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Caring HEADLINES

Inside:

Latino Heritage Month
Mes de la herencia latina

—by Carmen Vega-Barachowitz, CCC-SLP

On September 22, 2006, for the sixth consecutive year, MGH celebrated Latino Heritage Month. Latino Heritage Month is celebrated nationwide from September 15th to October 15th. Since 2000, MGH has recognized the contributions of our Latino workforce with a series of events. This year the main event featured Puerto Rican author, Esmeralda Santiago, who spoke candidly about her experiences as a Latina woman. More than 115 people filled O'Keeffe Auditorium to hear Santiago's inspirational talk. Said Beth Schneider, director of Treadwell Library, "Esmeralda Santiago is a force of nature and a delightful one at that. She is a role model for all humankind."

Santiago is a renowned writer whose books include: *When I was Puerto Rican, Almost a Woman*, and *The Turkish Lover.* She came from a very poor family in Puerto Rico, moving to New York City at age 13, where, through hard work and perseverance she learned English, attended the acclaimed High School of Performing Arts, and after eight years of community college, transferred to, and graduated magna cum laude from, Harvard University. Santiago spoke about why she began writing and how important it was for her to share her experiences. "In the books I was reading, I never saw anyone like me," said Santiago.

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Guest speaker, Esmeralda Santiago (center) with (l-r): Ara Romero Perez, Elena Olson, Carmen Vega-Barachowitz, and Digna Gerena. At right is jazz pianist, Leo Blanco.

La presentadora invitada, Esmeralda Santiago, (centro), el pianista Leo Blanco (a la derecha) y Ara Romero Pérez, Elena Olson, Carmen Vega-Barachowitz, y Digna Gerena (de izquierda a derecha).

(Photo by Abram Bekker)

Celebrating our Latino community

Celebrando a nuestra comunidad latina

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

Imagine you've been looking forward to your vacation for a long time. Finally, after much planning and anticipation, you escape the harsh New England weather for the warmth of Puerto Vallarta. By your second night, over dinner at a lovely little restaurant, you realize you're actually starting to relax. And that's when it happens.

Your traveling companion falls and becomes disoriented. An ambulance arrives and rushes you to a local emergency room. All you care about is your loved one and getting the best possible care for him. You want to be able to tell the medical team about his recent headaches, his slurred speech, and the medications he's been taking. You know time is of the essence. But there's a problem: you don't speak Spanish, and these clinicians don't speak English. You feel desperately helpless and alone.

Virtually every day at MGH, we see patients from various cultures and backgrounds who turn to us for help at similar, vulnerable times. As a world-class healthcare organization, we're privileged to serve a global patient population and an increasing number of immigrants within our own community. And our workforce increasingly reflects this diversity.

When we talk about our Diversity Program, we're talking about creating a welcoming environment for all who visit or work at MGH. We're talking about providing the best and safest patient-focused care for every patient and family member. This means looking at our practice and our environment through the patient's eyes and overcoming any barriers that threaten to interfere with that care. It means exchanging information in the patient's language. It means respecting what we might consider unusual customs and beliefs and incorporating those beliefs into our plan of care.

Respecting diversity is more than a clinical nicety. As healthcare providers, it's an essential part of our practice. Without knowing the person, we can't meet their needs.

As we observe Latino Heritage Month, we have a wonderful opportunity to celebrate the people, customs, and contributions of the vital and growing Latino community. We have an opportunity to ask how we can provide even better care and support for patients, families, and employees of Latino decent and all the diverse populations we're privileged to serve.

Suponga que lleva largo tiempo haciendo planes para sus vacaciones. Eso no es nada difícil imaginar. Finalmente, después de muchos planes y de mucha anticipación usted y su ser querido se escapan del clima aspero de Nueva Inglaterra hacia el clima cálido de Puerto Vallarta. Agradable idea. Dos noches después de su llegada, mientras cenan en un pequeño y encantador restaurante, cae en cuenta de que ha empezado a sentirse más relajada. Pero en ese instante sucede algo.

Su ser querido se ha caído repentinamente y se ve desorientado. Llega una ambulancia y los lleva a la sala de emergencia del hospital local. Su preocupación es por su ser querido y por darle al grupo médico toda la información que pueda acerca del historial medico, los dolores de cabeza recientes, su habla distorsionada antes de caer al piso, los medicamentos que está tomando y los motivos por los que los toma. Usted sabe la urgencia con la que se necesita esa información. Pero hay un problema: Usted no habla español y el personal médico no habla inglés. Ahora se siente desesperada y totalmente aislada y sola.

En el MGH, todos los días atendemos pacientes de varias culturas o herencias culturales que acuden buscando ayuda y apoyo en momentos de vulnerabilidad. Como entidad de atención médica conocida en todo el mundo, tenemos el privilegio de atender tanto a pacientes internacionales como a pacientes que han inmigrado a nuestra comunidad y cuyo número aumenta continuamente. Nuestros empleados también reflejan esa misma diversidad de orígenes.

Así que cuando hablamos de nuestro Programa de diversidad, sí hablamos de crear un ambiente de bienvenida para todos los que visitan o trabajan en el hospital. Pero también estamos hablando de proveer la mejor atención posible a cada uno de nuestros pacientes y a sus familias, de un modo seguro y enfocado hacia el paciente. O sea, justamente el mismo tipo de atención que esperaríamos recibir si estuviésemos en su lugar. Esto implica mirar nuestro entorno y nuestras prácticas por los ojos del paciente y sobreponernos a toda barrera que pudiera impedirnos proveer atención de óptima calidad. Esto incluye intercambiar información en el idioma del paciente y su familia. Esto implica respetar su cultura y creencias e incorporarlas al cuidado y el tratamiento. Y, a veces, significa traer un poco de esa cultura a nuestro mundo.

Respetar la diversidad es más que una gentileza. Es un elemento esencial de nuestra práctica como proveedores de cuidados de salud. Sin conocer bien al paciente, podemos atender sólo parte de sus necesidades.

Al celebrar el Mes de la herencia latina en MGH, tenemos una oportunidad maravillosa de reconocer a las personas, costumbres, contribuciones y recursos de este segmento vital de la comunidad latina. También tenemos la oportunidad de preguntarnos cómo podemos apoyar y atender aun mejor a los pacientes, sus familias y empleados de ascendencia latina, y a los de las demás culturas que tenemos el privilegio de servir.

Latino Heritage Month at MGH and across the country

Question: What is the origin of Latino Heritage Month?

Jeanette: On September 17, 1968, Congress resolved that the President was authorized to issue an annual proclamation designating the week of September 15th and 16th National Hispanic Heritage Week. The people of the United States, especially the educational community, are called upon to observe the week with appropriate activities and festivities.

In 1988, the celebration was expanded to a month beginning on September 15th, the anniversary of the independence of five Latin American countries: Costa Rica, El Salvador, Guatemala, Honduras, and Nicaragua. Mexico declared its independence on September 16th and Chile on September 18th.

Question: I often hear the words Hispanic and Latino. Do they mean the same thing?

