive, informative, and rewarding.

Keeley and Perleberg enjoyed working with the fellows and acquainting them to Patient Care Services. They allowed the fellows to take the lead on a number of unit-based projects. Said Keeley, "We had an administrative fellow on the unit last year and I was happy to have another this year to continue our efforts with the End-of-Life Quality of Care initiative. It's not like you're hosting just anybody—you're hosting someone very bright."

In addition to working on projects, the most positive aspect of the rotation were the relationships that developed between preceptors and fellows. Said Perleberg, "Adele recommended working with administrative fellows because you can get to those projects that have been on the back burner because you just didn't have time to work on them. But what amazed me was the level of friendship that developed. I never expected that."

Administrative fellows, David Reisman, left, and Angela Marquez, second from right, with their respective preceptors, Keith Perleberg, RN, and Adele Keeley, RN

The fellows benefited from being a part of a patient care unit and having access to preceptors to guide and mentor them during their rotations. For healthcare professionals who won't be directly involved in the delivery of patient care, the experience was especially rewarding. Said Marquez, "When I found out I was going to be in the MICU, I was very excited. I knew the intensive, fast-paced, environment of an ICU would provide a great opportunity to see firsthand how care is delivered at the bedside. A comprehensive understanding of what's involved in providing appropriate care is essential for hospital administrators. But what I gained from working in the MICU is so much more than that. I developed a rapport and a friendship with everyone on the unit."

Reflecting on their PCS rotation, Marquez and Reisman were thankful for the unique perspective they gained. "Seeing the way care is provided on units is an incredible experience. The quality of care and the compassion staff show to patients and families is remarkable. I know this experience will help me make more informed decisions about hospital operations and resource-allocation in my career," said Reisman.

In agreeing to work with administrative fellows, preceptors assume a significant responsibility. Says Keeley, "I view the fellow's experience as a study in the sociology and anthropology of the organizational culture. The rotation is an introduction to MGH, the unit, and how the organization functions. For the fellows to gain a true understanding of patient care, the preceptor has to feel comfortable enough to be honest and open about every aspect of the unit, the hospital, and how we work together as an organization."

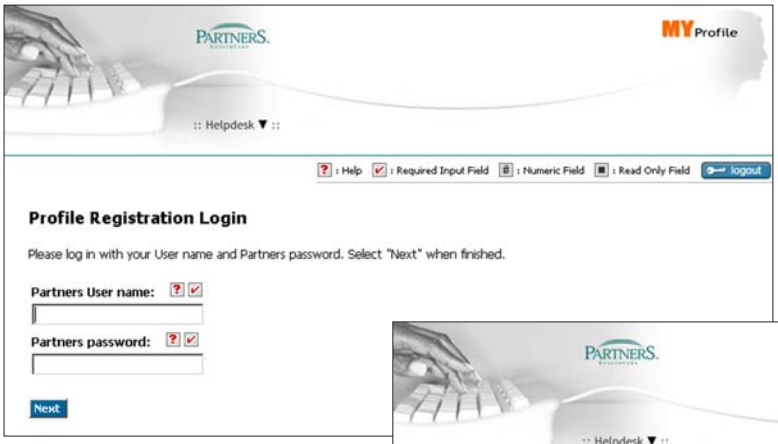
Both Perleberg and Keeley agree that working with a fellow is a rewarding and worthwhile experience. Said Keeley, "It was fascinating to hear Angela's perspective on the inner-workings of the unit and the organization. Hearing about our operations from someone with a fresh perspective is very eye-opening."

The PCS administrative fellowship rotation was personally and professionally rewarding for all involved. Marquez and Reisman expect the relationships they formed to last far beyond their rotation in Patient Care Services.

