March 2, 2006

Caring HEADLINES

9th annual collaborative governance celebration

—by Trish Gibbons, RN, associate chief nurse, The Knight Nursing Center for Clinical & Professional Development

Can you imagine MGH without collaborative governance? That was the question posed by Jeanette Ives Erickson, RN, senior vice president for Patient Care, to attendees of the ninth annual collaborative governance Grand Rounds on Tuesday, February 7, 2006, in O'Keeffe Auditorium.

Ives Erickson reflected back to the summer of 1997, when collaborative governance was first implemented as part of Patient Care Services' (PCS) professional practice model. Collaborative governance was designed to ensure that clinicians have a strong voice in shaping the professional practice environment. Collaborative governance places the authority, responsibility, and accountability for patient care with practicing clinicians,

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Collaborative governance representatives (l-r): Wendylee Baer, RN; Kathleen Tiberii, RN; Donna Lawson, RN; Catherine Griffith, RN; Catherine Mackinaw, RN; Regina Holdstock, RPh; and Lourdes Sanchez

Inside:

MGH Patient Care Services

Working together to shape the future

JCAHO, safety, and a new patient care and environment evaluation tool

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

One characteristic of a Magnet hospital is its unwavering commitment to provide a safe and secure environment for patients and families. As anyone who works in a Magnet hospital will tell you, that kind of commitment can't be imposed by an outside agency. That kind of commitment comes from within. It comes from an innate desire to do what's right for our patients, families, and staff.

The same commitment to patient safety that keeps us striving for new solutions and improved systems, is what drives us to maintain continuous readiness for a visit from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which could occur at any time. Unannounced JCAHO surveys provide a more realistic view of a hospital's practices and its ability to care for patients is a safe environment. Unannounced JCAHO visits give the public an honest look at their healthcare organization's commitment to quality and safety.

This month, MGH is rolling out a new tool that will give us a meaningful way to look at practice and environmental issues on each unit. The new tool, the Patient Care and Environment Evaluation Tool, replaces some of our other auditing tools, such as the documentation audit and monthly environmental rounds. The Patient Care and Environment Evaluation Tool will be distributed monthly to every patient care unit and be completed interactively by unit-based staff in collaboration with the nurse manager, the clinical nurse specialist, and the operations coordinator. Other clinicians (outside of Patient Care Services) who practice on the unit may participate.

The tool incorporates first-hand observations, dialogues with staff, and a review of patients' medical records to give unit leadership an effective look at practice and the environment of care on their unit.

Similar to the JCAHO survey process, the tool traces the experiences of one patient on each unit, taking into account: the initial nursing assessment, advance directives, patient education, pain management, medication management, falls, communication, referrals, restraints, and a number of other patient-care-related issues.

Questions having to do with the environment of care address: fire safety, cleanliness, infection control, equipment management, and patient confidentiality among other things.

Data collected using The Patient Care and Environment Evaluation Tool will be collated by the Office of Quality & Safety, and a report will be sent each month to individual units based on their responses. Staff and unit leadership will have an opportunity to see an overview of the results and, over time, compare

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National Patient Safety Goals (an abridged version)

- Improve the accuracy of patient identification
  - Use at least two patient identifiers
- Improve the effectiveness of communication among caregivers
  - Verify the complete order or test result by having the person receiving the order or test result 'read-back' the complete order or test result
  - Standardize a list of abbreviations not to be used
  - Measure, assess, and improve the timeliness of reporting critical test results and values
  - Implement a standardized approach to 'hand off' communication
- Improve the safety of using medications
  - Standardize and limit the number of drug concentrations available
  - Identify and review 'look-alike/sound-alike' drugs and take action to prevent errors involving the interchange of these drugs
  - Label all medications and medication containers
- Reduce the risk of healthcare-associated infections
  - Comply with current CDC hand-hygiene guidelines
  - Manage as sentinel events, all cases of unanticipated death or major permanent loss of function associated with healthcare-associated infection
- Accurately reconcile medications across the continuum of care
  - Implement a process for obtaining and documenting a complete list of the patient's medications upon admission
  - A complete list of patient's medications is communicated to next provider
- Reduce the risk of patient harm resulting from falls
  - Implement a fall-reduction program and evaluate its effectiveness

Yes, you can get there from here

As the main campus of MGH grows, it might become difficult for patients to find specific locations for appointments and tests. Some have even worried, "You can't get there from here." Many people and departments throughout the hospital have been working to address these issues.

Question: One of my patients is receiving infusion treatments in the Yawkey Building and radiation treatments in the Cox Building. What's the best way for her to get from one location to the other?

Jeanette: When the Yawkey Center for Outpatient Care opened last year, MGH started running a shuttle bus that makes a continuous loop around the main campus. Stops include the Wang Ambulatory Care Center (WACC), the Yawkey Building, the Cox Building, the Jackson Building, 50 Staniford Street (and the rear access ramp to Charles River Plaza), and New Chardon Street (Cardiac Rehabilitation). The shuttle bus was generously donated by the Ladies Visiting Committee.

Question: Do I need to schedule a time for a patient to ride on the campus loop shuttle?

Jeanette: No. The loop shuttle runs continuously from 8:00am–4:00pm, Monday–Friday. It takes approximately 20 minutes to complete the entire route. Entrance ambassadors at the Yawkey, Wang, and Cox buildings are available to assist patients getting on and off the shuttle. The vehicle is equipped with a special lift for easy wheelchair access.

Question:I've noticed that not all shuttle buses have wheelchair lifts. How does that work?

Jeanette: The Partners Transportation Department offers wheelchair-access shuttle service on all patient shuttle *routes*. Ideally, 24-hour advance notice is preferred when wheelchair access will be required. With sufficient notice, the Transportation Department can send a van to transport a patient between locations. This allows shuttle buses to stay on schedule.