Jeanette: Hispanic refers to individuals of Spanish or Latin American origin of any race who live in the United States. This includes individuals from Spain, Mexico, Central America, South America, and the Caribbean (Puerto Rico, the Dominican Republic, and Cuba). Latino and Hispanic are frequently used interchangeably, but in its purest sense, Latino refers to people of Latin American descent, including those not of Spanish origin.

Question: Does the Spanish language differ from country to country?

Jeanette: The language itself is virtually the same from one Spanish-speaking country to another, and people from different countries are able to understand each other. However, as is the case with various English-speaking countries such as the United States and Great Britain, there are some differences. These include intonation, articulation of sounds, differences in vocabulary, and sometimes, specific words may need clarification between the speakers.

Question: Can nurses educated in Central America, South America, or the Caribbean practice in the United States once they have a work visa?

Jeanette: There is a two-step process for obtaining a nursing license in the United States. The process is separate and distinct from that of obtaining a work visa. The first step is to contact the Commission on Graduates of Foreign Nursing Schools (CGFNS). The CGFNS pre-screens foreign-educated nurses, including a review of the nurse's education, licensure in his/her home country, an English-language proficiency test, and a 'predictor' exam that provides an indication of the nurse's ability to pass the US national licensure exam (NCLEX). The nurse must then meet state requirements and successfully pass the NCLEX as established by that state's Board of Nursing.

El Mes de la herencia latina, en el MGH y en todo el país

Pregunta: ¿Qué origen tiene el Mes de la Herencia Latina?

Jeanette: El 17 de septiembre de 1968, el 90avo congreso de los Estado Unidos resolvió que el Presidente tenía autoridad para proclamar que la Semana nacional de la herencia latina se reconocería anualmente durante una semana que incluyera las fechas del 15 y 16 de septiembre. Se insta anualmente al pueblo de los Estados Unidos, en especial al sector educativo, a llevar a cabo ceremonias y actos propios para celebrar la semana.

En 1988 una enmienda a la ley extendió la celebración a un mes a partir de todos los 15 de septiembre, aniversario de la independencia de 5 países latinoamericanos (Costa Rica, El Salvador, Guatemala, Honduras y Nicaragua). Además México declaró su independencia el 16 de septiembre y Chile la suya el 18 de septiembre.

Pregunta: A menudo oigo que se usa tanto la palabra *hispano* como la palabra *latino*, ¿tienen el mismo significado?

Jeanette: Aquí en los Estados Unidos usamos hispano para referirnos a los individuos de origen español o hispanoamericano, de cualquier raza, que residen en los Estados Unidos. Esto abarca a individuos de España, de México, de Centro o Sur América y del Caribe (Puerto Rico, Republica Dominicana y Cuba). Frecuentemente se intercambia *latino* con *hispano* pero mas precisamente *latino* abarca a todos los de ascendencia latinoamericana, incluyendo a aquellos que no son de ascendencia española.

Pregunta: ¿Varía mucho el idioma español entre país y país?

Jeanette: En general el español es casi idéntico en todos los países hispanohablantes y la gente se entiende de un país a otro. Sin embargo, existen diferencias tal como las hay entre los países angloparlantes como los Estados Unidos y Gran Bretaña. Éstas se notan en la entonación, la pronunciación de algunos sonidos y en el vocabulario. Cuando conversan individuos de distintos países a veces tienen que aclarar el significado que cada uno le da a ciertas palabras.

Pregunta: En el caso de enfermeras que culminaron sus estudios en países de Centro América, Sur América o del Caribe, ¿pueden ejercer su profesión en los Estados Unidos apenas obtienen su visa de trabajo?

Jeanette: El proceso de obtener la licencia para ejercer la enfermería en los Estados Unidos tiene dos partes. Este proceso es distinto y completamente aparte del proceso de obtener visa de trabajo. El primer paso es contactar a la Comisión para enfermeras tituladas en escuelas de enfermería en el extranjero (CGFNS). Esta entidad hace una evaluación preliminar de la formación de las enfermeras educadas en el extranjero que desean ejercer en los Estados Unidos. La evaluación preliminar implica la revisión de la formación de la enfermera, la licencia o credencial del país de origen, un examen de inglés y un examen que predice la capacidad de la enfermera para pasar el examen nacional de licenciatura (NCLEX). Luego de pasar el primer paso, la enfermera tiene que cumplir con requisitos adicionales y pasar el examen NCLEX, según lo estipulado por cada concejo estatal de enfermería.

Medical interpreters overcome complex challenges every day

—by Susan Muller-Hershon, ASL interpreter

Imagine for a moment that you're Deaf and you grew up in a country where the primary language was Spanish. Imagine that you received little or no education and your language skills are extremely limited. You can't read; and communication with your family is based on made-up gestures and superficial lip-reading. At age 35, you and your family move to the United States and settle in the Boston area.

In Boston, you spend your days at home with your mother until eventually you're taken to an independent living center for Deaf individuals. There, you meet other Deaf, but your ability to communicate is limited because you don't know American Sign Language. You start on the difficult journey of developing your communication skills and learning American Sign Language.

One day, you begin to have seizures. You're brought to MGH. You're examined, scanned, probed, and admitted, but no one can communicate with you. You feel like you're in a vacuum. But soon, the ASL interpreter is notified and asked to assist with communication.

This scenario presents unique challenges for the patient, the caregivers, and me as the ASL interpreter. Upon arriving in the patient's room, I must do a quick assessment to identify what resources are required to achieve the best possible communication between the patient and the providers. For a Deaf patient fluent in ASL, communication would happen through me or another hearing ASL interpreter. But in this case, the patient is not conversant in ASL. We have to add other members to the team. We bring in a certified Deaf interpreter (CDI) to work in tandem with me.

When the provider speaks, I interpret the conversation into ASL for the CDI, who in turn uses a combination of gestures, mime, drawing, and colloquial signs to modify the language and get the message across to the patient. When the Deaf patient responds to a question, the CDI interprets his response into ASL and the ASL interpreter repeats it aloud in English. This works well for the patient, but it leaves the patient's mother out, since she speaks only Spanish.

Initially, the patient's hearing brother paraphrases for the mother, but this compromises her ability to obtain complete information and her son's ability to participate fully in the conversation. This challenge is overcome by including a Spanish medical interpreter on the team. The Spanish medical interpreter's presence gives the mother full access to exchanges with the providers and relieves the patient's brother of the burden of trying to communicate with the mother as the provider is speaking. All resources have been engaged to achieve the best possible communication. A scenario such as this might well be one of the few times in this patient's life where he is empowered to participate in his own care.

This patient received full access to communication because the ASL interpreter was promptly notified of the patient's arrival at MGH. Interpretation and assistive communication services for Deaf and hard-of-hearing individuals are available at MGH, and it is every patient's right to receive them. In this scenario, one phone call made good communication possible for all participants—the patient, family members, and providers. For more information about MGH Interpreter Services, call 6-6966.

Susan Muller-Hershon
ASL interpreter

Los intérpretes médicos sobreponiéndose a grandes retos

Suponga por un momento que es sordo, que nació y se crió en un país hispanohablante. Suponga que no asistió mucho a la escuela y que no sabe leer. Sus destrezas de comunicación son mínimas y se comunica con su familia por señas que han establecido entre ustedes y por lectura de labios muy superficial. A los 35 años de edad se traslada a los Estados Unidos para radicarse en Boston con su familia.