Change your password: protect your patients, protect your work

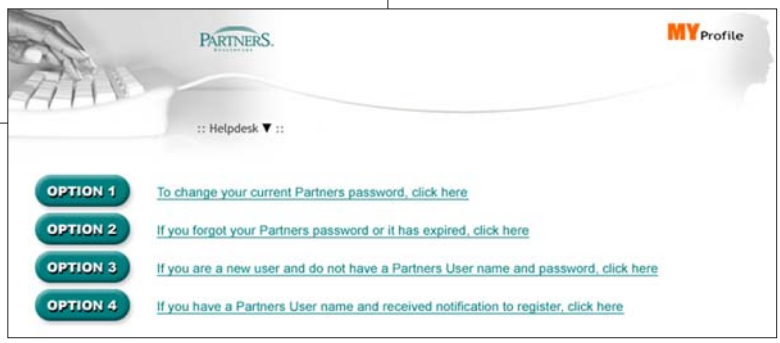
Beginning in January, 2007, all MGH employees and professional staff will need to change the password they use to log on to any Partners/MGH network computer. To ensure a greater level of security, the hospital is switching to a system whereby passwords will expire every 180 days (or every six months). The Password Self-Service system is quick and easy and allows employees to create, change, and manage their own passwords from their computer terminals.

On January 24, 2007, MGH employees will begin to be notified of this change. Every employee who logs on to a network computer will receive an e-mail informing her that her password will be expiring, on what date, and instructions on how to register and create a new password using the MYProfile program.



MYProfile is easy to use, leading employees through a step-by-step process to create their new passwords. Passwords must be at least eight characters long and contain both alpha and numeric characters.

Employees need to create their new Partners password before the expiration date. If a password is not selected before the expiration date, users will be locked out of the Partners network. Several e-mail reminders will be sent prior to the expiration date. Employees will be able to change their passwords at their convenience without any assistance from the Help Desk.



MGH and all Partners affiliates are implementing this new password system to ensure that computers are safe from security breaches such as identity theft, invasion of privacy, and violation of patient confidentiality. Using the new password self-service system puts Partners institutions in alignment with HIPAA guidelines and industry standards that call for stronger security.

Passwords for clinical applications—now called 'keys'—will remain the same. The five- or six-digit keys for clinical applications (examples listed below) will remain the same for signing purposes and will no longer be used as passwords to Partners-networked computers.

Computer systems where keys are currently used include:

- LMR
- PAML
- POE/COE
- PEDI Web
- Consent
- QACT Linkdown
- OR Scheduling
- Dynamic Scheduling
- Nursing Periop
- PATA
- OR Stats
- Periop Print
- Block Manager
- PrefCard
- PICK List

For more information, or a list of frequently asked questions, visit http://helpdesk.partners.org/passwordselfservice.htm. If you have specific questions about the new system, call the Help Desk at 6-5085.

Northeastern at MGH

Register now
Classes start January 8, 2007

Spring courses for the Masters/CNS program
Pharmacology: Mondays 6:00–8:00pm
(2 semester hours)
Pathophysiology: Thursdays 5:00–7:30pm
(3 semester hours)

Classes held at MGH
For more information, call Julie Goldman, RN, at 4-2295

Call for Abstracts

Nursing Research Day 2007

Categories:

- Encore presentations (posters presented at conferences since May, 2006)
- Original research
- Research utilization
- Performance improvement

Some restrictions apply

For more information, go to the Nursing Research Committee website at:
www.mghnursingresearchcommittee.org

Abstracts must be received by January 31, 2007

For experienced CCU nurse, precepting and patient care go hand in hand

J. Patrick Birkemose is an advanced clinician

J. Patrick Birkemose, RN
Ellison 9 Cardiac Care Unit

My name is Patrick Birkemose, and I am a certified critical care nurse on the Ellison 9 Cardiac Care Unit (CCU). Recently, I was orienting a new nurse to our unit. Joe had previous nursing experience but no Intensive Care Unit (ICU) experience. I had already familiarized him with a variety of vasopressors, inotropes and vasodilating medications. We had also worked with different types of equipment, such as the intra-aortic balloon pump (IABP) and pulmonary artery (PA) lines. He quickly grasped each of the basic concepts, but I was hoping for a patient-care experience that would help him put all the pieces together.

