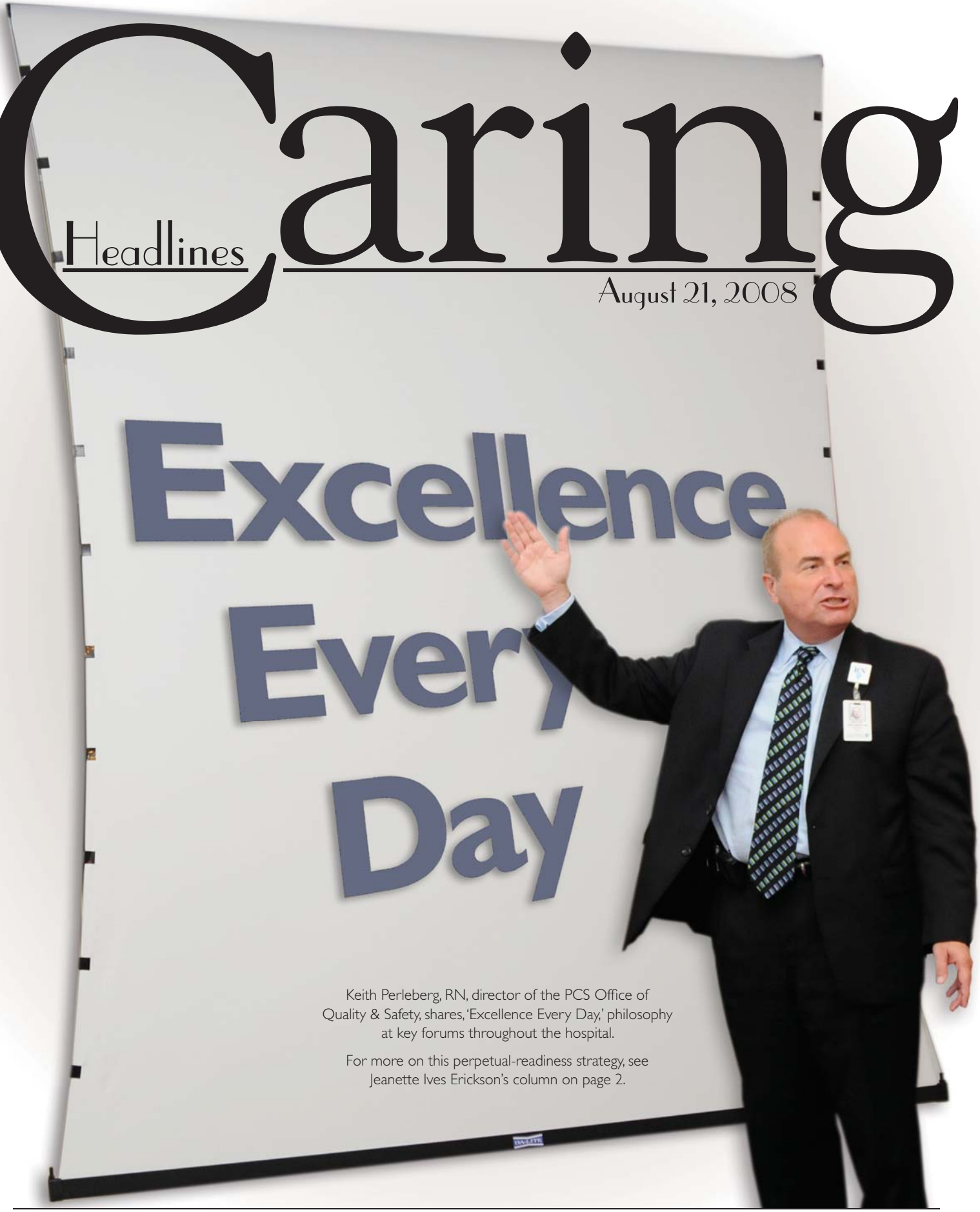
Caring Headlines

August 21, 2008



Keith Perleberg, RN, director of the PCS Office of Quality & Safety, shares, 'Excellence Every Day,' philosophy at key forums throughout the hospital.

For more on this perpetual-readiness strategy, see Jeanette Ives Erickson's column on page 2.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

High-quality care translates to excellence every day

We all take pride in our ability to meet and exceed our patients' expectations. Now, we need to talk about our practice in a way that lets people know, 'Excellence Every Day' is business as usual at MGH.

In past years, hospitals across the country have expended considerable effort 'gearing up' for Joint Commission accreditation surveys. The problem with that kind of cyclical preparedness is that it creates the impression that organizations aren't in compliance the rest of the time and they're only preparing in order to meet regulatory requirements. We at MGH know that's not the case, so we're embarking on a campaign that better represents our day-in, day-out commitment to the highest quality patient care. And we're calling it: Excellence Every Day.

The goal of this campaign, led jointly by the PCS Office of Quality & Safety, the MGH Center for Quality & Safety, and the Office of Corporate Compliance, is to bring this message to life on every unit, in every setting and practice throughout the hospital. We all know we deliver excellent care every day. We all take pride in our ability to meet and exceed patients' expectations. Now, we need to talk about our practice in a way that lets people know, 'Excellence Every Day' is business as usual at MGH.