En Boston pasa el tiempo con su mamá en su hogar hasta que eventualmente se muda a una residencia donde vive independientemente con otros sordos. Allí se encuentra limitado por sus destrezas de comunicación pues no sabe el lenguaje de señas americano (*ASL*). Se inicia en la difícil tarea de aprender el lenguaje de señas americano y mejorar su capacidad para comunicarse.

Un día le dan convulsiones y lo traen al *Massachusetts General Hospital*. En el hospital lo examinan a fondo, le hacen todo tipo de pruebas y lo hospitalizan; pero nadie puede comunicarle lo que sucede y se siente como en un vacío. Pronto se le avisa a la intérprete para el lenguaje de señas americano, empleada en el hospital, de su ingreso y se le pide que ayude a facilitar la comunicación.

Este tipo de situación presenta retos únicos para el paciente, para el personal clínico, y para mí, intérprete del lenguaje de señas americano. Al llegar a la habitación del paciente debo rápidamente determinar qué recursos hacen falta para lograr buena comunicación entre el paciente y el

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Latino Heritage Month

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She knew other Latinos living in the United States could relate to that feeling. She talked about the challenges and joys of living (and loving) two cultures. Often witty, her stories resonated with all members of the audience.

One attendee asked how Santiago felt about the way Puerto Ricans were portrayed in the movie, *West Side Story* (the fact that Puerto Ricans were played by Caucasians actors). Santiago shared that, through the years, she's learned that different experiences affect people in different ways and it's important to respect all views. "That movie is meaningful to a lot of people, including Latinos. It has influenced people in positive ways," said Santiago. "For that reason, I think it was an important film."

Following Santiago's presentation, many audience members stayed to meet her and express their gratitude to her for being such an inspiration to the Latino community.

The celebration continued with a reception under the Bulfinch tent with Latin jazz musician, Leo Blanco from Venezuela, who played piano as attendees enjoyed cuisine from several Latin and Central American countries, Cuba, Puerto Rico, and Spain. "The food is to die for," said one employee. More than 800 people tasted ropa viejo, paella, chicken empanadas, yuca chips, sweet plantains, guacamole and jicama sauce. But perhaps the most popular dish was the scrumptious dessert, *pastel de tres leches* (three milk cake).

(Photo by Abram Bekker)

Enjoying Latino Heritage Month festivities under the Bulfinch Tent

The goal in celebrating Latino Heritage Month is to let employees of Latino heritage know that the contributions they bring to MGH and the United States are recognized and appreciated. This message, articulated by MGH president, Peter Slavin, MD, as he welcomed attendees to O'Keeffe Auditorium, resonated with Latino and non-Latino employees alike.

Los intérpretes médicos

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personal clínico. Con los pacientes sordos que saben *ASL* la comunicación se logra a través de mí o de otro intérprete de *ASL* oyente. Sin embargo, en este caso el paciente no sabe conversar en *ASL*. Hay que integrar más personal al equipo y se trae a un intérprete sordo certificado (*CDI-Certified Deaf Interpreter*) para que trabaje a la par conmigo.

Cuando el personal clínico habla yo interpreto sus palabras a *ASL* y el intérprete sordo (*CDI*) las interpreta para el paciente, usando una combinación de gestos, mimos, dibujos, y señas coloquiales, modificando el idioma y transmitiendo el mensaje al paciente. Cuando el paciente sordo responde a las preguntas del personal clínico, el intérprete *CDI* interpreta las respuestas a *ASL* y yo, la intérprete de *ASL*, las repito en voz alta en inglés. Este arreglo soluciona la comunicación del paciente con el personal clínico pero excluye a la madre del paciente pues ella sólo habla español.

Inicialmente un hermano oyente del paciente, que habla inglés y español, va resumiendo la conversación para la madre. Sin embargo, esto le impide a ella participar plenamente en el diálogo. Para sobreponernos a esto integramos un intérprete médico de español al equipo. Con este último intérprete se logra la plena participación de la madre y el hermano en el diálogo con el personal clínico. De este modo se aprovechan todos los recursos disponibles para lograr la mejor comunicación posible. Puede que esta sea una de las pocas ocasiones en la vida del paciente en las que se le otorgó el poder de participar de lleno en su atención médica.

Este paciente se benefició de poder comunicarse plenamente con el personal clínico debido que se le dio avisó oportuno al intérprete de *ASL* de su ingreso al hospital. En el *MGH* hay servicios de interpretación y de dispositivos auxiliares de comunicación y todo paciente sordo o con capacidad de audición disminuida tiene derecho a recibirlos. En el caso aquí descrito con sólo una llamada telefónica se le posibilitó la buena comunicación a todas las partes –el paciente, su familia, y el personal clínico Para más información acerca de los servicios de interpretación y comunicación en el hospital llame al 617-726-6966.

Mes de la herencia latina

—by Carmen Vega-Barachowitz, CCC-SLP

El 22 de septiembre por sexto año consecutivo se celebró el Mes de herencia latina en el MGH. Este mes se celebra todos los años del 15 de septiembre al 15 de octubre en los Estados Unidos. Desde el año 2000 el MGH ha reconocido las contribuciones de los empleados de ascendencia latina con varios eventos. Este año el evento principal fue la charla de la escritora puertorriqueña Esmeralda Santiago, quien hablo abiertamente de sus experiencias como mujer latina. Más de 115 personas acudieron al auditorio *O'Keeffe* para escuchar la inspiradora charla de Santiago. Beth Schneider, directora de la biblioteca *Treadwell*, comentó "Esmeralda es una fuerza de la naturaleza y encantadora. Ella es un modelo ejemplar para toda la humanidad". Santiago es una escritora muy conocida cuyos libros incluyen: *Cuando era puertorriqueña, Casi una mujer*, y *El amante turco*. Hija de una familia muy pobre de Puerto Rico, Esmeralda se traslado a la ciudad de Nueva York con su familia a los 13 anos de edad. Allí, con arduo trabajo y perseverancia, aprendió ingles y estudió en la escuela secundaria de artes escénicas de la ciudad. Luego hizo ocho años de estudios en varios centros de estudios superiores antes de ingresar a *Harvard University* donde culminó sus estudios universitarios con reconocimiento *magna cum laude*. Santiago conversó acerca de cómo se inició como escritora y lo importante que fue para ella compartir sus vivencias. "En los libros que leía, nunca encontraba personajes que se parecieran a mí", dijo Santiago. Ella sabía que otros latinos en los Estados Unidos podrían identificarse con ese sentimiento. Santiago habló acerca de los retos y el placer de vivir y amar a dos culturas. Los relatos de Santiago resonaron mucho con el público presente pues ella los cuenta con gracia y humor.