Mrs. A is an 84-year-old woman who was admitted to MGH from another hospital. She had an extensive cardiac history and had been admitted to one of our general-care units for shortness of breath. Tests showed that Mrs. A was having a myocardial infarction. She was quickly brought to the Cardiac Catheratization Lab. A stent was placed in her left anterior descending (LAD) coronary artery that feeds the left ventricle, the major pumping chamber of the heart. She developed hypotension after the artery was opened so an intra-aortic balloon pump (IABP) was placed to help with tissue perfusion to her vital organs, especially her heart. A PA line was placed to help determine her cardiac function.

When Mrs. A arrived in the CCU, her very pleasant and understandably distraught daughter was with her. She was overwhelmed with her mother's sudden illness and the dozens of IV lines and machines in the room. As Joe and I began the task of organizing all the lines, medicines, and machines, I took the opportunity to speak with Mrs. A's daughter. I asked if she had any questions about her mother's procedure and explained the equipment to both Mrs. A and her daughter. I explained that the IABP inflates when the heart is relaxed, pushing more blood into the coronary arteries thereby improving oxygenation to the cardiac muscle as well as other vital organs and tissue. I told them that the IABP deflates when the heart contracts. When it does, it creates a sort of vacuum that lowers the amount of force the heart has to overcome to pump blood, making it easier for the heart to work. In short, the IABP was letting her heart rest. I explained to Mrs. A and her daughter that it was important for Mrs. A to lie flat to minimize the risk of injury or accidental removal of the IABP. I informed them I'd be checking her pulse (in her feet and wrists) and the warmth of her feet every hour. This would let me know that her aorta and subclavian arteries were not occluded. I've found that telling patients what to expect during their stay alleviates anxiety in the patient and their loved ones. Later, I reinforced to Joe the importance of communicating with patients and families. In addition to allaying fears, sharing knowledge inspires confidence in our skills and abilities.

I explained that a PA line is used to assess heart function. By injecting normal saline we're able to tell how much blood the heart pumps each minute, how much blood the tissues are getting, and how much resistance the heart is working against. This information put some of Mrs. A and her daughter's concerns to rest. I assured them they would be involved in every decision the healthcare team made and they'd be kept informed of any changes in Mrs. A's condition. I let them know I was available to answer any questions they had.

From my initial assessment, based on Mrs. A's appearance and hemodynamic status, it was apparent that Mrs. A was transferred to the CCU in cardiogenic shock. She had a low cardiac output (CO) and cardiac index (CI) and a high systemic vascular resistance (SVR). It occurred to me that Mrs. A was the perfect patient to help reinforce Joe's learning.

To make sure Mrs. A and her daughter were confident in Joe's ability to care for Mrs. A, I made sure we had a plan for her care and reviewed all pertinent information before entering her room. I wanted them to see Joe as a competent member of the team. This, in turn, would inspire Joe to have confidence in himself. I asked him questions to test his knowledge and assess his plan of care. I asked him how an IABP would help in cardiogenic shock. He correctly responded that it allows the heart to pump more effectively by decreasing the work load of the heart. The IABP also helps improve perfusion to the coronary arteries. One goal of the team was to wean Mrs. A from the IABP. I explained the protocol for weaning to Joe. We reviewed the correct way to care for a patient with an IABP, assessing peripheral pulses, positioning the bed at no greater the 30 degrees. I stressed that weaning required diligence. We needed to assess Mrs. A's ejection fraction (EF) using the echocardiogram to determine how quickly we could wean her. We would need to continue monitoring her using visual assessment, checking her EKGs, cardiac output, cardiac index, and systemic vascular resistance.

Before beginning, we obtained another set of cardiac numbers using the PA line. We determined that her CO remained

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Some portions of this text may have been altered to make the story more understandable to non-clinicians.

Clinical Narrative

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low, and her SVR was increasing. I was concerned that in her current condition, Mrs. A would not be able to wean from the IABP, and I expressed my concerns to Joe. We began to develop a plan of care based on my past experience and the clinical data we had obtained. We would present this to the medical staff at morning rounds.