We are employing a number of strategies in this effort, including unit- and discipline-specific record reviews. We've seen that reviewing records helps initiate constructive dialogue about our knowledge, skill, and experience.

Keith Perleberg, RN, director of the PCS Office of Quality & Safety has been sharing our Excellence Every Day campaign in key forums throughout the hospital. His presentation is available to all role groups and disciplines within and outside of Patient Care Services.

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

The Joint Commission Communications Subgroup has developed a tool kit for managers to help staff articulate their practice in a way that reveals their underlying expertise and qualifications.

And of course, no discussion about excellence in clinical practice would be complete without a reference to the National Patient Safety Goals. First developed by the Joint Commission in 2002, National Patient Safety Goals came about as the result of a comprehensive review of sentinel events in hospitals across the county. In an effort to reduce the occurrence of these events, the Joint Commission translated their findings into a list of quality and safety goals. The goals are reviewed and updated regularly. The 2009 National Patient Safety Goals represent a synthesis of the original 2002 goals and those that have been added over the years.

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No one knows more about our practice than we do. No one cares more about our patients than we do. Our only challenge is communicating that passion and commitment to others. And we don't have to wait for the Joint Commission to do that.

2009 National Patient Safety Goals

- Improve the accuracy of patient identification
- Improve the effectiveness of communication among caregivers
- Improve the safety of using medications
- Reduce the risk of healthcare-associated infections
- Accurately and completely reconcile medications across the continuum of care
- Reduce the risk of patient harm resulting from falls
- Encourage patients' active involvement in their own care as a patient-safety strategy
- Identify safety risks inherent in patient populations
- Improve recognition and response to changes in a patient's condition
- Employ the Universal Protocol to prevent wrong-site, wrong-person, wrong-procedure errors

Another strategy we're employing to advance Excellence Every Day is the use of focused record audits based on the above goals and the RFIs (recommendations for improvement) identified in our 2006 Joint Commission survey. Keith and his staff in the Office of Quality & Safety are available to provide whatever support is necessary to implement improvements and ensure our practice aligns with these goals.

Our next Joint Commission survey could occur at any time. I remember the enthusiasm you all showed during our Magnet site visit. I hope you'll welcome our Joint Commission surveyors with the same pride and confidence.

No one knows more about our practice than we do. No one cares more about our patients than we do. Our only challenge is communicating that passion and commitment to others. And we don't have to wait for the Joint Commission to do that. We can start right now—talking about our specialized skills, our experience and expertise, the resources we draw on every day to provide the best possible care at the bedside. We can talk about all the elements that come together to make it possible for us to achieve Excellence Every Day.

Update

I'm very happy to announce that MGH has hired Lela Holden, RN, as its first patient safety officer. In this new role, Lela will be a key member of the Quality & Safety leadership team as we advance our commitment to lead the nation in quality and safety.

Colleen Snydeman, RN, nursing director for the Cardiac Intensive Care Unit, has accepted the position of co-chair of the Critical Care Committee.

Kelly Santomas, RN, will assume the position of nursing director for the Cardiac Surgical Step-Down Unit.

In this Issue

Introducing the Patient Education Competency Packet

—by Judith Gullage, RN; Elaine Gaffney, RN; Erin Emanuelson, RN; and Judith Schiff, RN, of the Patient Education Committee

The committee wanted to enhance clinicians' teaching skills by providing information on how to assess patients' learning needs, develop a teaching plan, evaluate and document the plan, and access on-line patient-education resources.

Patients need information in order to make informed decisions about their health. They may need information on new medications, upcoming procedures, or how to perform a new skill. It's our responsibility as clinicians to provide patients with the information they need to safely manage their care at home. Every clinician should have the skill and ability to teach patients effectively.

Recently, the Patient Education Committee conducted a patient-education survey and based on the results, developed a Patient Education Competency Packet. The committee wanted to enhance clinicians' teaching skills by providing information on how to assess patients' learning needs, develop a teaching plan, evaluate and document the plan, and access on-line patient-education resources.

The Patient Education Competency Packet provides clinicians with the information and resources necessary to teach patients and family members about their health and diagnosis. The packet includes:

- Patient Education Nursing Practice Guidelines
- Documentation example
- Competency quiz
- Guidelines on how to access on-line resources

The Patient Education Nursing Practice Guidelines describe how to use the Nursing Dataset Form to assess patients' and families' educational needs. The guidelines help staff identify key factors necessary to develop a teaching plan and determine patients' readiness to learn. The guidelines provide general tips for teaching and how to evaluate a teaching plan.

One tool discussed in the guidelines is the, 'teach-back technique.' The clinician provides written, verbal, and/or audio materials to the patient and family then asks questions in a way that demonstrates whether the patient and family understand the content. With this technique, the clinician is able to evaluate their knowledge, skill, and confidence while identifying any barriers that might prevent them from achieving their goals.

The documentation section shows how best to document what was taught. The competency quiz assesses the clinician's proficiency in educating and organizing a teaching plan.

On-line patient-education resources are listed in the packet. This section provides step-by-step instructions on how to access information about diseases, procedures, or medications, many of which are available in other languages. Here, clinicians will find instruction on how to access on-line resources such as MGH Discharge Documents, the MGH Patient Education TV Channel, The Blum Patient & Family Learning Center, The Blum Cancer Resource Room, The Patient Education Committee website, and more.