Un concurrente le preguntó qué siente acerca de cómo fueron representados los puertorriqueños en la película *West Side Story*, teniendo en cuenta que el papel de los personajes puertorriqueños se le dio a actores no puertorriqueños de raza blanca. Santiago compartió que con el paso de los años ha aprendido que cada experiencia nos afecta a cada uno de un modo distinto y que es importante respetar todos los puntos de vista. "Esa película tiene gran importancia y significado para muchos, inclusive para muchos latinos. Ésta ha tenido influencias positivas sobre muchos," dijo Santiago. "Por eso pienso que es una película importante." Al terminar la presentación de Santiago, mucho público se quedó para conocerla y agradecerle por ser una inspiración a la comunidad latina.

La celebración siguió con una recepción en el toldo Bulfinch donde Leo Blanco, el músico venezolano de jazz latino, tocó piano mientras el público disfrutó de la cocina de varios países latino y centroamericanos. "La comida está de ataque", comento un empleado. Más de 800 personas probaron paella, ropa vieja, empanadas de pollo, frituritas de yuca, plátanos fritos maduros, guacamole y salsa jícama. Pero el plato mas popular fue un suculento postre, el *pastel de tres leches.*

Nuestro objetivo al celebrar el Mes de la herencia latina es dejarle saber a los empleados latinos que sus aportes al MGH y a los Estados Unidos son reconocidos y apreciados. Este mensaje expresado por el presidente del MGH, Peter Slavin, MD, al darle la bienvenida al público en el auditorio *O'Keeffe*, resonó con todos los empleados, latinos y no-latinos.

Disfrutando de la fiesta del Mes de la herencia latina en el toldo *Bulfinch*

Thank-you

Special thanks to translation specialist, Karin Hobrecker, for translating articles in this issue of *Caring Headlines*

Agradecimiento

Le agradecemos a Karin Hobrecker por las traducciones de esta edición de Caring Headlines

Quality core measures for heart failure: the role of the nurse

—by Diane Carroll, RN, nurse researcher, and Paul Nordberg

Over the past few years, the quality of care provided at MGH has become significantly more visible with the introduction of a number of national dashboards. These dashboards reflect a consensus of what the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Center for Medicare & Medicaid Services (CMS), and other national regulatory organizations agree quality core measures should be. Today, MGH quality scores are available on the Internet alongside the scores of other hospitals, allowing consumers to see and compare the quality of care provided at MGH and elsewhere. We're rightfully proud of the care we provide at MGH, but we cannot take it for granted. Our quality efforts must be constantly assessed, evaluated, and improved.

As science and public health advance, people are living longer and experiencing more chronic disease(s) including heart failure (HF). Because patients can and should contribute to their own care, their understanding and participation are key. Nurses play a central role in educating patients and families and in helping them understand how they can contribute to their own care.

The hospital quality core measures for HF highlight patient-teaching, which encompasses discharge instruction including *all* of the following:

- medications
- diet
- next appointment
- signs and symptoms to watch for
- activity
- weight-monitoring

Weight-monitoring is especially important for HF patients, since weight-gain is often the first sign of impending decompensation. Patients who have smoked in the last year should receive counseling about smoking. All teaching materials can be found in HF packets available on all medical and cardiac surgery units.

The first step is identifying patients with HF. Sometimes this is a challenge because patients have multiple medical conditions or are being admitted electively for procedures that reflect underlying chronic HF. A list of all HF patients is e-mailed daily to nurse leaders and champions on all units involved. HF packets contain booklets and summary sheets of topics that should be reviewed with patients and families. Nurses can stress patient-specific information, such as how much salt may be in prepared foods.

Because publicly reported scores are based on chart audits, it's important that patient teaching be documented in medical records. A recent survey found that some nurses, while providing excellent patient education, fail to document that patient education in the medical record. If nurses don't document their teaching, MGH scores don't reflect the excellent care we provide. The Interdisciplinary Patient/Family Teaching Form is the best place to document teaching, because everyone on the team can see what's been taught.

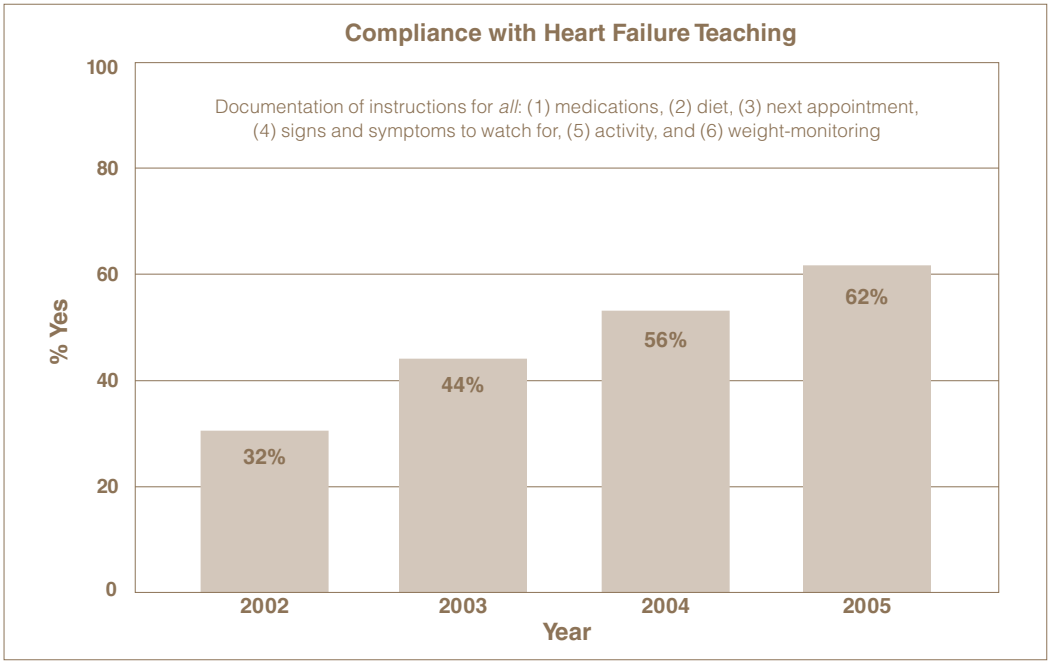
Units that care for HF patients employ a number of strategies to ensure patient education is documented. Best practices include: participation of resource nurses; keeping a central notebook of patient-teaching status; and placing materials in areas commonly used by nurses and in the slots for the green books near the entrance to the patients' rooms.

MGH has improved greatly in our publicly reported scores, moving from 18% compliance at baseline to about 60% in recent data (see figure). Other hospitals across the country are achieving similar improvements. This is good news for patients.

We need to be vigilant in ensuring that the excellent care we provide is accurately documented and reflected in publicly reported scores.

Says Judy Silva, RN, co-chair of the Cardiac Clinical Performance Management Team, "Heart-failure patients are everywhere, not just on cardiac units. Nurses are in the best position to educate patients and families on how best to care for themselves at home."

For more information, contact Diane Carroll, RN, at 4-4934.



