Caring Headlines
December 18, 2008

Patient Care Services implements new inpatient support structure


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Environment of care operations manager, Carolyn Washington (left), works with unit service associates, Loretta Johnson (center) and Cheryl Dear, to ensure adequate supplies are available on Bigelow 13.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

A look back at 2008:

every day brings new reasons to be proud

Looking back on our accomplishments over the past year, I feel privileged to work with such an extraordinary team of healthcare professionals. Together, we've made incredible contributions to patient care, education, research, and the communities we serve. Our commitment to excellence and innovation has had a palpable impact, and our hospital is a better place for our efforts. Let me remind you of just a *few* things we accomplished in 2008.

Our commitment to excellence and innovation has had a powerful impact, and our hospital is a better place for our efforts. Let me remind you of just a few of the things we accomplished in 2008.

Perhaps the most memorable event, because it truly was a team effort, was being notified by the Magnet Recognition Commission that our application for Magnet re-designation was approved and our Magnet status extended through 2012. This is an honor that reflects the exceptional practice and commitment of every individual in every role group at MGH. It was gratifying to see the efforts of our nurses, clinicians, and support staff recognized in this well-deserved and public way.

2008 saw the launching of our Excellence Every Day campaign, a coordinated effort of the PCS Office of Quality & Safety, the MGH Center for Quality & Safety, and the Office of Corporate Compliance, to formally commit to achieving the highest quality standards and maintaining perpetual compliance on all units. We'll talk a lot more about our quality and safety agenda in future issues of *Caring Headlines*, including a re-cap of the Excellence Every Day Champions Retreat held earlier this month.

Our participation in Transforming Care at the Bedside (TCAB), a project jointly sponsored by the Robert Wood Johnson Foundation, the Institute for Healthcare Improvement, and the American Organization of Nurse Executives, got under way in earnest this year.

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

TCAB empowers nurses and other front-line staff to quickly identify, test, and implement new ideas based on observations at the bedside. We're already finding that the TCAB approach allows clinicians to spend more time with patients at the bedside and in meaningful patient-clinician interactions.

We saw remarkable improvement in our hand-hygiene compliance rates this year with steadily rising scores. When this issue of *Caring Headlines* went to print, two units were on target to achieve quarterly scores of 100% before and after contact; and Physical Therapy, Occupational Therapy, and Respiratory Care all achieved 100% compliance before and after for the month of November. These are impressive results.

In May, along with Marianne Ditomassi, RN, executive director for PCS Operations, and Gaurdia Banister, RN, executive director for The Institute for Patient Care, I traveled to Dubai to help train, develop, and prepare staff of University Hospital to open as a fully operational Magnet hospital by June of 2011. The trip was an incredible opportunity to teach and learn.

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From our work around ceiling lifts, capacity-management, documentation, noise-reduction, electronic medical records, our participation in the planning and design of the Building for the Third Century, innovative new programs such as the OASIS program, and so much more, I am inspired by your vision, enthusiasm, and dedication.

Our Diversity Program continued to explore new ways to foster a welcoming environment for our multicultural patient population. We were privileged to host this year's Hausman fellows, Frew Fikru, Alexis Seggalye, and Christopher Uyiguosa Isibor, who took part in a rigorous learning experience geared at developing future nurses of color. As it turns out, we learned as much from them as they learned from us.

The Clinical Leadership Collaborative for Diversity in Nursing, co-sponsored by Partners HealthCare and the University of Massachusetts College of Nursing and Health Sciences, supports the leadership-development of diverse nursing students. The goal is for diverse students to feel nurtured and supported as they transition from student to clinical nurse. To date, 29 students have participated in the program, five have been hired by MGH.

We launched our Video Medical Interpreter service for Spanish-speaking patients and families. This is a video version of IPOP that can be rolled into an exam room for quick visual access to an interpreter.

We provided important forums for the exchange of knowledge and ideas through a number of conferences and programs, including the Symposium on Evidence-Based Nursing Practice, the Visiting Scholar Program, the Care of Patients with Vascular Disease Conference, and many other cutting-edge programs.

Our Dedicated Education Unit opened on Ellison 7. Under this innovative model of nursing education, the unit was transformed into a focused teaching/learning environment where staff nurses are clinical instructors supported by university faculty, hospital leadership, and nursing colleagues.

With an eye toward increasing efficiency and reducing unnecessary spending, we mobilized Tiger Teams to look at non-salary expenses. To date, Tiger Teams have identified more than $1 million in savings while supporting high-quality patient care, streamlining operations, and saving time.

In preparation for the February opening of the BWH-MGH Health Care Center in Foxborough, MGH clinicians worked tirelessly all year to ensure a smooth and seamless opening of the new facility, which will offer physical and occupational therapy, cardiac rehabilitation, and wellness programs.