Recently, a pilot conducted on Phillips House 20 and 21 evaluated the potential impact a patient education competency would have on nurses. Nurses from both units found the competency to be extremely useful. One nurse said, "The review of educational resources was extremely helpful." Another felt, "The whole packet was beneficial, and the patient education guidelines were a great review."

The Patient Education Competency Packet is a new resource to help nurses improve their teaching skills. Even experienced clinicians will find it helps organize their thoughts in documenting knowledge deficits.

To access the Patient Education Competency go to:

- Partners Handbook
- Patient Education Information
- Patient Education Committee Website
- Click on the Patient Education Competency Packet

For more information on the Patient Education Competency Packet, call Judith Gullage, RN, at 6-1409.

Incorporating spiritual caregiving into clinical practice

—by MaryAnn Columbia, RN, and Reverend Angelika Zollfrank

Six nurses, a social worker, and a physician's assistant recently completed the 2008 Clinical Pastoral Education Fellowship for Healthcare Providers, a spiritual caregiving program offered through the generosity of the Kenneth B. Schwartz Center and the department of Nursing. The fellowship, coordinated by Reverend Angelika Zollfrank, helps clinicians integrate spiritual caregiving into their clinical practice. Participants learn to initiate, develop, and end meaningful relationships in a clinical context. They perform individualized spiritual assessments and learn about cultural, spiritual, and religious diversity.

(Photo by Abram Bekker)

Reverend Angelika Zollfrank (back right) with members of the recent class of graduates from the Clinical Pastoral Education Fellowship for Healthcare Providers.

Theological and existential reflection are key components of the fellowship. Suzanne Reitz, RN, observes, "I've been able to expand my practice to include consciously and intentionally caring for the spiritual health of a person. Greater understanding of my own experiences of loss, suffering, hope, and the sacred led to the ability to build an empathy bridge with others."

"Persons who are hurting need accompaniment, which requires that we walk to meet them," says Ellen Robison, RN. "This program has influenced my journey as an ethicist in the most meaningful way."

Janice Cameron-Calef, RN, describes how she became more centered, focused, and present with acutely ill patients. "I became a guide in their journey through illness and am better equipped to provide spiritual and culturally competent care."

This year's graduates are: Janice Cameron-Calef, RN; MaryAnn Columbia, RN; Richard DiBella, MDiv; Louise Doyle, RN; Suzanne Reitz, RN; Todd Rinehardt, LICSW; Ellen Robinson, RN; and Adele Welch, RN.

To apply for the MGH Clinical Pastoral Education Program for Healthcare Providers, or for more information, contact Reverend Angelika Zollfrank at 4-3227. Applications are due September 2, 2008. The program is accredited by the Association of Clinical Pastoral Education (ACPE).

Within reach: MGH close to achieving 100% hand-hygiene compliance

MGH clinicians are to be applauded. Hand-hygiene compliance rates have reached 90% before and 99% after patient contact. But our ultimate goal is 100% compliance both before and after contact with patients and their environment. A look at how and why non-compliance occurs may be helpful in attaining this goal. The following Q&As were prepared by the STOP Task Force.

We will reach 100% compliance when all employees look at the practices of others and speak up when a reminder is appropriate. Good hand hygiene is a learned practice, so frequent reminders are necessary to help the practice become automatic. Look around and speak up on behalf of our patients

Question: When does non-compliance generally occur?

Answer: Most instances of non-compliance occur:

- immediately before or after glove use. (Gloves are not a substitute for hand hygiene.)
- when moving from a desk, chart, computer or other high-touch surface to the patient or the patient's environment. (Hand hygiene is required before contact.)
- when contact is made only with the patient's environment (as opposed to the patient). This includes the patient's belongings, equipment, and surfaces within the patient's room.

Question: What will it take to reach 100%?

Answer: We will reach 100% compliance when all employees *look* at the practices of others and *speak up* when a reminder is appropriate. Good hand hygiene is a learned practice, so frequent reminders are necessary to help the practice become automatic. Look around and speak up on behalf of our patients.

A hand-hygiene quiz

Can you identify where non-compliance occurs in each of the following scenarios?

Scenario #1: A nurse is working at a computer in the hallway and hears an alarm coming from a monitor in a patient's room. She enters the room, assesses her patient, and is satisfied he's resting comfortably. She reaches over to turn off the alarm then steps out of the room and uses Cal Stat before returning to the computer.

Scenario #2: A transporter, wearing a precaution gown and gloves, helps transfer a patient into bed. He removes the linens from the stretcher and cleans it. When finished, he removes his gown and gloves and disposes of them properly then checks his pager and heads to a nearby phone to answer the page. Before leaving the unit, he uses Cal Stat.

Scenario #3: A physician steps off the elevator, pushes open the door to the unit, and heads to the nurses' station where he reviews a chart and gets an update from the nurse. He dons a pair of gloves and enters the patient's room where he greets the patient with a smile and a handshake before conducting a brief exam. When finished, he removes his gloves and disposes of them in a nearby wastebasket, steps out of the room, picks up the chart, and heads back to the nurses' station where he enters new orders on the computer.

Answers

Answer #1: The nurse didn't use hand hygiene before touching the patient's equipment, which is part of the patient's environment.