Empathy and advocacy guide resource nurse caring for unsheduled endoscopy patient

Marjorie Voltero, is an advanced clinician in the PCS Clinical Recognition Program

Marjorie Voltero, RN
staff nurse, Endoscopy Unit

My name is Marjorie Voltero, and I am a staff nurse on the Blake 4 Endoscopy Unit. On the Endoscopy Unit, we provide diagnostic and interventional gastrointestinal procedures to a diverse population of inpatients and outpatients. Many of the outpatients we see are otherwise healthy and are here for preventative, screening colonoscopies. (A procedure where a video-assisted fiber-optic instrument is inserted through the rectum, then maneuvered through the large intestine to allow physicians to visualize and remove polyps. Some polyps can become cancerous and early detection is key to preventing and treating colon cancer.) Other patients may have chronic gastrointestinal disorders or cancer, and still others suffer from acute symptoms of gastrointestinal bleeding, biliary, or pancreatic disease.

A major part of nursing care for endoscopy patients is managing anxiety and pain before, during, and after the procedure. For all patients, this includes pre-procedure assessment, pre-procedure teaching, and formulating an individualized plan of care. During most procedures, intravenous procedural sedation is used to minimize the discomfort of the procedure. The combination of sedation medication, procedural breathing techniques, and emotional support provided by the nurse is usually very effective in eliminating or controlling the pain and discomfort patients can experience.

Some procedures don't routinely require sedation. One procedure that doesn't generally involve anxiolytics or narcotic pain control is a sigmoidoscopy. Similar to a colonoscopy, this procedure can serve as a colon cancer screening exam, but only examines the lower third of the colon. Because less of the colon is examined, and the procedure takes only about five minutes, there is less need to use procedural sedation. Most patients are able to tolerate sigmoidoscopies with only pre-procedure teaching and emotional support during the procedure.

One afternoon when I was working as the resource nurse, one of our endoscopists informed me he had a patient, Mr. M, who needed a procedure right away. He asked if we'd be able to fit him in for a sigmoidoscopy that afternoon. As the resource nurse, it's my responsibility to keep the unit running smoothly, be aware of available resources, and allocate them efficiently to provide optimal patient care. It was a busy day, and our resources were being fully utilized at the time. Wanting to keep the unit running smoothly, but also wanting to accommodate Mr. M in a timely fashion, I reassessed the afternoon schedule. I was able to create an opportunity for Mr. M's procedure within the hour.

I met Mr. M and his family in the main waiting room. He seemed frail and tired; his family was very supportive and offered to help in any way they could. As I explained how to fill out the assessment form, I noticed Mr. M was shifting his weight in his chair and grimacing. I thought he might be in pain and asked if he was uncomfortable. He said he was. He'd had rectal bleeding and pain for about a week, especially when sitting. I told him I thought he might be more comfortable lying on a stretcher, and he agreed. After obtaining his permission, I asked his wife to help complete the admission paperwork as I helped Mr. M get ready for the exam and get comfortable on the stretcher.

Mr. M was scheduled for a routine sigmoidoscopy and wasn't scheduled to receive sedation during the exam. Given Mr. M's current level of discomfort, I thought it might be better if the procedure was performed with sedation. I spoke to the doctor about my assessment and explored the possibility of offering Mr. M sedation for his exam. The doctor was willing to do the procedure with sedation. I made the necessary changes and went back to where Mr. M was lying comfortably on the stretcher with his wife and son by his side. I spoke with Mr. M and his family about the availability of sedation, and Mr. M admitted to being afraid of how much it would hurt. He and his family expressed relief at being able to receive pain control for the procedure. I explained it would require placing an intravenous and he would need someone to be responsible for him after the procedure. Anyone receiving sedation must have a responsible escort at the time of discharge for safety reasons. I completed Mr. M's assessment, explained the procedure, and answered the questions he and his family had. After I placed the IV, he was ready to have the procedure.

As I reviewed Mr. M's assessment form, I noticed he had prostate cancer and had received radiation treatment six months before. I thought it might be possible that Mr. M's bleeding was the result of damage to his rectum as a side-effect of radiation. I've cared for patients with a condition called radiation proctitis before, and I knew it could be controlled by treating the weakened blood vessels with a special type of cauterization involving argon gas. And I knew it could be done during the procedure Mr. M was about to have. This reinforced how important it was for Mr. M to have sedation during what would now be a more painful and lengthy

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Clinical Narrative

continued from previous page

exam than originally scheduled. I spoke with the nurse who would be caring for Mr. M during the procedure, explained all that had transpired, and arranged to have the necessary equipment available.

Mr. M was able to tolerate the procedure with moderate doses of sedation, and the bleeding was stopped with argon gas coagulation. Because of the type of mucosal injury he had sustained, he would need at least one more treatment to keep the bleeding controlled. The doctor thanked me for my assistance in facilitating the successful exam and made arrangements with his office to ensure Mr. M's next sigmoidoscopy was scheduled with sedation, too.

One of the challenges in a busy, outpatient setting can be establishing a therapeutic relationship with patients and their families. Because of the nature of an outpatient practice, the amount of time spent with individual patients may be small, but every patient presents with specific needs to be identified and addressed. I was able to communicate effectively and compassionately with Mr. M and his family to identify a need for effective pain management during his procedure. Using my knowledge and experience, I was able to relay this assessment and potential solutions in a cooperative and collegial manner to other members of the team. This helped create an environment conducive to providing the best possible patient care. I know that because of my interventions, Mr. M and his family experienced less anxiety and discomfort during their stay in the Endoscopy Unit.

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

The Endoscopy Unit is a busy, fast-paced, predominately outpatient practice. As resource nurse, Marjorie had a wide range of responsibilities. She quickly prioritized her work and was able to fit Mr. M into the schedule without compromising the care of other patients, and ensuring that Mr. M was seen in a timely fashion. She advocated for Mr. M to receive sedation to ensure optimal comfort during his procedure and proactively addressed the issue of his rectal bleeding. Her quick thinking, knowledge, and ability to work effectively with the team led to a positive experience and minimal discomfort for Mr. M and his family.

As Marjorie pointed out, every patient presents with a unique set of needs whether it's an inpatient or outpatient unit. It's our job to meet those needs no matter what the setting. Marjorie did that, and more.

Thank-you, Marjorie.

The Employee Assistance Program

presents

Working and Breastfeeding

by Germaine Lamberge, RN

Presentaion will provide expectant and nursing parents with all the basics of breastfeeding, pumping, problem-solving, and a tour of the MGH Mother's Corner

Thursday, November 9, 2006
12:00–1:00pm
VBK 401

For more information, please contact the Employee Assistance Program at 726-6976

The MGH Chaplaincy invites you to celebrate

Pastoral Care Week

Tuesday, October 24, 2006
11:00am–1:00pm
Main Corridor

The blessing of the hands

Thursday, October 26, 2006
6:30–8:00am; 11:30am–1:00pm; 3:00–5:00pm
The MGH Chapel

All are welcome to join us in the Chapel for this special blessing. We offer the blessing of the hands as affirmation and appreciation for all the tasks our hands do to provide comfort and care for one another

If you would like to speak to a chaplain, call the Chaplaincy at 617-726-2220.