When there is no advance notice, shuttle drivers will transport patients if their vehicle has wheelchair access or call for a van with a wheelchair lift to come to the appropriate location. Wait times should not exceed 15 minutes.

Question:I see that construction is moving forward on the Charles Street/MGH T station. Will the new station be handicapped accessible?

Jeanette: The new T station at Charles Street/MGH will comply with the Americans with Disabilities Act (ADA) and be barrier-free. It will have elevators and escalators to bring patients from the street-level entrance to the tracks above (and vice versa). A new exit on the north side of the station (facing Cambridge Street and City Hall) will align with the entrance to the Yawkey Building. Patients, visitors, and employees will be able to use a crosswalk, complete with traffic signals, to cross the two lanes of traffic on Cambridge Street between the new station and the Yawkey Building.

The artist's rendering on this page will give you an idea of the finished project. The new station is scheduled to open in November, 2006.

Jeanette Ives Erickson

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their performance with those of past months.

As I said, the tool is being launched this month. Leadership training is currently being conducted. The first tool will go out in the coming weeks, and the first report will be issued in April.

The Patient Care and Environment Evaluation Tool is one of many initiatives being implemented (or already in place) to ensure our patients receive the highest quality care in the safest possible environment. While we always strive to meet and exceed the standards set by the JCAHO, our unfaltering attention to quality and safety is not prescribed by others, it is a by-product of our commitment to do right by our patients.

Constant monitoring of the care we provide and the environment we provide it in, translates to a safer healthcare experience for everyone.

Collaborative Governance Celebration

continued from front cover

integrating clinical staff into formal decision-making within Patient Care Services. Grounded in the concept of empowerment, collaborative governance gives professionals an opportunity to influence strategic direction and participate in achieving the goals established by the PCS Executive Committee.

And that's exactly what collaborative governance is doing, which became apparent as representatives from each committee shared the accomplishments of their committees for 2005 and their goals for 2006.

After the committees' reports, Ives Erickson again asked, "Can you imagine MGH without collaborative governance? The journey has been amazing. It has required the commitment of managers and clinicians alike to make this work. Whether supporting clinicians who need time off to attend meetings, or making time for staff to share information with colleagues, it takes the entire professional community."

After Grand Rounds, more than 140 clinicians and managers gathered at the Holiday Inn to celebrate the accomplishments of 2005 and the good work yet to be done. Networking and fun were the order of the evening, but as always, work is never far away. In fulfilling a recommendation of the Leaders Committee, as staff entered the Holiday Inn, they were asked to look into a camera and share a personal statement about what it means to be a member of collaborative governance. Their responses will be compiled in a video under the watchful eye of Dr. Susan Lee of The Knight Nursing Center for Clinical & Professional Development. The video will be used to orient new staff, recruit new committee members, and be shared with other organizations interested in implementing their own collaborative governance programs. The video will be completed later this year.

In her opening remarks, Ives Erickson welcomed the high-spirited crowd and observed that the success of collaborative governance did not occur by chance. Rather, careful attention to the charge of each committee, its structure, resources, and leadership has resulted in a sophisticated, productive group of more than 250 members who work with other staff and departments to ensure that goals are achieved.

In his best-selling book, *Built to Last*, Jim Collins explains why some companies thrive and others fail. Successful companies build things that make a lasting contribution. They create structures rooted in core values with high standards of performance. In essence, it's about building something of such intrinsic excellence that it would be a significant loss to the organization if it ceased to exist. Said Ives Erickson, "Collaborative governance was 'built to last.' We know the passion and joy of being involved, of making a contribution, of making a difference in the ability of clinicians to provide the best possible care to patients and families is what sustains us."

Evaluation is an important part of our culture, so it is critical to periodically examine collaborative governance. Lee, along with Dorothy Jones, RN, nurse scientist, and Trish Gibbons, RN, associate chief nurse for The Knight Nursing Center, will evaluate the program looking at the concepts of empowerment, professional growth, and organizational influence. The results of the evaluation will be shared throughout PCS. In the past, we've learned that participation in collaborative governance increases clinicians' sense of empowerment, fosters professional growth and the ability to influence the organization.

In closing, Ives Erickson asked each committee to stand and be recognized as she summarized their contributions for 2005. To see the collaborative governance annual report, visit: www.massgeneral.org/pcs/ccpd/cpd_govern. asp.

Advisory Committee

Staff Nurse

Diversity Committee

Continued on next page

Nursing Practice Committee

Ethics in Clinical Practice Committee

Quality Committee

The mission of collaborative governance is to stimulate, facilitate, and generate knowledge that will improve patient care and enhance the environment in which clinicians shape their practice.

—Mission Statement, 2001

Patient Education Committee

Nursing Research Committee

(Photos by Abram Bekker)

African American Pinning Ceremony: an occasion to reflect, learn, and celebrate

—by Deborah Washington, RN, director, PCS Diversity

On February 17, 2006, Patient Care Services held its annual African American Pinning Ceremony. Since its inception in 2000, this MGH Black History Month event has been an uplifting and unconventional celebration of the contributions of the African American community. Over the years, the ceremony has evolved into an opportunity for those who attend to reflect and learn. It's an occasion for the MGH community to come together and celebrate the success stories of black nurses, patient care associates, unit service associates, operations associates, and operations coordinators as mentors, leaders, volunteers, and examples of cultural and ethnic pride.

This year's honorees were Carly Jean-Francois, RN, staff nurse, Ellison 18, and Celeste Peters, a member of the MGH Ambassador team, who staffs the White front desk. Jean-Francois, current co-chair of the PCS Diversity Committee, values her Haitian American background and is a resource for culturally competent care on her unit. A 1996 graduate of Boston College, Jean-Francois believes her ability to manage difficult situations related to her ethnic background stems from her philosophy that respect is the bottom line. "I owe my parents a great deal for my success," says Jean-Francois.