This was a great opportunity to assess Joe's knowledge and evaluate my own precepting ability. I asked Joe what medications would be best. We considered how dobutamine would help squeeze the heart and allow it to pump more efficiently, helping to improve her CO. Nipride, a vasodilator, would decrease her SVR. We brought this information to rounds and discussed it with the medical team. Based on the data we presented, they came to the same conclusions. They thought it best to start Nipride first and assess its effectiveness. If it wasn't effective, dobutamine would be added. I explained to Joe that this was a safe way to approach Mrs. A's care. Nipride is a very potent vasodilator. Two side-effects of dobutamine are hypotension and cardiac arrhythmias, so together they should be used with care.

We started Mrs. A on Nipride, explaining the reasons and the side-effects to both Mrs. A and her family. After an hour, we obtained another set of cardiac numbers. Mrs. A's SVR had decreased to normal levels (800-1200) but her cardiac output and cardiac index remained low. We approached the medical team and together decided dobutamine should be added to help increase the efficiency of her heart. I explained that we would start at a low dose and monitor for side-effects, such as arrhythmias or hypotension. Then we would re-check her heart to see if the treatment worked. After Mrs. A had been receiving dobutamine for an hour, we obtained more data. Mrs. A's CO and CI had both increased to normal levels, and the SVR remained within normal limits.

The next step was to begin weaning Mrs. A from the IABP. I explained to Joe that in weaning her from the IABP, there could be an increase in after-load and a decrease in coronary artery perfusion. I explained that at every step of the weaning process we would obtain another set of cardiac numbers and an EKG. The cardiac numbers would allow us to adjust her medications as needed, and the EKG would tell us if there was evidence of cardiac ischemia. I stressed the importance of conferring with the medical team as we began the weaning process.

We made sure to explain everything we were doing to Mrs. A and her daughter, which put their minds at ease. At one point, Mrs. A's daughter felt comfortable enough to leave for a few minutes to get a cup of coffee. Mrs. A was able to sleep, even with all the equipment around her. After spending more than 24 hours with her mother, Mrs. A's daughter decided to take a break and return home. We promised to call her if there were any changes. She said she felt comfortable leaving her mother in our care.

Throughout our shift, we were able to successfully wean Mrs. A from the IABP. The following day, Mrs. A was transferred back to a general-care unit and ultimately to a cardiac rehabilitation hospital. It was very rewarding to see Mrs. A respond to treatment and see improvement in her condition. A week after her discharge, Mrs. A's daughter came to the CCU to personally deliver a thank-you note and let us know how Mrs. A was doing.

Joe learned a great deal from this experience. In the following weeks, he showed he had retained knowledge from our experience with Mrs. A and was able to incorporate it into new nursing experiences. It was very satisfying for me as a preceptor to pass on my knowledge and experience.

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

Precepting truly is an art and a science. Patrick's narrative eloquently shows the level of knowledge, skill, attention, and confidence necessary to precept well. Patrick coaches and educates Joe while ensuring that Mrs. A and her family receive the highest quality care. He gives Joe both theoretical knowledge and the hands-on experience he'll need to practice on his own. In a major teaching hospital the caliber of MGH, precepting is a cornerstone of professional practice.

It's a testament to Patrick's skill as a nurse that he was able to make caring for Mrs. A and her family while precepting Joe look so effortless.

Thank-you, Patrick.

Have yourself a multi-cultural holiday

Honoring traditions

New Playroom

continued from front cover

Child life specialists help children and adolescents cope with illness by creating a comfortable, therapeutic, family-centered environment in the hospital setting. And the playroom is an important part of that environment.

Says child life specialist, Sacha Field, CCLS, "Within minutes of the re-opening, the playroom was filled with patients anxious to explore the new space."

For more information about the Child Life Program at MGH, call child life specialist, Ann Bouchard at 4-5839.

Below: interim chief of Pediatrics, Ron Kleinman, MD, speaks at ribbon-cutting ceremony with support from Geoffrey the Giraffe; patient enjoys the new aquarium; and new shelves and cabinets provide ample space and easy access for new toys and games and books

(Photo by Michelle Rose)

Law presents

Suy-Sinh Law, PT, physical therapist, presented, "Maintaining Healthy Bones," at the Gee How Oak Tin Association meeting in Boston, November 12, 2006.