Answer #2: The transporter didn't use hand hygiene after removing his gloves possibly contaminating his pager and the phone.

Answer #3: The physician failed to use hand hygiene both before and after contact. He may have contaminated his gloves when he picked them up and put them on (potentially spreading germs from high-touch surfaces to his patient). And he may have contaminated his hands while removing the gloves (potentially spreading germs from his patient to the chart, desk, and keyboard.)

Neurology team recognized: clinicians *Get with the Guidelines*

—by Emily Parker, Public Affairs

MGH is among more than 100 hospitals nationwide to receive a Gold Performance Achievement Award from the American Heart Association and the American Stroke Association for consistently following the *Get with the Guidelines* program jointly developed by these two national associations. The guidelines were created to help hospitals provide the most up-to-date standard of care for patients with coronary artery disease, stroke, and heart failure.

Nurses are instrumental in ensuring that patients with stroke or transient ischemic attacks (TIAs) receive these acute and secondary prevention therapies. Says Jean Fahey, RN, neuroscience clinical nurse specialist, "We strive to provide the best possible care to stroke patients, and it's gratifying to receive this recognition for our efforts to provide top-quality care."

The MGH Stroke Service implemented the *Get with the Guidelines* program in 2002. The guidelines are aligned with the latest scientific research to ensure the best treatment for patients with stroke or TIA. Guidelines focus on protocols that ensure patients are treated and discharged appropriately. They include therapies to prevent complications such as DVT and pneumonia, and risk-factor control at discharge such as cholesterol medicines, anti-thrombotics, and advice on smoking-cessation.

Stroke patients who arrives through the Emergency Department need immediate care. Nurses play a key role in ensuring patients are triaged and assessed rapidly. Says Joyce McIntyre, RN, clinical nurse specialist in the Emergency Department, "Time is crucial because eligible patients must receive t-PA, the intravenous drug that breaks up clots in the brain, within a short time frame. Providing this drug in a timely manner is one of the guidelines described in the program."

Typically, stroke patients are transferred to a neurology inpatient unit for follow-up care and observation. Nurses, in particular, ensure that patients receive the evidence-based treatments outlined in the guidelines. MGH is seeing great improvements in terms of patient outcomes. The Acute Stroke Quality Task Force meets on a consistent basis to discuss and strategize how to improve the process even more.

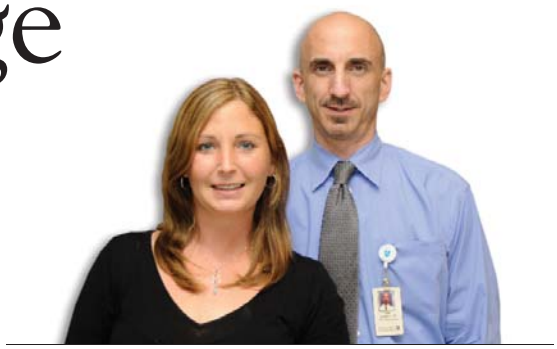
"Nurses have given greatly to this effort," says Lee Schwamm, MD, director of the Acute Stroke Service and a member of the steering committee that developed *Get with the Guidelines*. "Treating stroke patients is a multi-disciplinary effort, and nurses are instrumental every step of the way—from the Emergency Department to Radiology to inpatient units."

For more information on stroke care or the *Get with the Guidelines* program, call Jean Fahey, RN, at 6-9490.

(Photo provided by staff)

Members of the Acute Stroke Quality Task Force celebrate their "Get with the Guidelines" Gold Performance Achievement Award.

Inter-disciplinary collaboration ensures smooth discharge



Danielle Nolan, LICSW, social worker, and Dana Madden, RN, case manager

My name is Dana Madden, and I am a float case manager. 'Floating' means I don't have a permanent assignment, and most of the time, I don't find out where I'll be working until I arrive in the morning. Usually, I have a different assignment every day, but on occasion, I keep the same assignment for several days or even weeks at a time. The following story is based on one of those extended-coverage periods during which I had the opportunity to work closely with Danielle Nolan from the department of Social Services.

My name is Danielle Nolan, and I am a clinical social worker on an inpatient medical unit. I worked with 'Betty' from August of last year until her discharge in October.

Last September, I was assigned to cover the recently vacated position of house medicine traveler. The assignment had a reputation among floats as being challenging due to its coverage of patients on three different units. Betty was a patient in need of rehabilitation placement. Unfortunately, she had a myriad of discharge barriers, and I was thankful for Danielle's early involvement in the case.

When I began working with Betty, many details of her history were instructive to her care. Betty was a 50-year-old woman; she had two brothers, both very involved in her care. She had an extensive history of mental-health issues, which had been exacerbated by the death of her parents. During her illness, Betty suffered from extreme fevers that left her with numerous neurological issues, polyneuropathy (peripheral nerves malfunctioning simultaneously), and tremors.

Betty had been a patient at MGH or in a rehabilitation setting for nine months. She had suffered many setbacks, including deterioration of her sensorium (the part of the brain that experiences sensation), with resultant disorientation and agitation. She had contracted a number of infections. And adding to the challenge, her needs disqualified her from acute-care rehabilitation, which meant she would need to go to a skilled nursing facility (SNF). Due to the complexities of her case, Betty's significant other had retained a private case manager. But despite everyone's best efforts, a discharge plan had not yet been developed on which everyone could agree.