Overall, Patient Care Services welcomed 646 new employees in fiscal year, 2008.

We continue to foster partnerships with schools and universities to ensure we're actively supporting future generations of caregivers. In 2008, The Norman Knight Nursing Center for Clinical & Professional Development placed approximately 1,300 students in clinical learning situations throughout the hospital.

The list goes on and on. Every day brings new reasons to be proud. From our work around ceiling lifts, capacity-management, documentation, noise-reduction, electronic medical records, our participation in the planning and design of the Building for the Third Century, innovative new programs such as the OASIS program, and so much more, I am inspired by your vision, enthusiasm, and dedication. It is working with this extraordinary team that makes me so thankful for the past and so hopeful for the future.

Have a safe and happy holiday.

In this Issue

Swallow Screening Tool helps identify patients at risk for aspiration

—Audrey Kurash Cohen, CCC-SLP, speech-language pathologist

In 2004, a multi-disciplinary group of MGH speech-language pathologists, neurologists, and clinical nurse specialists developed the MGH Swallow Screening Tool (MGH-SST).

It is well documented that patients with acquired, acute, and progressive neurogenic disorders such as stroke, brain tumors, ALS, and traumatic brain injury have a high incidence of swallowing disorders, also known as dysphagia. In fact, 40-60% of acute stroke patients experience dysphagia. Serious adverse health effects are associated with this condition, including aspiration, pneumonia, malnutrition, increased length of stay (13 additional days at MGH for stroke patients with aspiration pneumonia) and death. Early detection and prevention of aspiration in patients admitted with acquired neurogenic disorders is critical, and we can all help.

Several regulatory agencies such as the Joint Commission and the Centers for Disease Control recognize that swallowing screenings before feeding patients is a key quality and safety measure. All credentialed stroke centers must perform a swallow screening on acute stroke patients before giving them any food, fluids, or oral medications. One study found the use of formal dysphagia screening in acute stroke patients reduced the incidence of pneumonia. Researchers believe as many as 8,300 lives could be saved and 40,000 pneumonias prevented annually by employing swallow screening.

In 2004, a multi-disciplinary group of MGH speech-language pathologists, neurologists, and clinical nurse specialists developed the MGH Swallow Screening Tool (MGH-SST). This two-part, swallow screening tool was developed to test for clinical indications that a patient may be sensitive to aspiration, such as the ability to produce a strong and sharp cough, or the ability to drink water without coughing or clearing their throat, or experiencing a change in voice quality. The MGH-SST is designed to be administered by trained staff on inpatient neuroscience units before patients are given any oral intake, including medications. It helps identify aspiration risk, guides decisions around whether it's safe for a patient to eat or drink, and alerts caregivers that a comprehensive swallow evaluation is needed by a speech-language pathologist for patients who fail the screening.

A study comparing pass-fail results on the SST to objective swallowing assessments via endoscopy was conducted in 2007 on 100 neurology and neurosurgery patients at MGH. The study, one of the first of its kind, confirmed the SST accurately detects patients at risk for aspiration. If a patient passes the SST, we can be 87% certain they can safely eat without restriction.

A comprehensive training module, including online video training, pre- and post-module testing, and competencies has been developed for staff. Correct screening is highly subjective and relies on comprehensive training and accuracy of the screener. The training video includes background information on swallowing, the nature of dysphagia, aspiration pneumonia, the importance of oral care, the purpose of swallowing screening, and a description of the tool. Simulation of clinical situations and a demonstration of the correct screening process are provided via video clips to maximize accuracy.

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On-going process-improvement ensures accuracy and consistency of use. Using the MGH-SST as part of the admission process and incorporating swallow screening into the Physician Order Entry to guide diet orders are two measures being considered. Next steps include establishing a process for screening acute neuro patients on non-neurology units as well as non-neuro patients throughout the hospital. The goal is to screen 90% of newly admitted neuroscience patients before they're given anything to eat or drink, including medications.

If you're caring for a patient and are concerned about his or her swallowing safety or risk for aspiration, you should:

- alert the primary care team and consider NPO
- request a swallowing evaluation by a speech-language pathologist
- maintain vigilant oral care, as patients with colonized oral secretions are at greater risk of developing a pneumonia should they aspirate

For more information about the MGH-SST, call Audrey Kurash Cohen, at 6-1571 or speak with one of the neurology clinical nurse specialists.