Peters, known for her unwavering commitment to customer service, is well-versed in the skills necessary to achieve positive interactions with visitors who come through our doors. A letter from one grateful patient described the active support and unselfishness that are the hallmark of Peters' customer-service philosophy. Says Peters, "I love my job. I love my boss. I love coming to work every day."

Immacula 'KiKi' Benjamin, RN, pediatric staff nurse on Ellison 18, was an honoree at last year's pinning ceremony but was unable to attend the event. Benjamin was on hand to receive her recognition this year.

This year's ceremony recognized four alumni of the MGH School of Nursing who were in attendance.They were: Shirley Fortson (class of 1955, resident of Maryland); Christine Reid (class of 1954, resident of Connecticut); Barbara Hemingway (class of 1959, Massachusetts resident); and Edith Clark (class of 1958, resident of Vermont).

Master of ceremonies, Ron Greene, RN, told the stories of these four African American nurses who have gone on to teach and enjoy careers in public

Attendees play the interactive 'African American History Game'

A reunion of alumni of the MGH School of Nursing

Continued on next page

health. He told of their student years as 17-year-old 'probies,' who lived in dorms and abided by curfews; the black-and-white checked uniforms they wore; the half aprons and black shoes; and the big-sister, little-sister support network that helped bring them a sense of belonging.

These former MGH nurses fondly remembered nursing instructors from 'back in the day' and an educational philosophy that encouraged 'getting that next degree.' All agreed it was a positive backdrop for their individual achievements. MGH School of Nursing alumni, all accompanied by their husbands, were pinned by current members of the MGH nursing staff.

In keeping with the theme of history and reflection, MGH nurse, Pat Beckles was recognized for 50 years of service to MGH Nursing.

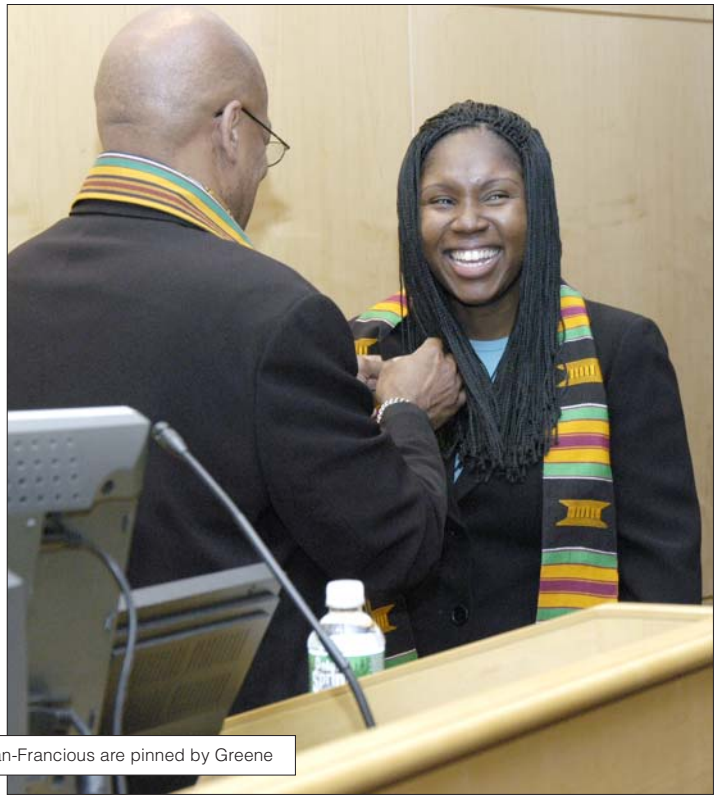
In a departure from past pinning ceremonies, this year's event included an interactive history lesson facilitated by diversity consultants, Vincent Licenziato and Kari Heistad. The exercise provided some surprising insights into African American history and made the indisputable point that black history *is* American history and can't be separated out as some 'special subsection' of the events that shaped our nation.

A rousing audience-participation sing-along brought people of all ages together in a rendition of the 1960's protest song, Put a Little Love in Your Heart. For a brief moment in time, O'Keeffe Auditorium was transformed into the 'beloved community' Dr. Martin Luther King, Jr. so passionately dreamed of.

As our PCS Diversity Program continues to engage the MGH community in addressing important issues such as disparities in care and cultural competence, the African American Pinning Ceremony will continue to evolve, always reminding us where we came from, how we got here... and where we're going.

Immacula 'KiKi' Benjamin gets pinned

Organizers, Deb Washington and Ron Greene



Celeste Peters (left) and Carly Jean-Francious are pinned by Greene

Collaborative, holistic care puts young cancer patient on road to recovery

Rachel Bolton is an advanced clinician in the PCS Clinical Recognition Program

Rachel Bolton, RN
pediatric radiation oncology staff nurse
Proton Therapy Center

My name is Rachel Bolton, and in 30 years of pediatric nursing, I have cared for hundreds of children and each has left indelible memories. Children diagnosed with cancer hold a special place in my heart.

As a pediatric radiation oncology nurse, I've had the privilege of meeting and caring for many of these special families. I say 'families' because the entire family is diagnosed with cancer, not just the child.

One particular family comes to mind—they 'hailed from Texas.' Their daughter had been diagnosed with a tumor at the base of her skull.

Jen was 15 years, 10 months old when I first met her. By the time I met Jen, her twin brother and her parents had undergone four surgical procedures to resect her tumor. The surgeries were successful, however, Jen was left with several significant side-effects, including: dysarthria, dysphagia, a blockage of her right auditory canal, and injury/palsy to many of her cranial nerves. These cranial nerve injuries greatly impacted Jen's ability to speak, chew, swallow, secrete saliva, and move her tongue. In addition to these complications, Jen had mild cerebral palsy, a learning disability, and was developmentally delayed. Could anything else complicate her young life?