Due to the complexities of her case, Betty's significant other had retained a private case manager. But despite everyone's best efforts, a discharge plan had not yet been developed on which everyone could agree.

I was initially consulted to support Betty's partner, 'Alice,' who had assumed a major role in Betty's care. She was in touch with me and other mem-

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As Dana and I strategized the best way to prioritize Betty's interests, I made sure that Alice and Betty's brothers were included in the decision-making. I made myself available to Alice every day hoping she'd feel more confident in the communication she was receiving. Partnering with Dana helped strengthen the link between all parties involved in the decisions.

bers of the team daily. Due to the number of people involved, it became increasingly difficult to communicate about a safe and appropriate discharge plan. Alice was discouraged by what she felt was a lack of collaboration on Betty's behalf. The team suggested that a Social Services consult might help—it would give Alice someone to talk to about her concerns and a consistent presence to advocate for her and Betty in the midst of this complicated case.

I began looking for a facility that would be able to care for Betty by going through the referrals and investigating their current status. I involved the private case manager and worked closely with him, conveying the need to follow up on the status of the referrals and also the need to widen our search. I obtained a list of participating rehabilitation facilities, reviewed any barriers to Betty's placement, and cross-referenced it with our on-line database. I entered search parameters that took into account Betty's town of origin, her insurance, and those facilities that offered neurological or neuro-behavioral rehabilitation.

I was off the following day, and Alice learned from the private case manager that we had widened the search. The decision to widen the search was difficult for both Alice and the private case manager. Alice was requiring more and more support and wanted the private case manager to have increased involvement in the search. Worried about Betty, she contacted the Case Management Office to voice her concern. When I returned to work the following day, I was informed about Alice's concerns, so I quickly agreed to stay on the assignment to see the case through to discharge.

Due to her work schedule, Alice visited mostly at night, so our conversations with her took place on conference calls during the day. During one call, Alice mentioned she had her own list of facilities and made it clear she wanted Betty to be discharged to one of them. These calls were challenging because there were many issues to be addressed, and we would often have to revisit topics because someone had missed an important detail.

In addition to collaborating with Dana, who was trying to keep Betty's best interests (and the wishes of her family) at the forefront, I acted as liaison for Alice. As Dana and I strategized the best way to prioritize Betty's interests, I made sure that Alice and Betty's brothers were included in the decision-making. I made myself available to Alice every day hoping she'd feel more confident in the communication she was receiving. Partnering with Dana helped strengthen the link between all parties involved in the decisions.

As time went on, Betty experienced a clearing of her sensorium, resulting in less disruptive behavior. I contacted Infection Control to get information on the infections for which Betty was being treated and our policies surrounding them. I conveyed this information to the most promising and appropriate skilled nursing facilities and began to get interest from the leading facilities in neuro-behavioral rehabilitation. The facility that specialized in neuro-behavioral rehabilitation gave clinical approval to accept Betty and received HMO approval for her transfer. To the delight of the private case manager, Betty's family, and the team, I had secured the most appropriate, most desirable placement for Betty. I met with Betty and briefly described the efforts we had made on her behalf. I informed her that she would be transferred to rehabilitation the following Monday. She was able to comprehend the news and began to weep. She thanked me for helping her on the long road back home.

This was a rare opportunity for me to work over an extended period of time with one patient and build a strong alliance with another caregiver. Danielle and I helped one another keep our priorities in order.

I had never worked with two case managers before I met Betty. I witnessed daily the efforts that Dana made on her behalf. As he carefully sifted through the options, I maintained open communication with the family to help alleviate their concerns. Dana and I supported one another during this time to ensure our actions were thoughtful and coordinated. Together, we brought resolution to Betty's complicated case, arranging for her to receive the level of care she needed and at the same time meeting the expectations of her family.

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

What a terrific story of teamwork and perseverance on behalf of a patient. The nature of health care requires that complex patients receive complex care, which often means an expanded team of caregivers. Dana and Danielle's ability to work together and maintain effective communication with the patient and family throughout this eventful process led to the most desirable outcome for Betty. Patient advocacy comes in many forms, but it is always enhanced by effective collaboration and communication.

Thank-you Dana and Danielle.

A rare glimpse at nursing in the NICU

NICU patients are either premature or full-term babies who require a level of care beyond that which can be delivered in a level I or level II nursery. We see babies born at the cusp of viability, approximately 23–24 weeks of gestation, to those just shy of full-term.

My name is Janet Madden, and I am the clinical nurse specialist for the Newborn Intensive Care Unit (NICU), an 18-bed unit that sees approximately 425 babies each year. The majority of these babies are born at MGH; a smaller percentage are transported from outlying hospitals by our Neonatal Transport Team. NICU patients are either premature or full-term babies who require a level of care beyond that which can be delivered in a level I or level II nursery. We see babies born at the cusp of viability, approximately 23–24 weeks of gestation, to those just shy of full-term. Our level III-D status, designated by the Department of Public Health, indicates that we are a full-service NICU offering treatments not available in all NICUs, such as extra corporeal membrane oxygenation (ECMO). This is a form of cardio-respiratory support used for critically ill babies suffering from persistent pulmonary hypertension.