Some useful swallowing information

Swallow Screening:

- helps triage patients
- identifies patients 'at risk' for aspiration

Swallow evaluation by a speech-language pathologist:

- reviews patient's history and complaints
- examines structures and function (at bedside, using video-fluoroscopy, endoscopy)
- identifies causes and etiologies of swallowing difficulty
- helps determine treatment, including safest consistency of food and compensatory strategies
- plans and prognosticates

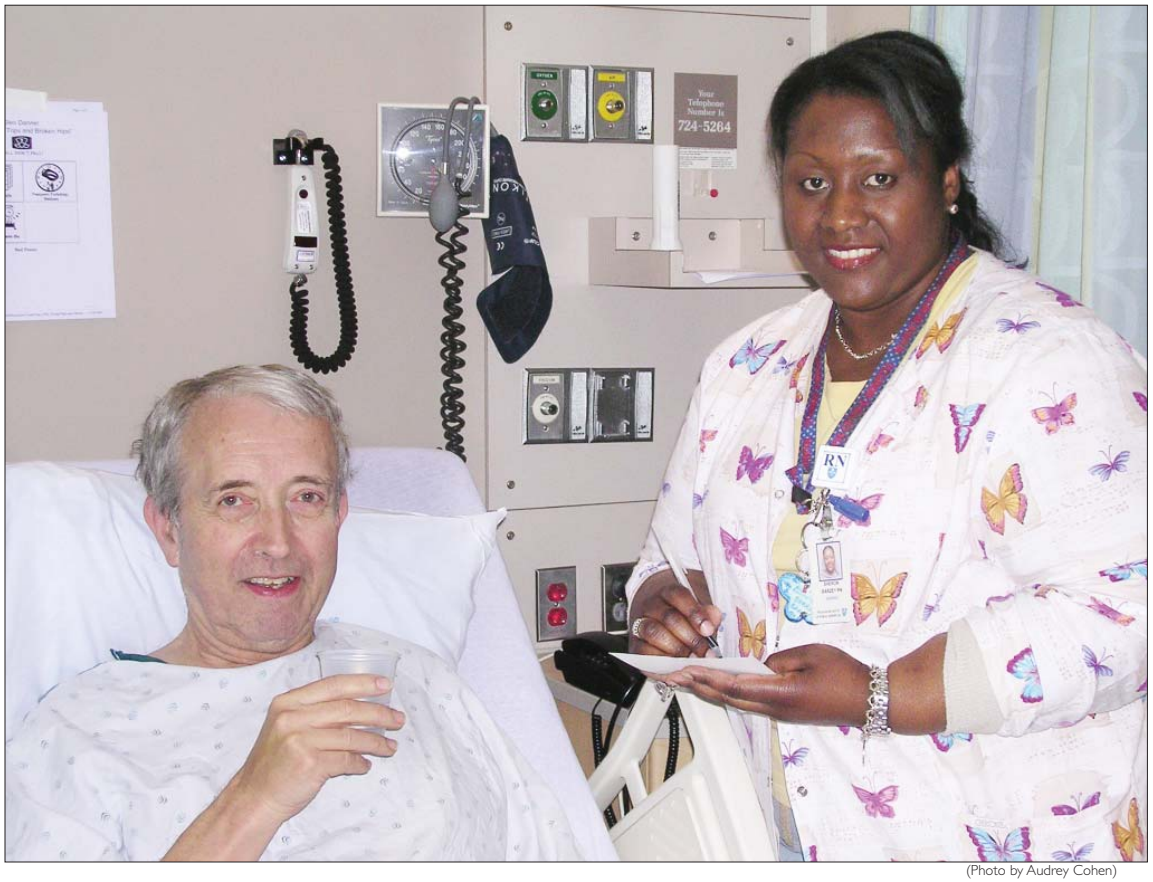
Definitions:

- Dysphagia (dys-fah-dja): swallowing disorder that can range in etiology and severity
- Aspiration: when food, liquid, saliva, or gastric contents enter the airway
- Aspiration pneumonia: pulmonary infection that results from foreign substances entering the lungs, such as food, liquid, medications, or gastric contents

Warning Signs of Potential Dysphagia:

- Coughing or choking when eating
- Shortness of breath or change in breathing during or after a meal
- Slurred, imprecise speech
- Impaired voice or cough—wet or breathy; weak or ineffective
- Difficulty managing secretions; drooling
- Inability to stay awake
- Inability to sip from straw or take food off utensil
- Food remaining in mouth after swallowing
- Trouble breathing or shortness of breath
- Regurgitation of food after a meal
- Unexplained weight loss
- Pain on swallowing

40% of patients do *not* cough when they aspirate.



(Photo by Audrey Cohen)

On the Ellison 12 Neurology Unit, staff nurse, Sheron Barzey, RN, conducts a swallow screening with patient G. Richard Danner

Meet our operations managers

As reported in the October 2, 2008, *Caring Headlines*, an examination of our unit operations and support systems revealed an opportunity to improve service and efficiency through a re-design of our inpatient support structure. Instead of unit-based operations coordinators, the new model introduces the operations manager role, with each operations manager having responsibility for a cluster of clinical areas. Under the new model, which went into effect last month, each cluster of units typically has one administrative and one environment-of-care operations manager.