Sabo certified

Kathryn Sabo, RN, became certified as a medical-surgical nurse by the Medical Surgical Certification Board in October, 2006.

Phillips presents

Katherine Phillips, PT, physical therapist, presented, "Splinting Principles" lecture and lab at Tufts University, Boston School of Occupational Therapy, November 20, 2006.
Phillips also presented, "Evaluation of the Upper Extremity," at Tufts, November 27, 2006.

Seitz presents

Amee Seitz, physical therapist, presented, "Shoulder Anatomy and Biomechanics," at Tufts University, Boston School of Occupational Therapy, November 6, 2006.
Seitz also presented, "Shoulder Examination, Diagnosis and Treatment," at Tufts, November 11, 2006.

Brackett, Cresia, and Parker publish

Sharon Brackett, RN; Joan Cresia, RN; and Barbara Parker, RN, authored the chapter, "Profile in Practice, Ethical Dimensions of Nursing and Health Care," in *Conceptual Foundations: the Bridge to Professional Nursing Practice*, fourth edition, 2006.

Nippins presents

Matthew Nippins, PT, physical therapist was a roundtable moderator for "Designing an Inpatient Exercise Program," at the 2006 North American Cystic Fibrosis Conference in Denver, November 2–5, 2006.
Nippins was also an abstract reviewer and a workshop moderator for, "Exercise: Physiology, Testing and Prescription."

Hannon certified

Cecile Hannon, RN, became certified by the CCI Credentialing Institute, as a certified operating room nurse in October, 2006.

Haywood-Baxter certified

Reverend Ann Haywood-Baxter, MDiv, became a board-certified chaplain by the Association of Professional Chaplains, October 30, 2006.

Levin and Morris publish

Barbara Levin, RN, and Nancy Morris, RN, co-authored the chapter, "Complications in Orthopaedics," in *Core Curriculum for Orthopaedic Nursing*, fifth edition, November, 2006.

McCormick-Gendzel and Jurchak publish

Mary McCormick-Gendzel, RN, and Martha Jurchak, RN, co-authored the article, "A Pathway for Moral Reasoning in Home Health Care," in *Home Healthcare Nurse*, Volume 24, Number 10, November-December, 2006.

Cohoon and Lawrence certified

Lisa Cohoon, RN, and Donna Lawrence, RN, Medical Unit, were certified in Cardiovascular Nursing by the American Nurses Credentialing Center in November, 2006.

Nurses and social workers publish

Social workers, Marguerite Hamel-Nardozzi, LICSW, and Angelica Tsoumas, LICSW, co-authored the article, "Complexities in Decision-Making for Persons with Disabilities Nearing the End of Life," with clinical nurse specialists, Ellen M. Robinson, RN, Marion Phipps, RN, and professor and chair of ethics at the MGH Institute of Health Professions, Ruth Purtilo. The article was published in the ethics-themed edition of *Topics in Stroke Rehabilitation*, Fall, 2006.

Levin presents

Barbara Levin, RN, Orthopaedics, presented, "When the Call Bell Rings," at the American Society for Healthcare Risk Management National Conference in San Diego, October 30, 2006.

O'Brien certified

Mary O'Brien, RN, of The Knight Nursing Center for Clinical & Professional Development, was certified in Nursing Professional Development by the American Nurses Credentialing Center in October, 2006.

Macauley presents

Kelly Macauley, PT, physical therapist, presented her poster, "Informational Poster on Massachusetts Geriatric Special Interest Group," at the American Physical Therapy Association, Massachusetts Chapter, in Marlborough, November 4, 2006.

Michel presents

Theresa Michel, PT, physical therapist, presented her poster, "Case-Based Approach to Diagnostic Reasoning," at the American Physical Therapy Association, Massachusetts Chapter, in Marlborough, November 4, 2006.