On any given day, there is a mix of patients in the NICU. Most have some type of respiratory issue requiring oxygen or more complex ventilator therapy. There may be babies with cardiac disease, gastro-intestinal, renal, or neurological issues. Others are here for evaluation for genetic or metabolic issues. The smallest of our patients can weigh as little as one pound, so small that a wedding ring could completely encircle their upper arm.

Janet Madden, RN, clinical nurse specialist

No matter what the gestational age, size, diagnosis, or prognosis, the NICU is a place of intense emotions. It's not part of the dream that families usually have as they anticipate the birth of their child.

Two years ago, the NICU re-located to its current home on Blake 10. The new unit is comprised almost exclusively of private rooms. Each room has enough space to accommodate any equipment that may be needed to support the sickest baby, and there's room for parents and caregivers to be with the baby at the same time. The environment is developmentally appropriate, allowing extremely pre-term and sick babies to heal and grow.

As a CNS, I spend a great deal of time collaborating with colleagues about individual patient situations, changes in practice, and improvement of care. Primary nursing is paramount in the NICU. It provides a frame-

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NICU nursing director, Peggy Settle, RN, and I are a good team in terms of how we encourage staff to participate... We are mindful that we're not the only NICU in town; we try to create an environment where staff have opportunities to care for a variety of patients, constantly learn, and are challenged both at and the bedside away from it.

work for consistency in care-giving that allows the most subtle changes to be detected. Nurses get to know individual babies, pick up on minute changes, and are able to prevent serious events before they happen.

Relationships formed between primary nurses and families are powerful, and in some cases, long-term. Nurses shows parents how to look beyond the tubes and wires to see their baby. Nurses encourage parents to care for their baby despite intimidating circumstances. In many cases, nurses are the only ones who ever know a baby. NICU nurses are privileged to be with families during the worst and most intimate moments. Some of the greatest joys and sorrows of life are experienced in the NICU.

As a CNS, an over-arching aspect of my role is to provide staff with the tools they need to do their job. My work is to support their work. I help staff 'own' their practice and take pride in their unit.

I've always approached my role with a focus on practice. I ask myself what needs to be done to make care better, safer, and more consistent. I ask myself if staff have the tools they need to deliver the best care in the most efficient manner. I ask myself where I want to see the unit in six months, a year, ten years. I ask myself how staff can contribute to the unit in a way they'll feel good about and be proud of.

I subscribe to the philosophy that the unit is ours, not mine. I expect staff to take an active role in operations. It's a thrill to work with staff and see them develop in all aspects of their practice and professionalism. NICU nursing director, Peggy Settle, RN, and I are a good team in terms of how we encourage staff to participate. She recently shared an article with me from the *Harvard Business Review* that describes the concept of, "leading from behind." I think that's what both Peggy and I do. We are mindful that we're not the only NICU in town; we try to create an environment where staff have opportunities to care for a variety of patients, constantly learn, and are challenged both at the bedside and away from it.

Patient safety is a priority in the NICU. Practice and process changes are made to enhance the safety of our babies or improve the practice of our nurses ensuring better, safer care. At weekly staff meetings, safety reports are shared anonymously to heighten awareness about actual and potential problems and seek input for solutions.

We foster an environment where nurses have an opportunity to impact what goes on in the unit. A newly formed NICU Nursing Practice Committee enabled staff to write specialized guidelines for practice in our unique setting. The project gave staff an opportunity to evaluate practice on the unit, consult the literature, and get a taste of what it's like to write for a diverse audience.

Our nurses have accomplished much and continue to be involved in a variety of initiatives. From the Neonatal Transport Team to the bereavement program to changing our practice with PICC lines (through our work with The Center for Innovations in Care Delivery) NICU nurses are making a difference.

We have dedicated resource nurses and nurses experienced with specialized treatments such as CVVH (continuous veno-venous hemofiltration) and SCUF (slow continuous ultra filtration). Many staff nurses act as preceptors providing a wonderful orientation experience for new staff. In trying to create a framework for orienting new nurses, with input from preceptors and new staff, we recognized the benefit of collaborating with colleagues in the Special Care Nursery and Obstetrics. Now, new staff learn the assessment and care of well and less acutely ill babies before coming to the NICU to practice.

On those few occasions when I wonder if we're doing a good job, I have only to look as far as the door to the unit to find my answer. Parents routinely bring their NICU 'graduates' back for a visit. And it's not uncommon for parents of babies who didn't survive to come back and see the individuals who cared for their baby. When this happens, every member of the NICU team—operations associates, unit service associates, nurses, respiratory therapists, nurse practitioners, physicians, and all the other disciplines welcome these families back. I realize that if bereaved families want to come back to the place where they experienced one of life's greatest tragedies, we must be doing something right. When I see this and all the other opportunities staff have in the NICU, I believe this is a place of hope for patients and families, and for nurses, too.

Staff Perceptions of the Professional Practice Environment Survey

The Staff Perceptions of the Professional Practice Environment Survey was developed to provide an annual assessment of the professional practice environment as perceived by clinical staff. The survey measures staff's perceptions of autonomy, control over practice, relationships with physicians, communication, conflict-management, teamwork, internal work motivation, and cultural sensitivity. These organizational characteristics are widely considered influential in determining clinician satisfaction with the professional practice environment.