From my initial assessment, I knew Jen's care would be fraught with challenges, the main one being the potential for aspiration. I had to make sure Jen would have access to every resource at our disposal to ensure a safe treatment course. My focus was caring for a child with both physical and emotional needs. I spoke with Jen's primary radiation oncologist about my concerns regarding her risk of aspiration, weight loss, and depression, to mention only a few, and requested a consult with Pediatric Hematology/Oncology, Occupational Therapy, and Psychiatry. He agreed and appointments were made. This proved to be a vital intervention as Jen and her family saw many of these clinicians on a regular basis throughout her seven-week treatment.

From the outset of Jen's treatment, she experienced nausea and vomiting, which was exacerbated by thick oral secretions. There were many days I would send Jen to the clinic for IV hydration and anti-emetics (agents to prevent vomiting). Jen would report feeling better after these visits, but her relief was short-lived. By the second week, Jen had lost almost 20 pounds. She couldn't consume enough food to maintain her weight. She expended calories just chewing her food. And she had to be extremely careful when chewing and swallowing because she had episodes of choking. So far, she hadn't aspirated anything, but how long would that last?

Jen's family was becoming concerned as they saw Jen getting thinner, weaker, and more depressed. Jen and her brother had that special twin bond, and I believe that bond helped Jen through the rough times.

I spoke to her parents about the likely possibility that a feeding tube would have to be placed. They were prepared that this might be necessary. Jen's parents, however, were not yet ready to pursue that option. The hope was that Jen's nausea and vomiting were related to photon therapy, and would resolve once proton radiation started. Unfortunately, that was not to be the case.

Jen continued to have daily, frequent episodes of nausea and vomiting. She went to the Pediatric Hematology/Oncology Clinic for IV hydration almost every day. Her parents worried that Jen wasn't her usual giddy self; she didn't smile anymore.

Despite all interventions, Jen continued to lose weight. Her parents were now ready to proceed with placement of a feeding tube. Jen's mom shed many tears with me as she spoke of her fears. I was able to sit with her to help her through this crisis. Jen's dad was on 'auto pilot.' During my daily visits with him, and through our common bond (he considered me a Texan!) he was able to cry and express his feelings. He was hurting for his daughter. This opportunity to spend time with this family made me thankful to be a member of the proton therapy team. I have the chance to sit with patients and families, unhurried, listen to them and provide support. This is what nursing is and why I love this career.

Almost four weeks into Jen's treatment, plans were made to place a feeding tube and PICC line. Teaching was provided to the family on the care, feedings, and duration of placement.

Jen began to gain weight about a week after the tube was placed. Her parents became adept at providing feedings and caring for the tube. They did very well. The PICC line was discontinued a week after placement.

Jen's secretions became more tenacious as treatment proceeded. This was due to the radiation side-effects and the damage to her cranial nerves. Jen's parents had many sleepless nights, worried that Jen would suffocate. A suction machine was ordered, and the family was instructed on how to use it. Jen and her parents rested more easily with the suction machine at Jen's bedside.

Jen's physical care was not my only concern. Her emotional health was an issue. As I mentioned, she was becoming more

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

Clinical Narrative

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depressed. I wondered what I could do to raise her spirits. I knew she was a piano player, having taken lessons for eight years. But she had no access to a piano. I brought in my keyboard for her to use and several music books. The smile on her face was all I needed to see to know her days would be better.

Jen and her twin brother celebrated their 16th birthdays during her radiation therapy. Our child life specialist and I planned a birthday party for them, complete with streamers, cake and presents. The medical team was invited, and Jen had a wonderful time. More smiles.

Near the end of Jen's treatment, she started to make progress. She gained weight, became stronger, had fewer episodes of vomiting, and smiled a lot more. She started making plans for the future: a trip to New York, buying a puppy, and seeing her new niece.

Jen's recovery was made possible through the efforts of the entire healthcare team. Jen's family was in constant communication with the medical team. To this day, her parents communicate with me every month to let me know of Jen's continued progress. They've made me a member of their family—an honorary Texan!

Each and every day, I pray the care I give families is compassionate and the best I have to give. I've always lived by The Golden Rule (Do unto others as you would have them do unto you). I care for and love my young patients the way I would want my children cared for if they were in the same situation. I love what I do, and I'll continue to do it for as long as the Lord allows.

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

This is a wonderful story of presence, compassion, patient-teaching, and gentle interventions. Rachel was concerned that Jen was losing a lot of weight, but she knew that Jen and her family were not yet ready to consider a feeding tube. She supported Jen with medication, hydration, and consults with specialists. She supported Jen's family with information, encouragement, and her presence during times of crisis.

Tending to her emotional as well as her physical needs, Rachel brought in a keyboard to give Jen a diversion from her treatments. With her child life colleague, she arranged a party for Jen's 16th birthday. Not the way most teen-ages want to spend their 'Sweet 16,' but with Rachel's help, not so bad, either.

Thank-you, Rachel.

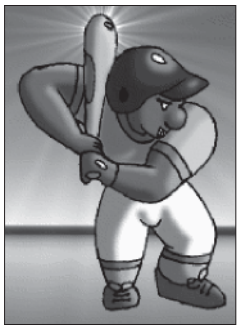
Nursing Grand Rounds

On February 8, 2006, White 9 nurses presented, "Nursing Assessment and Management of Atypical Chest Pain and Documented Myocardial Infarction in an Elderly Female Complicated by Congestive Heart Failure (CHF) and Undiagnosed Diabetes," at Nursing Grand Rounds. Kristen Desrosiers, RN, staff nurse (left); Sarah Guyette, RN, staff nurse (center); and Cynthia LaSala, RN, clinical nurse specialist, used a case-study approach to discuss pathophysiology, age-related changes, medical-management, nursing assessment, plan of care, and gender differences associated with coronary artery disease, CHF, and diabetes.