Call for Nominations

Norman Knight Preceptor of Distinction Award

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

Nurses may nominate nurse colleagues whom they know to be strong educators, preceptors, mentors, and coaches. Nomination forms will be available on all inpatient units, in The Knight Nursing Center for Clinical & Professional Development (located on Founders 3 effective October 1st), or upon request by e-mail

Nominations must be received by November 10, 2006

The Norman Knight Preceptor of Distinction Award ceremony will be held March 8, 2007. Recipient will receive a certificate and professional-development award in the form of tuition for a nursing course or a program of study with a clinical nurse specialist

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

One therapist's journey of professional development

—by Melanie Struzzi, PT, staff physical therapist, speaking on the occasion of National Physical Therapy Month

Melanie Struzzi, PT
staff physical therapist

I am honored to speak today about professional development and share my experiences with you.

When I graduated from Physical Therapy school back in 1994, when programs were still offering bachelor's degrees, my goals were non-specific and probably similar to those of most new PTs: learn and grow and be the best PT I could be. As I reflect on the choices I've made and the direction they've led me, I realize I have accomplished more than I ever thought possible by keeping those goals in mind.

My first job was in an acute care hospital where I rotated between inpatient teams every three months. The orientation process wasn't very long or involved, there was no structure in place for mentoring or development, and I found myself 'on my own' early in my career. The majority of learning that took place was due to my own initiative, seeking out colleagues for guidance and confirmation, attending continuing-education programs, reading articles in journals, and of course, learning by trial and error. I remember wondering when I received positive feedback at my annual reviews how my supervisors could accurately evaluate my performance as I rarely interacted with them or had and oversight in my practice.

In less than two years, I recognized the need for more challenge and stimulation in my work environment. I accepted a position in a rural hospital where the director of PT was a former clinical instructor whom I had admired. I thought this would be a place where I could branch out into outpatient and home-health settings as well as acute and sub-acute care.

In this new position, I was challenged in many ways and developed my clinical, professional, and leadership skills. The PT director was actively involved in the American Physical Therapy Aassociation (APTA) as the chair of our district, and his commitment to the profession made a lasting impression on me. He encouraged me to get involved with the association, introduced me to others from whom I could learn, and eventually supported me in taking on the position of district chair. When he returned to graduate school to earn his master's degree, he would share what he was learning, and I was inspired to do the same. We would integrate this new information into our practice. As I expressed interest, he gave me opportunities to assist in the leadership and management of the department. My role grew to include these new responsibilities in addition to patient care and clinical education.

After visiting Boston and deciding to move here, my connections in the APTA led me to MGH. As is typical in the association, people were more than happy to help. Massachusetts was considered an active chapter and many of the names I was given as resources are people I now know in person. Before I knew it, I had interviewed for and accepted a position at MGH. (It's a testament to how much I wanted the job that I moved here in December and was immediately introduced to the northeast winters.)

The transition to MGH was more challenging than I could have imagined. My practice and clinical decision-making had never been scrutinized to such a degree, and I became acutely aware of how much I didn't know. I was awed and inspired by the knowledge and skill around me. I continuously researched and integrated new information into my practice. Everything was questioned. Everything required evidence. Everything could be improved upon or done better.

With the generous support of the department, I decided to embark on my DPT. It seemed a natural extension of the work I was doing, another opportunity to learn and develop, and it was in line with APTA's vision. Though time-consuming, it was well worth the effort and not as difficult as I had imagined. This was an indication of how far I'd come during my time at MGH. Somewhere along the way, it had become easier—not less challenging—just more natural. Questions asked by the clinical specialist as I oriented now came to my own mind as I went through my day. The 'Guide' language was on the tip of my tongue, and documentation flowed more efficiently.

Over time, I was increasingly able to see how much I knew, how much my practice had changed, and how much more I had to offer my patients. I don't remember exactly when I started to consider applying for advanced clinician through the Clinical Recognition Program. I was hesitant that I might be over-estimating my level of practice, but I broached the subject with my clinical specialist, and she gave me the support and encouragement I needed to move forward. I can honestly say that the process was its own reward. I strongly encourage clinicians to engage in the process, as I found it to be an invaluable and affirming experience. By the time I compiled my portfolio, I had a fully realized appreciation of where I was clinically and all I had achieved. It gave me the opportunity to reflect on my career and professional development.

I've always been open to new learning experiences. If something is scary, intimidating, and exciting all at the same time, that's generally a

continued on next page

The Ernesto Gonzalez Award for Outstanding Service to the Latino Community

On Thursday, October 5, 2006, in the East Garden Dining Room, Lourdes (Lulu) Sanchez, manager of Medical Interpreter Services, became the second recipient of The Ernesto Gonzalez Award for Outstanding Service to the Latino Community.

The award was created and named in 2005 to honor Ernesto Gonzalez, MD, for his contributions to Latino patients, families, and communities. It now recognizes MGH employees who contribute to Latino-based initiatives within or outside the institution, and whose contributions help build bridges with the MGH Latino community beyond their daily duties and responsibilities.

Sanchez was nominated by Katia Canenguez and Jossety Parada, who wrote in their letter of nomination: "We would like to nominate Lulu because she embodies all the criteria for this award. Lulu has worked arduously to provide this hospital with an excellent Interpreters Department. She has raised the bar for medical interpreters and helped her staff gain the respect and recognition they deserve. She has found ways to establish and maintain positive relationships with people within and outside of MGH.

"It is with great enthusiasm that we nominate Lulu for the outstanding job she does to ensure Latino patients in our community receive the high-quality care they deserve."

This year's Gonzalez award recipient, Lulu Sanchez, with first recipient, Ernesto Gonzalez, MD.

Lulu Sánchez ganadora del Premio para el 2006, acompañada por el primer galardonado, el Dr. Ernesto González

(Photo by Michelle Rose)

Con el Premio Ernesto González se reconoce una labor sobresaliente en servicio de la comunidad latina

El jueves 5 de octubre último se otorgó por segunda vez el Premio Ernesto González. Este año se premió a Lourdes (Lulu) Sánchez, administradora del Servicio de interpretación médica, en reconocimiento de su ejemplar labor sirviendo a la comunidad latina.

El Premio se estableció en el año 2005 y se nombró en honor del Dr. Ernesto González, MD, por sus contribuciones al bienestar de los pacientes latinos y sus familias y de la comunidad latina en general. El Premio se otorga a empleados del MGH que contribuyen a iniciativas para el bien de los latinos, dentro y fuera del hospital, y cuyas contribuciones fomentan la unidad en la comunidad latina del hospital, yendo más allá de sus deberes y responsabilidades cotidianas.

Katia Canénguez y Jossety Parada postularon a Sánchez para el Premio. Ellas escribieron en la postulación: "Queremos postular a Lulu pues ella representa todos los criterios del premio. Lulu ha trabajado arduamente para darle un excelente Departamento de intérpretes al hospital. Ella le ha exigido mejor desempeño a los intérpretes médicos logrando para ellos el respeto y reconocimiento que merecen. Y ha hallado formas de forjar y conservar relaciones positivas con personas dentro y fuera del MGH".

"Postulamos a Lulu con gran entusiasmo por motivo de la labor sobresaliente que hace día a día para asegurarse de que los pacientes latinos reciban la atención de alta calidad que se merecen".