Question: What is the purpose of the Staff Perceptions of the Professional Practice Environment Survey?

Jeanette: The survey was developed to obtain feedback from staff about the environment of practice at MGH. We know that to enhance the quality of care, it's important that staff feel supported in their practice. The survey is, in essence, a report card that I take very seriously. The Patient Care Services Executive Team uses this information to identify opportunities to improve the environment for clinicians.

Question: Who receives the survey?

Jeanette: The survey is mailed to all direct-care providers throughout Patient Care Services. I'm hoping we have an even higher response rate this year than we did last year.

Question: Is there anything new this year?

Jeanette: In 2006, the on-line version of the survey was very well received. So, on September 8, 2008, we will again distribute the on-line survey. The MGH Institute for Health Policy will independently distribute the survey and analyze responses. They will work with Dottie Jones, RN, director of The Yvonne L. Munn Center for Nursing Research in preparing the final report. To ensure that no one's voice is lost, in mid-September, we will distribute a paper version of the survey to staff who have not yet completed the on-line survey.

Question: Does my participation really make a difference?

Jeanette: Yes. It's your opportunity to tell me how we're doing in creating an environment in which clinicians feel supported in their practice. Many improvements have been implemented based on feedback from this survey. The Culturally Competent Care Curriculum, the Materials Management Nursing Task Force, pagers for social workers, and even this column were implemented because I heard from you that these issues are important. Please take the time to complete the survey.

Question: How do you ensure confidentiality?

Jeanette: The survey is voluntary and all survey answers are completely confidential. Each survey contains a randomly generated ID number, which is used only by the Institute of Health Policy to enable clinicians to complete the on-line survey over multiple sessions (if desired) and to prevent multiple surveys from being submitted by the same individual. Neither the ID number nor the survey answers are shared with anyone in Patient Care Services. Survey responses are not linked to individual names.

Question: Who sees the results?

Jeanette: Results of the survey are reported at three organizational levels: the PCS executive team, discipline-specific leadership (Nursing, Social Services, Chaplaincy, and the therapies), and by patient care unit. So, at each level there should be discussions about what the survey tells us and how we can use the information to sustain our successes and implement improvements. This process is one more way we can ensure that MGH remains the employer of choice for clinicians in all disciplines.

Tiger Team looks at bed rentals, wound-care supplies, and vacs

I have asked this Tiger Team to look for ways to reduce costs related to the use of bed rentals, vacuum-assisted closure devices (what we call 'vacs,') and wound-care products. In the current economic climate, we're looking at all non-salary opportunities to streamline processes and decrease costs.

Question: I heard there's a Tiger Team looking at bed rentals. What is that about?

Jeanette: I have asked this Tiger Team to look for ways to reduce costs related to the use of bed rentals, vacuum-assisted closure devices (what we call 'vacs,') and wound-care products. In the current economic climate, we're looking at all non-salary opportunities to streamline processes and decrease costs.

Question: Who is on this team?

Jeanette: Gaurdia Banister, RN, and Jackie Somerville, RN, are executive sponsors of the team. They have pulled together members of the Wound Care Task Force; representatives from Materials Management; Tony DiGiovine, RN, from the Burn Unit; and staff specialists, Nancy McCarthy, RN, and Mandi Coakley, RN. Their charge is to develop a system for initiating and discontinuing bed and vac rentals to eliminate unnecessary expenditures. This group is also looking at ways to standardize wound-care supplies and utilization on inpatient units.

Question: When will we hear about the recommendations of this team?

Jeanette: I've asked the team to have recommendations about wound-care and bed-rental processes by the end of the summer. We want to implement these recommendations by the beginning of the next fiscal year, October 1, 2008.

Question: How can we help reduce costs related to wound care and bed rentals?

Jeanette: Much of the problems stems from beds and vacs remaining on units when they're no longer needed, which is expensive and wasteful. Every unit should have a system for notifying companies such as KCI that their products are no longer required. Each month, a report produced by PCS Financial Management Systems shows we're being charged for beds and supplies that are no longer being used, but no one has called to discontinue them.

Question: Is there anything else we can do?

Jeanette: Nurses can educate themselves about the costs of wound-care supplies so they can make informed decisions when choosing dressings, vacs, and other supplies. Cost-management is an important aspect of patient care. Many new wound-care supplies are available, and some are more expensive than others. Cost should not be the primary consideration, but when appropriate, it should be taken into account. You can talk with the clinical nurse specialist on your unit about the cost of supplies.

Announcements

Clinical Pastoral Education Fellowships for Healthcare Providers

The Kenneth B. Schwartz Center and the department of Nursing are offering fellowships for the 2009 MGH Clinical Pastoral Education Program for Healthcare Providers

Open to clinicians from any discipline who work directly with patients and families or staff who wish to integrate spiritual caregiving into their professional practice

The Clinical Pastoral Education Program for Healthcare Providers is a part-time program with group sessions on Mondays from 8:30am–5:00pm (ddditional hours negotiated for the clinical component).

Applications are due by September 2, 2008.

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

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Save the dates:

Symposium on geriatric care

65Plus and The Norman Knight Nursing Center for Clinical & Professional Development present:
the second annual
Best Practices in Acute Care for Older Adults

This two-day program brings together experts to discuss patient-centered and evidence-based care of older adults. Participants will develop a better understanding of best practices in geriatric care in order to promote safety, prevent harm, and recognize common geriatric syndromes. All clinicians are welcome; recommended for those interested in geriatric certification.