Dorman and Mulgrew present

Physical therapists, Robert Dorman, PT, and Jacqueline Mulgrew, PT, co-presented their poster, "Minimally-Invasive Hip Arthroplasty vs. Traditional Hip Arthroplasty Surgery: Early Functional Outcomes and the Impact on the Frequency and Duration of Acute-Care Physical Therapy," at the American Physical Therapy Association, Massachusetts Chapter, in Marlborough, November 4, 2006.

Caring HEADLINES

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

2007 Clinical Pastoral Education Program for Healthcare Professionals

—by Reverend Angelika Zollfrank, CPE educator

"I hope to learn more about the beliefs of various cultures and religions in understanding the meaning of illness and suffering."

"I anticipate that speaking to patients about existential concerns will uncover many of my own questions and challenge my own faith."

"I want to learn more about what it means to care for the souls of others as I grow in the care of my own soul."

These are the kinds of expectations identified by the healthcare professionals who will participate in the 2007 Clinical Pastoral Education Program at MGH. Of the eight healthcare providers chosen, six are recipients of the Kenneth B. Schwartz Fellowship in Pastoral Care, and two are awardees of the Spiritual Fellowship for Nurses at MGH.

In the mid-1990s, the Kenneth B. Schwartz Center was established to promote compassionate practice in healthcare settings. The Schwartz Center is committed to strengthening the connection between patients and caregivers, a commitment shared by the department of Nursing. For nine years, the Schwartz Center and the department of Nursing have sponsored fellowships for healthcare providers to learn about the art and practice of spiritual care as a component of quality medical care. The educational format of the program has been adapted to meet the needs of medical caregivers: nurses, social workers, respiratory therapists, speech-language pathologists, physicians, psychologists, and hospital administrators.

A growing consensus has emerged about the importance of addressing patients' and families' spiritual and religious needs in a responsible, professional, and knowledgeable manner. In the Clinical Pastoral Education Program for Healthcare Professionals, caregivers approach their patients' as well as their own spiritual and existential concerns both intellectually and experientially.

The goals of the program are to help healthcare providers:

- integrate spiritual care into their clinical practice
- relate to patients and families more compassionately
- initiate, deepen, and terminate relationships more meaningfully
- balance professional boundaries with all-important human connections
- appropriately use their own life story, while keeping the focus on the other person's experience
- perform individualized spiritual assessments and deliver spiritual care
- offer human care in ways transformative for patients, families, and caregivers

The 2007 class is diverse and includes:

- Lynda Gillan, nurse anesthetist
- Anne Marie Kaune, RN
- Pamela McCabe, RN,
- Alyssa Rosen, medical student
- Nancy Strong, LICSW
- Claire Willis, LICSW
- Heather Carlson, RN
- Virginia Jones, RN

This class of healthcare providers will begin their spiritual and educational journey in the Clinical Pastoral Education Program in January.

For more information on the Clinical Pastoral Education Program under the leadership of Reverend Angelika Zollfrank, director of Clinical Pastoral Education, please call 4-3227.

Hand Hygiene

Fingernail Policy for healthcare workers:

- Fingernails should be no longer than 1/4 inch
  - Long nails harbor organisms and can foster the spread of infection
- Fingernails must be kept clean
- Nail polish is allowed, but discouraged; If worn, nail polish should be:
  - Preferably clear; clear polish allows good visualization of soil or debris under nails
  - Smooth and intact: chipped polish and rough edges allow entrapment and growth of organisms

Stop the Transmission of Pathogens
Infection Control Unit
Clinics 131
726-2036

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

Managing Editor
Susan Sabia

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Distribution
Please contact Ursula Hoehl at 726-9057 for questions related to distribution

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Clinical Recognition Program Review Board

Question: What is the review board's role in the Clinical Recognition Program?

Jeanette: The review board is a multi-disciplinary group of PCS clinicians who review the portfolios submitted by clinical staff seeking recognition at the advanced clinician or clinical scholar level. The board ensures that each clinicians' practice, as portrayed in their portfolio and interview, meets the criteria for the level of practice for which he/she is applying.

Question: Who are the members of the review board?