Physical Therapy

continued from previous page

good indication it's the right path to take. You don't necessarily have to know your final destination in order to accomplish a lot along the way.

I've surrounded myself with good people, which is not hard to do in the PT profession. By this I mean people who see the best in you and push you to achieve it, who are good role models and mentors, and who possess characteristics you'd like to develop in yourself.

I've been actively involved in the APTA and state chapters. A community of people committed to the profession and to helping you along the way is inspiring. It's great for networking, developing professional skills, and accessing resources.

I've given back along the way. I volunteered at a free-care PT clinic in this country and at a rural clinic in Mexico. I gained far more from that experience than I gave. I encourage you to look for ways to give back to the community beyond your daily work. We're fortunate to be in a profession that gives us so much. With the knowledge we have, we're in a unique position to contribute through volunteerism to the health and wellness of those who might not otherwise have access.

I'm grateful to be in a profession where I can continue to grow and learn, where I'm surrounded by so many wonderful people, and where I have the opportunity to touch so many lives. I'm grateful to work in an environment where quality of care is the top priority, where professional development is encouraged and valued, and where the commitment to both is evident in the leadership and accomplishments of the department and the hospital.

Evolution of collaborative practice in the Medical Intensive Care Unit

—by Mary Lavieri, RN, clinical nurse specialist

It has been well demonstrated in the literature that when nurses, physicians, and other healthcare professionals work together as a team, patient outcomes are improved. In 1992, one research study predicted a decrease in the risk of negative outcomes in the Medical Intensive Care Unit at a large teaching hospital in New York. They found that when collaboration was perceived as strong between nurses and physicians, the predicted risk of negative outcomes dropped from 16% to 5%. A subsequent study in 2003 found that intensive care units with the highest functioning teams had statistically lower morbidity rates.

Over the past four years, the culture in the MGH Medical Intensive Care Unit (MICU) has moved toward a more collaborative model. Medical and nursing leadership have met frequently to discuss strategies for increasing collaboration on the unit. Several retreats were held where MICU nurses and attending physicians discussed practice and outcomes compared to other ICUs; plans for the coming year, and strategies to improve collaboration and practice.

The goal was to shift from a 'medical model,' focusing strictly on medical issues presented by physicians, to a 'collaborative model' where nurses, physicians, and therapists present, interact, and work together to improve outcomes. When disciplines work collaboratively, everyone benefits—most importantly—the patient. As an integral part of the team, nurses and therapists develop stronger communication skills, more autonomy, and an elevated sense of self-worth.

The goal was to shift from a 'medical model,' focusing strictly on medical issues presented by physicians, to a 'collaborative model' where nurses, physicians, and therapists present, interact, and work together to improve outcomes

To create a more collaborative practice in the MICU, the nurse manager, the unit medical director, and I met frequently to discuss medical and nursing practice issues on the unit. Our priority was to create a culture in which nurses would *want* to be included in rounds.

Cultural changes usually take time. We talked with nurses about participating in rounds. We asked questions like: Why is it important for us to be part of rounds? What's preventing us from participating in rounds? We discussed improved outcomes when nurses and physicians work collaboratively as a team.

Every month, the nurse manager, medical director, operations coordinator, a staff nurse, and I met with the incoming medical teams. We welcomed them to the unit and talked about collaborative practice. We stressed teamwork, the importance of good communication, and the need for nurses to be present at rounds.

Within the first few days of each month, staff would let me know how things were working.

(Photo provided by staff)

Mary Lavieri, RN
clinical nurse specialist

We'd discuss issues that might arise, such as ordering scans without the nurse or therapist being informed.

Part of my role was to facilitate nurses' presence at rounds. This sometimes meant talking with individual nurses or physicians to ensure that everyone felt welcome and included in the process. When I'd see a team making rounds without a nurse, I'd go and relieve the nurse at the patient's bedside so he/she could join rounds.

This past February, the MICU held a nursing retreat where we discussed problem-solving and team-building strategies. We talked about nurses being present at rounds. I brought up the idea of nurses *presenting* at rounds. The response was overwhelmingly positive. We decided that nurses would present overnight events in conjuction with interns, and they would review flowsheets.

Following the retreat, the nurse manager and I met with our medical director to discuss the possibility of nurses presenting at rounds. We all agreed it was a good idea. We decided to implement the change following the next MICU medicine-nursing retreat in the spring.

We began having nurses present at rounds on one team and continued with the traditional method on the other team. A week later, house staff, nurses, and attending physicians met to discuss the impact of the change. Feedback was overwhelmingly positive, especially from house staff. Some of their comments were: Rounds are faster, more efficient; interns are able to learn more at rounds when they don't have to do the whole presentation themselves; it's nice to hear nurses present first rather than hear a different perspective later on.

Nurses also had a favorable response, saying, 'Who better to review flowsheets than nurses? After all, we're the ones filling them out.'

The decision was made to continue with

continued on next page

The MGH Quit Smoking Service has changed its name to: the 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

Patients may be more comfortable in the smoke-free environment of the hospital if they have access to nicotine-replacement products. The Tobacco Treatment Service can help patients avoid nicotine withdrawal

If patients want to quit smoking, the Tobacco Treatment Service is available for assistance

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.

Be sure to document your work and make your practice visible

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

Helping children successfully navigate the teenage years

Attention-deficit/hyperactivity disorder

A one-day conference for parents, educators, and healthcare professionals

Wednesday, November 1, 2006
7:30am–4:45pm
Sheraton Ferncroft, Route 1 Danvers

Registration is required
(discount for registering by October 25th)

For more information about rates, topics, and presenters, call 978-354-2660

Call for Proposals

The Yvonne L. Munn, RN, Nursing Research Awards

Staff are invited to submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Recognition Week, May 6-12, 2007
Proposals are due January 16, 2007
Guidelines for developing proposals are available at:
www.mghnursingresearchcommittee.org
under "Funding Sources"
For more information, contact Virginia Capasso, RN, at 617-726-3836, or by e-mail at vcapasso@partners.org

Collaborative Practice in the MICU

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nurses presenting at rounds on both teams. But there *were* some stumbling blocks. One problem was communication. As new teams and attending physicians rotated through the MICU, the new plan wasn't consistently disseminated to everyone. And there was some misunderstanding as to whether nurses presenting at rounds was mandatory or optional. We're currently working to resolve those issues.

Have we attained our goal of creating a more collaborative practice in the MICU? I believe we have. A few weeks ago, the medical director approached me and asked me to observe the team rounding. "Look at that," he said. "Margaret [the nurse] is at the head of the table reviewing the chart. She has house staff's undivided attention. They're talking about the care of the patient together."

Our practice is always evolving. Though we've succeeded in implementing an important change on our unit, it's easy to slip back into old habits. We must continue to value change and look for ways to improve our practice and the care we deliver. Our experience in the MICU supports the research that collaborative practice improves patient care.

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Next Publication Date:
November 2, 2006

MGH dietetic interns: who are they and what do they do?