Friday October 31, 2008, and
Monday November 17, 2008
8:00am–4:00pm
O'Keeffe Auditorium

For more information, call 643-4873

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday,
7:30am – 5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday, Thursday,
7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

2008 Robert W. Carey, MD, Lectureship

Sponsored by the nursing staff of the Yawkey 8 Infusion Unit

Speaker: Debra Jarvis, MDiv, oncology chaplain, Seattle Cancer Care Alliance

Topic: "Caring for Our Own in Times of Serious Illness and Stress"

Thursday, September 25, 2008
5:00–7:30pm
O'Keeffe Auditorium

All are welcome
No charge for MGH employees
Other fees may apply

For more information or to register, e-mail: cghiloni@partners.org, or call 617-724-5420.

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For more information, call: 617-724-1746

Next Publication
September 4, 2008

Educational Offerings – 2008

August 27

BLS/CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

August 28

BLS Instructor Program

Founders 325
8:00am–4:30pm
No contact hours

August 28

Nursing Grand Rounds

O'Keeffe Auditorium
1:30–2:30pm
Contact hours: 1

September 2

BLS/CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

September 4

Pacing Concepts

Burr Conference Room
12:15–4:30pm
Contact hours: 3.75

September 4

Intermediate Arrhythmia

Burr Conference Room
8:00–11:30am
Contact hours: 3.5

September 5

On-Line Electronic Resources for Patient Education

Founders 334
9:00am–12:00pm
Contact hours: 2.7

September 8

BLS/CPR Re-Certification

Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

September 8 & 22

ACLS Provider Course

Day 1: 8:00am–4:30pm
O'Keeffe Auditorium
Day 2: 8:00am–3:00pm
Thier Conference Room
No contact hours

September 9

BLS/CPR Certification for Healthcare Providers

Founders 325
8:00am–12:30pm
No contact hours

September 9

Chaplaincy Grand Rounds

Yawkey 2-220
11:00am–12:00pm
No contact hours

September 10

Phase I Wound-Care Education Program

Simches Conference Room 3120
8:00am–4:30pm
Contact hours: 6.6

September 10

Nursing Resilience: Bouncing Back

Charles River Park
8:00am–4:30pm
Contact hours: TBA

September 10

Nursing Grand Rounds

Haber Conference Room
11:00am–12:00pm
Contact hours: 1

September 10

OA/PCA/USA Connections

Bigelow 4 Amphitheater
1:30–2:30pm
No contact hours

September 10

Nursing Research Committee's Journal Club

Yawkey 2-210
4:00–5:00pm
Contact hours: 1

September 11, 16, 18, 23, 30 and October 2

Greater Boston ICU Consortium Core Program

BMC
7:30am–4:30pm
Contact hours: TBA

September 12 & 15

Neuroscience Nursing Certification Course

Simches Conference Room 3110
8:00am–4:30pm
Contact hours TBA

September 12

Basic Respiratory Nursing Care

Bigelow Amphitheater
12:00–4:00pm
No contact hours

September 12

Assessment and Management of Psychiatric Problems in Patients at Risk

O'Keeffe Auditorium
8:00am–4:30pm
Contact hours: TBA

For more information about educational offerings, go to: http//mghnursing.org, or call 6-3111

The Ben Corrao Clanon Award for Excellence in Primary Nursing

—by Mary Ellin Smith, professional development coordinator

As they have for the past 22 years, on July 31, 2008, staff of the Newborn Intensive Care Unit (NICU) took time out to join Regina Corrao and Jeff Clanon in paying tribute to their son, Ben. The occasion was the annual presentation of the Ben Corrao Clanon Award, which recognizes a nurse whose practice exemplifies the essence of primary nursing. The Corrao Clanons established the scholarship in memory of their son, a patient in the NICU prior to his death on August 13, 1986. Their experience with primary nursing made such an impression, they were moved to create this annual observance, and this year's recipient was NICU nurse, Joanne Henningsen, RN.

Ben Corrao Clanon Award recipient, Joanne Henningsen, RN (right) with (l-r): Jeanette Ives Erickson, RN; Peggy Settle, RN; Regina Corrao, and Jeff Clanon.

(Photo by Paul Batista)

In her introduction, nursing director, Peggy Settle, RN, described Henningsen as a nurse of exceptional patience who creates a supportive space for parents to care for their child. Henningsen thanked the Corrao Clanons for their generosity and her colleagues for their continued support.

Regina Corrao read a passage about living and laughing again after the death of a child. The passage ended, "He is still loved and missed and life goes on."

Jeff Clanon reflected on the narrative Henningsen had written as part of her nomination for the award. It described a situation in which she supported a family whose child had died. "That support is what we felt from the nurses here when Ben died, and we were so grateful for it."

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, concluded the ceremony, noting the pride on the faces of Henningsen's family and colleagues. "It is that teamwork," said Ives Erickson, "that allows Joanne and all clinicians at MGH to do such excellent work for their patients and families."

For more information about the Ben Corrao Clanon Award, contact Mary Ellin Smith, RN, at 4-5801.

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