Jeanette: Currently, 15 board members representing the six disciplines within Patient Care Services, include:

- Neila Altobelli, RRT, clinical scholar
- Gae Burchill, OTR/L
- Barbara Cashavelly, RN, nurse manager
- Jacqui Collins, RN, clinical nurse specialist
- Ann Daniels, LICSW (co-chair)
- Marie Elena Gioiella, LICSW, clinical scholar
- Tessa Goldsmith, SLP
- Tina Gulliver, RN, clinical nurse specialist
- Ann Jampel, PT
- Bob Kacmarek, RRT
- Bernadette Reilly-Smorawski, RN, clinical scholar
- Mary Ellin Smith, RN (co-chair)
- Jenny Sweet, RN, clinical scholar
- Sue Tully, RN, nurse manager
- Deb Whitaker, RN, clinical scholar

In January, 2007, Barbara Cashavelly, RN, will leave the board and Susan Morash, RN, nurse manager, and Kelly Grealish, RN, will join the board.

Question: What is the review board's process for reviewing portfolios?

Jeanette: Members of the review board read and review each portfolio prior to meeting with the applicant. They look for evidence of the criteria in the three themes at the level at which the clinician is applying. Three members of the board then interview the clinician. The lead interviewer is always a member of the applicant's own discipline. During the interview, questions raised by the review board are addressed, and the applicant has an opportunity to provide further insight into his/her practice. Following the interview, the team presents a detailed summary of the interview to the entire review board. After a thorough discussion based on information from the portfolio and the interview, the board makes a decision about whether or not the clinician has met recognition criteria. All decisions are made by consensus.

Question: I've heard that board members aren't allowed to review portfolios before they're submitted. Why is that?

Jeanette: Board members are always available to talk with you about the program and answer any questions about the application process. However, the review board must maintain the integrity of the review process. Reading or assisting clinicians in developing portfolios could create the appearance of unfairness. The board recommends that every applicant visit the Clinical Recognition Program website for assistance, and many clinicians and members of leadership are available to mentor you. Members of the board can refer you to someone who can assist you. If a board member has concerns about her objectivity in reviewing a portfolio, she will recuse herself from the process.

Question: How can I learn more about the board and the work they do?

Jeanette: Every month two members of leadership have the opportunity to observe the review board's process. Leaders who have attended have found this observation helpful. If you would like more information, you should inquire as to whether leadership from your area has attended; you can contact any member of the review board; or you can contact the co-chairs, Mary Ellin Smith (4-5801) or Ann Daniels (6-2657).

MGH Chaplaincy
Schedule of holiday services

Buddhist meditation sittings

There will be a special Buddhist meditation sitting on January 1, 2007, at 5:30pm in the Chapel

Chanukah

Special Chanukah services will be held as part of our regular pre-Shabbat services at 11:00am on Fridays during Chanukah, December 15–22, 2006

Shedding New Light on Diversity: Judaism and Other Traditions

Candle-lighting *will take place in the MGH Chapel foyer*

- December 18 at 5:00pm: Jews and Other Abrahamic Traditions
- December 19 at 5:00pm: Jews of Ashkenazi background
- December 20 at 5:00pm: Jews and Other Eastern Traditions
- December 21 at 3:30pm: Jews of Sephardi Background

Christmas

A Christmas service will be held on December 25, 2006, at 12:15pm in the Chapel

Roman Catholic masses

All masses held in the MGH Chapel

- 4:00pm mass on Sunday, December 24, and Monday, December 25th
- 4:00pm on Sunday, December 31, and Monday, January 1, 2007

(this year, January 1st is not a holy day of obligation)

The Chaplaincy would like to extend greetings to those in our community who have recently celebrated Ramadan, the Hindu festival of Diwali, to those who will celebrate Kwanzaa, and to those of all other faiths and spiritualities.