—by Kathleen E. Creedon, RD
director, Dietetic Internship, and education manager

Dietetic interns (DIs) are students working at MGH to learn as much as possible about all areas of dietetic practice. DIs work with clinical registered dietitians (RDs) in inpatient areas learning to assess patient nutrition needs. Here, they consult and communicate with other healthcare professionals, learning from all members of the team. Nurses help DIs understand the patients' conditions, whether or not they're eating, and other nutritional needs they may have. Nurses play a pivotal part in helping DIs navigate the patient-care process. With the guidance of an RD preceptor, DIs implement nutrition care plans and continually monitor and adjust those plans as patients' conditions change.

In the Main Kitchen, patient food service, and retail areas, DIs learn culinary and management skills in preparation for delivering safe, efficient and tasty meals to patients and customers in a timely fashion.

Outpatient registered dietitians teach counseling techniques to DIs so they can work with clients, special program participants, and high-school groups to encourage good nutrition.

As part of the program, interns form teams to create a formal business plan—develop a business venture concept and translate it into a business proposal. Some of the business plans developed by DIs have been selected for implementation at MGH.

Upon completion of the internship, DIs are eligible to sit for the Registered Dietitian Examination to become registered dietitians.

The MGH Dietetic Internship is the only one in the country accredited to prepare students to practice in the four areas of: Clinical Nutrition/ Medical Nutrition Therapy; Community Nutrition; Food Service Systems Management; and Business Entrepreneur.

The Dietetic internship is a 50-week, post-baccalaureate program sponsored by the MGH department of Nutrition & Food Services and accredited by the Commission on Accreditation for Dietetic Education. Applicants must have completed a specified undergraduate dietetic curriculum that includes sciences, nutrition, management, accounting, economics, psychology and other areas of study. It's a plus if interns have had experience in health care, food service, or have had business or retail experience.

Many graduates of the MGH Dietetic Internship have gone on to hold positions such as president of our professional association, college professors, physicians, and managers. Many have continued as MGH staff members and moved into leadership positions here.

For more information about the MGH Dietetic Internship, contact Kathy Creedon at 617-726-2589.

(Photos provided by staff)

Students participating in the MGH Dietetic Internship are exposed to a number of learning experiences, nutrition experts, and clinical situations during their 50-week program at MGH

When	Description	Contact Hours
October 31 8:00am–12:00pm	**BLS Certification–Heartsaver** VBK601	- - -
November 1 and 8 8:00am–4:30pm	**Phase II: Wound Care Education** Training Department, Charles River Plaza	TBA
November 2 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
November 2 8:00–4:00pm	**Oncology Nursing Concepts: Advancing Clinical Practice** Yawkey 2210	TBA
November 3, 7, 10, 14, 17, 21 7:30am–4:30pm	**Greater Boston ICU Consortium CORE Program** Mount Auburn Hospital	44.8 for completing all six days
November 3 8:00am–4:00pm	**Creating a Therapeutic and Healing Environment Part II** O'Keeffe Auditorium	- - -
November 8 8:00am–2:00pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
November 8 4:00–5:00pm	**More than Just a Journal Club** Yawkey 2210	1.2
November 8 11:00am–12:00pm	**Nursing Grand Rounds** "Zambia Nursing Project." Haber Conference Room	1.2
November 8 1:30–2:30pm	**OA/PCA/USA Connections** Bigelow 4 Amphitheater	- - -
November 10 and 20 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	- - -
November 13 8:00am–12:00pm	**The Essence of Patient Education** Thier Conference Room	TBA
November 14 11:00am–12:00pm	**Chaplaincy Grand Rounds** "Parenting at a Challenging Time." Gray Building, 4th floor	- - -
November 15 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
November 15 8:00am–12:30pm	**Pediatric Advanced Life Support (PALS) Re-Certification Program** VBK601-607	- - -
November 16 12:00–4:00pm	**Basic Respiratory Nursing Care** Sweet Conference Room	- - -
November 16 8:00am–4:30pm	**Workforce Dynamics: Skills for Success** Training Department, Charles River Plaza	TBA
November 16 1:30–2:30pm	**Nursing Grand Rounds** "How to Write a Research Abstract." O'Keeffe Auditorium	1.2
November 20 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
November 20 8:00am–4:30pm	**A Diabetic Odyssey** O'Keeffe Auditorium	TBA
November 21 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)	- - -
November 22 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)

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.

Universal Protocol: how does it affect my practice?

—by Ruth J. Bryan, RN, clinical nurse specialist

When caring for patients, what is it you value most? The safe, quality care you provide? Your capacity for empathy? Your ability to share with patients and families? Is it that feeling that you've accomplished all you can for your patient?

Some elements of practice are so ingrained in us that we no longer have to consciously think about every little step. But what about new policies and practices? How do we integrate new elements of practice into our daily routine without sacrificing patient safety and quality of care?

The Universal Protocol or 'Time-Out' policy has been an integral part of practice in the Operating Rooms since June, 2000. Now, in accordance with Joint Commission on Accreditation of Healthcare Organizations standards, the Universal Protocol policy has been adopted throughout the hospital, including ambulatory settings. The Universal Protocol policy prescribes a process whereby clinicians take a time-out before performing any invasive procedure to verify that the correct patient is having the correct procedure on the correct side at the correct site. As part of the process, a check-list is completed prior to any invasive procedure that poses a potential risk to a patient. Invasive procedures that require a time-out include: chest-tube placement, central line placement, paracentesis, thoracentesis, lumbar punctures, tracheostomy tube changes, or bronchoscopies. Time-outs should be observed no matter where in the hospital procedures are performed.

The Universal Protocol policy promotes safe, accurate patient care. Checking the patient's name and medical record number on the identification band prior to any procedure is already part of safe care at MGH. We do the same before sending a patient to another unit or test site. For example, if we send a patient for a needle-guided biopsy, we verify her identity and medical record number to make sure an order has been written prior to her leaving the unit. In many circumstances we also verify that a signed informed consent is in place prior to transport.

We all play a role in ensuring that Universal Protocol becomes ingrained in our practice. Invasive procedures may only be performed on your unit rarely, but we need to be vigilant in ensuring a time-out is observed every time, no matter how infrequently a procedure is performed. All staff should know where time-out check-lists are kept on their units and be able to identify Universal Protocol resources throughout the hospital. By taking these proactive steps, we can integrate Universal Protocol into our practice and continue to promote excellence and safety in patient care.

For more information on the Universal Protocol, to read the policy, see the check-list, or access an educational tool, visit the MGH JCAHO website. If you have questions, please call Ruth Bryan at 6-8945.

Caring means not sharing (the flu!)

In preparation for the 2006-2007 flu season, Occupational Health Services is offering its annual flu clinic. All staff, employees, and volunteers are encouraged to be vaccinated

Clinic dates:
October 30–November 3, 2006
7:00am–5:00pm
WACC Cafeteria

November 4–November 5, 2006
7:00am–5:00pm
Main Corridor

Please bring your MGH/PHS ID badge and wear sleeves that roll up easily. For those unable to attend the clinics, walk-ins are welcome on Thursdays at Occupational Health, starting Thursday, November 9th. For more information, or to schedule an appointment, call Occupational Health Services at 617-726-2217

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