Quick Hits to improve your writing!

A low-stress, high-yield class aimed at helping you develop your writing style and eliminate some of the angst commonly associated with writing

Offered by Susan Sabia, editor of *Caring Headlines*



Classes now scheduled for:

Wednesday, March 15, 12:00–3:00pm
Monday, April 17, 11:00am–2:00pm
Tuesday, May 30, 11:00am–2:00pm
Monday, June 12, 10:00am–1:00pm

All classes held in GRB-015 Conference Room A

Classes limited to 12; pre-registration is required
To register, call Theresa Rico at 4-7840

There's more than one way to help in a disaster

—by Maryellen McNamara, RN

In late September, I was invited, along with other nurses and physicians from Partners HealthCare, to take part in a medical mission to Baton Rouge, Louisiana. We spent two weeks caring for evacuees from New Orleans following hurricane Katrina. It turned out to be an incredible experience, one I'll never forget.

Everyone we cared for had a story, a story of survival. The resiliency of the human spirit continually amazed us. Despite the adversity, every person we cared for had an unshakable faith and trust in God.

When I returned to Boston, I realized I wanted to do more. I wanted to be part of the rebuilding process. I attended a presentation by David Campbell, who spoke about his experiences in Biloxi, Mississippi. He and his team, Hands On USA, arrived in Biloxi a few days after Katrina hit. Right away, they started clearing trees and putting blue tarps on the rooftops of Biloxi police and firemen. Volunteers came from around the country, more volunteers every day. I was inspired by his talk and decided to go to Biloxi.

My son, Adam, and I flew to Biloxi on January 4, 2006, and stayed for five days at the Hands On USA facility. Days started with breakfast at 7:00am. Meals were prepared by volunteers. Team assignments were given the night before, so right after breakfast teams headed out for their various assignments. Teams were formed based on the experience and expertise that people brought. Adam and I were on the Interiors Team for a day. The Interiors Team demolded and cleaned debris from homes. Everything had to be removed right down to the studs. Then homes were cleaned and prepared for the demolding process. It was incredibly hard work, but once it was done they could start re-building. It was nice to be able to take out our aggressions on wall board and lathe.

Maryellen McNamara and her son, Adam

The Street Team walked the streets connecting with residents of Biloxi. Volunteers listened to stories and made themselves available to people who needed services.

There was a lot of debris around Biloxi, and the city couldn't pick it up unless it was bagged. That was the job of the Street Cleaning Team. I can't even imagine how many big, black bags we filled. We hoped when residents saw how nice things looked, they'd be able to take pride in their neighborhoods again.

A few teams worked with relief agencies in Biloxi. They assisted residents in re-stocking their homes, providing food, clothing and supplies. They worked in large distribution centers, receiving pallettes of goods, sorting them, and getting them ready for distribution.

Adam and I spent time at the Jefferson Davis House searching through rubble looking for artifacts from the Civil War. Artifacts had been buried when the museum imploded during the storm. I found one of the 12 Medals of Honor, and Adam found a domino from the museum gift shop.

There was unbelievable destruction in the Biloxi area. Houses along the coast were gone. All that remained of some homes were brick stairways leading to nowhere. We saw the floating casino that had 'jumped' the highway and landed on a Holiday Inn. A lot of work had been done already, but full recovery would take years and a lot of hard work. The Hands On organization will be in the Biloxi area for a long time.

The volunteers we met at Hands On were incredible. They were all ages, from all walks of life, joining together to make a difference in this devastated area. Hands On is different from other organizations. They provide food and shleter to their volunteers and don't require a firm time commitment. If you visit: handsonnetwork.org. you'll see a link to the Biloxi contingent.

This was an experience I'll never forget. I got back so much more than I gave. I encourage anyone who'd like to contribute to the re-building of the Gulf Coast to contact Hands On. You won't regret your decision.

New web-based safety reporting system

For years, MGH has used a paper-based incident-reporting system to identify events ranging from minor spills and mishaps to more serious events such as adverse reactions to medications. This month, the hospital will introduce a new web-based safety reporting system. The new system will make maintaining a safe environment for patients, families, visitors, and staff a more effective and efficient process.

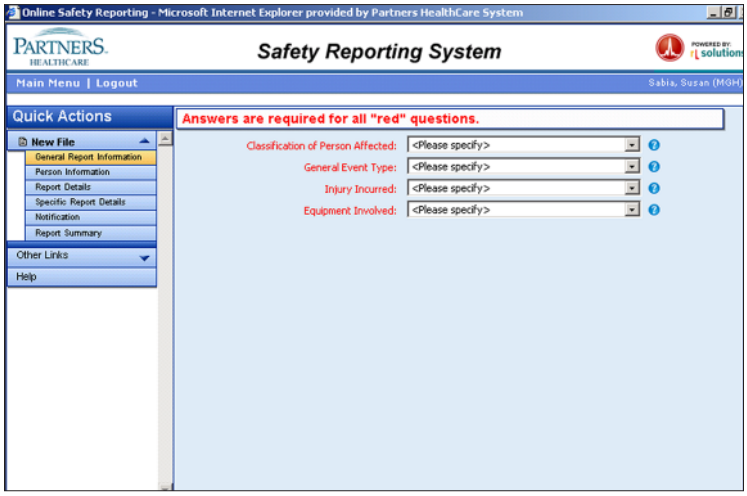
Says Joan Fitzmaurice, RN, director of the MGH Office of Quality & Safety, "The MGH community has an active safety reporting culture. Having a healthy reporting system is crucial to our ability to address problems immediately, fix systems that can cause break-downs in care, and identify trends to guide our patient-safety efforts."