For more information, call the MGH Chaplaincy at 6-2220

When	Description	Contact Hours
January 8 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** FND325	- - -
January 9 8:00am–2:00pm	**BLS Certification for Healthcare Providers** FND325	- - -
January 10 8:00am–2:00pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
January 10 11:00am–12:00pm	**Nursing Grand Rounds** Haber Conference Room	1.2
January 10 1:30–2:30pm	**OA/PCA/USA Connections** Bigelow 4 Amphitheater	- - -
January 11 8:00am–4:30pm	**Psychological Type & Personal Style: Maximizing Your Effectiveness** Training Department, Charles River Plaza	8.1
January 11 2:00–3:00pm	**Ovid/Medline: Searching for Journal Articles** FND334	1
January 16 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** FND325	- - -
January 17 8:00–4:00pm	**Oncology Nursing Concepts: Advancing Clinical Practice** Yawkey 2200	TBA
January 24 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
January 24 and 31 8:00am–4:30pm	**Phase II: Wound Care Education** Training Department, Charles River Plaza	TBA
January 25 8:00am–12:30pm	**Pediatric Advanced Life Support (PALS) Re-Certification Program** Training Department, Charles River Plaza	- - -
January 25 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
January 25 12:00–4:00pm	**Basic Respiratory Nursing Care** Bigelow Amphitheatre	- - -
January 29 and 30 7:30am–4:30pm	**Intra-Aortic Balloon Pump Workshop** Day 1: NEMC; Day 2: FND325	14.4 for completing both days
January 31 8:00am–12:00pm	**BLS Certification–Heartsaver** FND325	- - -
February 2 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** FND325	- - -
February 3 (Saturday) 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** FND325 (No BLS card given)	- - -
February 5 8:00am–2:00pm	**BLS Certification for Healthcare Providers** FND325	- - -
February 6 and 7 8:00am–4:00pm	**Oncology Nursing Society Chemotherapy-Biotherapy Course** Yawkey 2220	16.8 for completing both days
February 6 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** FND325	- - -
February 8 8:00am–4:30pm	**Workforce Dynamics: Skills for Success** 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.

Food safety tips to guide you through the holidays

—by Lorraine Allan, RD, senior manager, Food Production and On-Campus Retail Operations

The holiday season is upon us, and typically that means lots of festive celebrations with lots and lots of food. Preparing food, transporting food, and serving food all present opportunities for food to become unsafe. We've all been to big family gatherings where perhaps someone forgets to wash their hands after petting the family dog then goes into the kitchen to carve the turkey. Maybe someone left the frozen turkey out to thaw overnight. And maybe leftovers sat for hours before being transferred to air-tight containers for storage in the refrigerator.

As you venture out to family and business gatherings this holiday season keep these food safety tips in mind:

- Always wash your hands before beginning food preparation. Frequent hand-washing is the best way to control the transmission of food-borne bacteria
- When transporting cold foods use a cooler or insulated container with ice packs
- Keep cold foods refrigerated until they're ready to be served. When serving cold foods buffet-style, place serving dishes in bowls filled with ice
- When transporting hot foods, wrap hot food well and place in an insulated container
- Keep hot foods hot by serving them in chafing dishes
- Always provide serving utensils if you are serving food buffet-style
- Raw and cooked foods should not sit out at room temperature for more than two hours
- Cold-food holding temperature should be 41° or below
- Hot-food holding temperature should be at or above 140°
- When in doubt, throw it out. This is a good rule if you have concerns about whether a food is safe to eat

Remember: maintaining proper food temperature is important in preventing harmful bacteria from causing food-borne illnesses.

Use a food thermometer to make sure foods are cooked to safe internal temperatures. Use the following safe cooking temperatures as a guide:

- chicken, turkey, stuffed meats, stuffed fish, stuffed pasta, ground turkey: 165°
- ground meats (beef, pork, veal, and lamb) pork roast: 160°
- roast beef, lamb, veal, (medium rare) fish, seafood, eggs: 145°

If you have leftovers, remember to re-heat to an internal temperature of 165°.

For more information on food safety this holiday season, call the department of Nutrition & Food Services at 6-2579.

Call for Proposals

The Yvonne L. Munn, RN, Nursing Research Awards

Submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Recognition Week, May 6-11, 2007

Proposals are due January 16, 2007

Guidelines are available at:
www.mghnursingresearchcommittee.org
For more information, call 617-726-3836

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