The web-based safety reporting system streamlines the way employees report incidents. The new system speeds communication and reduces delays in follow-up and improvement measures.

Says Fitzmaurice, "We hope the web-based system will encourage and empower staff to take action to help solve systems problems. Reporting events and potential problems is the right thing to do to keep patients, families, and staff safe. The web-based reporting system makes it easier for staff to take an active role."

The new safety reporting system is a product of the Quality and Patient Safety Task Force, led by Jeanette Ives Erickson, RN, senior vice president for Patient Care, Brit Nicholson, MD, chief medical officer; and Gregg Meyer, MD, medical director for the MGPO.

The site will go live on March 15, 2006. For more information, contact Laura Rossi, staff specialist, at 6-8310.



MGH nurse involved in planning for statewide flu pandemic

(Photos by Paul Batista)

On February 7, 2006, Gayle Peterson, RN, staff nurse, Phillips House 21 (far left), attended a special meeting of public health, business, and community leaders led by Governor Romney and the US Secretary of Health and Human Services to discuss measures the state can take to prepare for an influenza pandemic. Peterson is a member of Massachusetts Association of Registered Nurses (MARN) Health Policy Committee.

Belkin publishes

Melissa Belkin, LICSW, social worker, authored the article, "The Role of the NICU Social Worker," in *Preemie Magazine*, January, 2006.

Iyer, Levin and Shea publish

Patricia Iyer, RN; Barbara J. Levin, RN; and Mary Ann Shea, RN, published, *Medical Legal Aspects of Medical Records*, Lawyers & Judges Publishing Company, Inc., December, 2005.

Sinsheimer presents

Judith Sinsheimer, LICSW, social worker, presented the break-out session, "The Social Worker's Role in Pre-Symptomatic Testing for Genetic Illness: Using Huntington's Disease Model as a Paradigm," at Innovation at 100, October 27–28, 2005, in Boston.

Squadrito appointed founder and chair

Alison Squadrito, PT, physical therapist, has been appointed founder and chair of the Geriatric Special Interest Group of the American Physical Therapy Association of Massachusetts and bylaws chair of the American Physical Therapy Association of Massachusetts.

Madigan ushers in Patients First

Janet Madigan, RN, project manager and president of MONE, in partnership with the MHA, spoke on behalf of MONE and participated in 'flipping the switch' to the Patients First website staffing plans at www.patientsfirstma.org, along with Ron Hollander, president of the MHA and Dr. David Barrett, MHA board chair.

Schultz certified

Kathleen E. Schultz, RN, staff nurse, Cardiac SICU, was certified as a cardiac vascular nurse.

Schwartz certified

Brenda Schwartz, RN, staff nurse, General Medicine, was certified in Cardiovascular Nursing, in December, 2005.

Struzzi appointed treasurer

Melanie Struzzi, PT, physical therapist, has been appointed treasurer of the Geriatric Special Interest Group of the American Physical Therapy Association of Massachusetts.

Gelda presents

Linda Gelda, LICSW, social worker, presented the keynote address, "Treating Eating Disorders," at the Northeast Counseling Group, December 13, 2005, at Plimoth Plantation.

Macauley presents

Kelly Macauley, PT, senior physical therapist, presented, "APTA: Working for You," at the North Shore Community College, on November 14, 2005, in Danvers.

Seitz presents

Amee Seitz, PT, senior physical therapist, presented, "Shoulder Evaluation and Treatment," at Tufts University, November 21, 2005, in Boston.

Burchill and Curley present

Gae Burchill, OTR/L, and Suzanne Curley, OTR/L, occupational therapists, presented, "Upper Extremity Rehabilitation II–Anatomy: the Flexor and Extensor Tendons," at Tufts University, January 23, 2006, in Medford.

Jimenez certified

Evangeline Jimenez, RN, became certified as a critical care nurses in January, 2006.

Murphy Cruz certified

Constance Murphy Cruz, RN, Psychiatry, became certified as an advanced practice nurse in Psychiatric/Mental Health Nursing in January, 2006.

Burchill presents

Gae Burchill, OTR/L, occupational therapist, presented, "Upper Extremity Rehabilitation II: Management of Flexor Tendon Injuries," at Tufts University, on January 30, 2006, in Medford.

Brush, Schmidt publish

Kathryn Brush, RN, clinical nurse specialist, Surgical Intensive Care Unit, and Ulrich Schmidt, MD, authored the article, "Prophylaxis," in the *Critical Care Handbook of the Massachusetts General Hospita*l.

Munoz presents

Lauro Munoz, OTR/L, clinical specialist, Occupational Therapy, presented, "Introduction to NDT," and, "NDT and the Adult Hemi," at the Texas Occupational Therapy Association Annual Conference, November 4–5, 2005, in San Antonio, Texas.

Social workers present

Social workers, Angelica Tsoumas, LICSW; Shoshana Savitz, LICSW; Karon Konner, LICSW; and Marilyn Wise, LICSW, presented the break-out session, "Social Work at the Ethics Table," at Innovation at 100, October 27–28, 2005, in Boston.

New electronic request for security access

—by Joe Crowley, Police, Security & Outside Services

The department of Police, Security & Outside Services is switching to an electronic requesting process for those wishing to have Photo ID badges programmed to access secure or restricted areas. The new paperless system uses an Access Request Form easily obtained from the Police, Security & Outside Services website. Authorized access granters (please speak to your manager to find out who in your area is authorized to grant access) will log on to: www.mghpolice.com and click on a link to access the request form. By following step-by-step instructions and clicking on the appropriate area (MGH Photo ID Main Campus or MGH Photo ID CNY & Satellites) your request will be submitted electronically. Once your badge has been reprogrammed, the requestor will receive a confirmation e-mail.

New employees can now receive pre-programmed photo ID access. Managers of new employees will receive an e-mail from Human Resources containing instructions and a link to the Request for Access site. Managers responsible for new employees must send the request for access to the appropriate photo ID location by 4:00pm on the Thursday before the new employee's orientation class.

For multiple access authorizations (access to the main campus, CNY, and satellites) requests should be sent to the predominant location. For example, if an employee is based at the Charlestown Navy Yard, but also has business on the main campus, the form should be submitted to MGH Photo ID CNY& Satellites.

For more information, call 4-9339 (on the main campus) or 4-3031 (CNY and satellites). We're confident you'll find this new system helpful. While on our website feel free to familiarize yourself with our services and educational programs.

Access Request Process

Old System

- Speak with the individual authorized to grant access to an area
- Walk to the Photo ID Office and pick up an Access Request Form
- Find the person who grants authorized access and get his/her signature
- Walk back to the Photo ID Office and return the signed Access Request Form

New System

- Speak with the individual authorized to grant access to an area and have him or her submit an electronic Access Request Form via e-mail.

MGH is committed to improving hand hygiene

Fingernail Policy for healthcare workers:

- Fingernails should be no longer than 1/4 inch
  - Studies show that longer nails harbor more organisms, and they have been linked to outbreaks of infection at other hospitals
- Fingernails must be kept clean
- Nail polish is allowed, but discouraged
  - If worn, nail polish should be:
    - Preferably clear (although colored polish is acceptable) 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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For more information, call: 617-724-1746.

Next Publication Date:
March 16, 2006

Sharing positive palliative care outcomes in the ICU setting

—by Ed Coakley, RN

In February, Adele Keeley, RN; Andy Billings, MD; Gloria Gilson, RN; Taylor Thompson, MD; Mary Lauriat, RN; and Ed Coakley, RN, attended the annual meeting of the Quality Demonstration Project funded by the Robert Wood Johnson Foundation (RWJF) devoted to Promoting Palliative Care Excellence in End-of-Life Care in Intensive Care. The meeting was held in Big Sky, Montana. The project is dedicated to long-term changes to improve health care for dying people and their families.

The Medical Intensive Care Unit (MICU) on Blake 7 was one of four sites funded to develop innovative demonstration projects in intensive care units and communicate their findings with national workgroups. Principle investigators from the four sites presented their initial findings and action plans to disseminate their findings to the larger critical-care community.

Keeley and Billings, co-principle investigators at MGH, presented the interventions that have been most successful here. Some examples were the MICU's open visiting policy, the role of the Palliative Care Service, Ethics Rounds, and the work of palliative care nurse champions. Billings spoke about the benefits of collaborating with the Palliative Care Service.

RWJF participants from other sites were impressed with the role that nurses played in the MGH project. Keeley suggested that in her role as both principle investigator and nurse manager she was able to facilitate the collaborative process required for success and manage any conflict that inevitably arises when cultures change.

Connie Dahlin, APRN, from the Palliative Care Service, spoke about palliative care nurse champion interventions. Dahlin, a national leader in end-of-live care, developed the curriculum and provided the clinical education for the program.

Gilson and Lauriat attended as palliative care nurse champions. As nurses who, along with Coakley, are over 60 years old and want to continue to contribute to patient care, Gilson commented, "MGH is doing a superb job. It was wonderful, a chance to see how it works at the national level. It's clear to me that nursing leadership at MGH made this happen."

Lauriat was, "overwhelmed to feel so supported by doctors and others. Being part of this project that raises the standard of care for patients and families at the end of life made me proud to be a nurse."

Thompson's support of the MICU project has been instrumental in its success. All participants recognized that MGH was ahead of the curve when it came to physician-and-nurse collaboration. Thompson will present his findings at the annual meeting of the American Thoracic Society in May.

Reflecting on the experience, Keeley said, "Jeanette Ives Erickson's leadership in helping us achieve Magnet status and establishing our collaborative practice model was clearly a factor in our success. Nurses attending the conference from other sites felt that the nurse-champion model might not work at their institutions as their staff are not as empowered to care for patients at the bedside as we are at MGH. I was pretty proud."

Northeastern at MGH RN to BSN program

Next course offering:
NUR 4503
Caregiving: Nurses with Vulnerable Patients in the Community
(7 credits with a clinical component)

Begins at MGH March 13, 2006
prerequisites: Professional Transitions in Nursing Physical Assessment

For more informationcontact:
Gloria Hicks RN at Northeastern University
e-mail: g.hicks@neu.edu
telephone: 617-373-5474
or Miriam Greenspan, RN, at MGH
e-mail: mgreenspan@partners.org
telephone: 617-724 3506

Northeastern at MGH BSN to MS/CNS Summer Session

Epidemiology is being offered
Starts May 8, 2006
Course requires a minimum of 8 students

To enroll, contact Joanne Samuels at: j.samuels@neu.edu regarding special student status and course enrollment

or Miriam Greenspan at: mgreenspan@partners.org for more information.

Spring Human Resource course offerings

MGH Training & Workforce Development is pleased to announce the spring 2006 HR course offerings covering: communication and writing skills, time- and project-management, understanding hospital finances, and more. For complete schedule, visit: http://is.partners.org/hr/training/hr/training.html

Register now through PeopleSoft
For more information, e-mail MGHTraining@partners.org, or call Luisa Carvajal at 4-3368

When/Where	Description	Contact Hours
March 15 9:00am–3:30pm	**A Safer Start: Empowering Pregnant Women Living with Domestic Violence** Training Department, Charles River Plaza	- - -
March 15 4:00–5:00pm	**More than Just a Journal Club** Thier Conference Room	1.2
March 16 8:00am–4:30pm	**Workforce Dynamics: Skills for Success** Training Department, Charles River Plaza	TBA
March 16 1:30–2:30pm	**Nursing Grand Rounds** "Provoking Ischemia, Risking Infarction: Stress Testing." O'Keeffe Auditorium	1.2
March 20 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
March 20 and 22 7:30am–4:30pm	**Pain Relief Champion Day** Thier Conference Room	1.2
March 21 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
March 22 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
March 22 8:00am–4:00pm	**Beat Goes On:Ventricular Devices for Treatment of Heart Failure** Bigelow 4 Amphitheater	TBA
March 23 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)	- - -
March 23 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
March 30 12:00–3:30pm	**Basic Respiratory Nursing Care** Sweet Conference Room	- - -
April 5 8:00–11:30am	**Intermediate Arrhythmias** Haber Conference Room	3.9
April 5 12:15–4:30pm	**Pacing Concepts** Haber Conference Room	4.5
April 6 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
April 7 8:00am–4:30pm	**MGH School of Nursing Alumni Program** O'Keeffe Auditorium	- - -
April 10 and 11 7:30am–4:30pm	**Intra-Aortic Balloon Pump Workshop** Day 1: NEBH; Day 2: VBK401	14.4 for completing both days
April 10 8:00am–4:30pm	**A Diabetic Odyssey** Thier Conference Room	TBA
April 10 and 17 8:00am–4:00pm	**Oncology Nursing Society Chemotherapy-Biotherapy Course** Yawkey 2220	16.8 for completing both days
April 12 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
April 12 7:30am–12:00pm	**Congenital Heart Disease** Haber Conference Room	4.5

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.

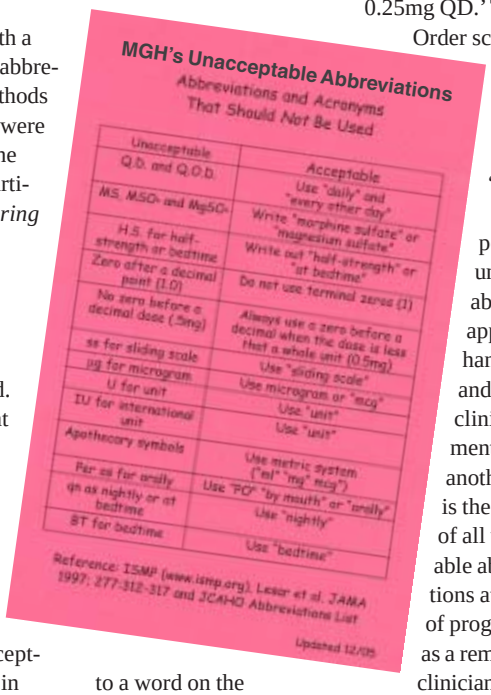
National Patient Safety Goals: Abbreviations

—by Katie Farraher

We use abbreviations all the time in everyday conversation. It's tempting to use abbreviations in documentation because most of us write the same way we speak. But certain abbreviations are no longer acceptable in medical documentation, and for good reason—they compromise patient safety. JCAHO's National Patient Safety Goals provide a list of unacceptable abbreviations.

In 2003, MGH embarked on a campaign to help staff familiarize themselves with unapproved abbreviations. Blue, pocket-sized cards were distributed throughout the hospital with a list of unapproved abbreviations. Many methods of communication were used to publicize the change including articles in *Hotline*, *Caring Headlines*, and the *Fruit Street Physician*. Flyers were posted, and a new policy on abbreviations was released.

One change that MGH has made recently is an upgrade to the Provider Order Entry (POE) system. When providers place an order that contains unacceptable abbreviations in POE, the abbreviation is automatically converted to a word on the screen. The operations associate or nurse then transcribes the word (instead of the unacceptable abbreviation). For example, if a provider wrote an order for 'Digoxin 0.25mg QD.' The View Order screen would convert the abbreviation, 'QD,' to 'daily.'


MGH's Unacceptable Abbreviations
Abbreviations and Acronyms That Should Not Be Used

Unacceptable	Acceptable
Q.D. and Q.O.D.	Use "daily" and "every other day"
MS, MSO4 and MgSO4	Write "morphine sulfate" or "magnesium sulfate"
H.S. for half-strength or bedtime	Write out "half-strength" or "at bedtime"
Zero after a decimal point (1.0)	Do not use terminal zeros (1)
No zero before a decimal dose (.5mg)	Always use a zero before a decimal when the dose is less that a whole unit (0.5mg)
ss for sliding scale	Use "sliding scale"
µg for microgram	Use microgram or "mcg"
U for unit	Use "unit"
IU for international unit	Use "unit"
Apothecary symbols	Use metric system ("ml" "mg" "mcg")
Per os for orally	Use "PO" "by mouth" or "orally"
qh as nightly or at bedtime	Use "nightly"
ST for bedtime	Use "bedtime"

Reference: ISMP (www.ismp.org), Lesar et al. JAMA 1997; 277-312-317 and JCAHO Abbreviations List

Updated 12/05

The MGH policy on unapproved abbreviations applies to all handwritten and free-text clinical documentation. So another change is the inclusion of all unacceptable abbreviations at the bottom of progress notes as a reminder to clinicians when writing notes. These progress notes are available from Standard Register (order #10267).

In the coming weeks MGH will re-distribute pocket-sized cards that can be posted at computers and carried by staff for quick reference. The new cards are coral in color and contain one important change. 'D/C' is no longer an unapproved abbreviation. You don't have to write out the word 'discharge.' D/C is now acceptable.

For clarification of any unapproved abbreviations, see "Abbreviations: Appropriate Use to Prevent Errors," in the on-line Clinical Policy & Procedure Manual.

For more information about the National Patient Safety Goals, please contact Katie Farraher in the Office of Quality & Safety, at 6-4709.

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