The new support structure is designed to positively impact patient satisfaction, quality and safety, staff satisfaction, efficiency, and patient flow.

Just weeks after roll-out of the new model, operations manager, Kathy Johansen, says, "With any change, there's a learning curve. We're off to a great start, and everyone is committed to ensuring a seamless transition for patients and staff during this shift to the new structure."

Nursing director, Sharon Bouvier, RN, says "I love the new model. It has brought a great new working relationship to our unit and is adding a new perspective and richness to our leadership team."

Says director of Clinical Support Services, George Reardon, "The new model is being closely monitored to ensure we're making progress toward achieving our goals of improving efficiency, enhancing patient and staff satisfaction, and creating a cleaner, quieter, environment for patients and families."

For more information on the new inpatient support structure, call George Reardon at 6-5392.


George Reardon, director
Clinical Support Services


Nancy Dorris
EOC operations manager


Ingrid Crichlow
EOC operations manager


Gerry Cronin
EOC operations manager


Julie Rossborough
EOC operations manager


Lori Powers
administrative operations
manager


Judy Pines
administrative operations
manager


Jim McCarthy
administrative operations
manager


Kathy Johansen
administrative operations
manager


DJ Farren
administrative operations
manager


Sheena Smead
administrative operations
manager

Patient Care Areas	Administrative OM	Environment of Care OM
Cardiac/Cardiac Surgery Cardiac Surgical ICU, Ellison 8, Ellison 9 CCU, Ellison 10, Ellison 11 CAU	Lori Powers	Nancy Dorris
Ellison Medicine Blake 7 – MICU, Ellison 16, Phillips House 20, Phillips House 21, Bigelow 9	Judy Pines	Ingrid Crichlow
Bigelow Medicine White 8, White 9, White 10,White 11, Bigelow 11,ED Observation Unit, White 13	Jim McCarthy	Gerry Cronin
Pediatrics and Psychiatry Blake 11, PICU, NICU, Ellison 17, Ellison 18,	Kathy Johansen	Julie Rossborough
OB/GYN Bigelow 7, Ellison 13, Blake 13, Blake 14 LDR	DJ Farren	Stella Moody
Infusion/Oncology Cox 1, Yawkey Infusion, Phillips House 22, Radiation Oncology	Sheena Smead	Frank Powers
Neuroscience/Thoracic/Oncology Ellison 19, Ellison 14, Blake 12, Ellison 12, White 12	Melissa Thurston	Trish Galvin
Trauma/General Surgery Bigelow 14, Bigelow 13, Blake 6, Ellison 4 SICU, White 7, Ellison 7	Jamie Breed	Carolyn Washington
Main OR Main OR, White, Jackson, and Gray	Erin Sullivan	N/A
PACU/Ortho White 3 PACU, SDSU PACU, White 6, Ellison 6	Dan Dolan	N/A
SDSU and PATA	Judy Sacco	N/A
Endoscopy/IV Therapy Blake 4 Endoscopy and CRP, IV Therapy	Angela Oliver	N/A
Off-Shift weekends/evenings	Lexi Vincent	
Off-Shift evenings White 6 and Ellison 6 (Environment of Care)	Pat Hally	

Stella Moody
EOC operations manager

Frank Powers
EOC operations manager

Carolyn Washington
EOC operations manager

Trish Galvin
EOC operations manager

Pat Hally
EOC and off-shift evenings operations manager

Lexi Vincent
EOC and off-shift weekend/evenings operations manager

Jamie Breed
administrative operations manager

Melissa Thurston
administrative operations manager

Erin Sullivan
administrative operations manager

Judy Sacco
administrative operations manager

Dan Dolan
administrative operations manager

Angela Oliver
administrative operations manager

Effective communication a key component of quality care

My goal was to give Mr. N a manageable task, a smaller component of the larger activity, to give him an opportunity to succeed, to give him a realistic sense of his energy level, and to help him develop trust in our ability to assist him.

My name is Heather Markham, and I have been a staff physical therapist at MGH since 2006. I would like to share an experience that demonstrates the importance of communication in addressing multiple domains of patients' well-being during their hospitalization. I began working with Mr. N shortly after he transferred to the Ellison 14 Oncology Unit to begin chemotherapy. During our first session Mr. N expressed a desire to 'get out of bed' but was hesitant to do so because he had fallen prior to admission. He wasn't sure he had the energy to perform any activity. Instead of explaining why I thought he should try, I re-directed the focus from trying to 'transfer to the chair' to trying to stand with our assistance. My goal was to give Mr. N a manageable task, a smaller component of the larger activity, to give him an opportunity to succeed, to give him a realistic sense of his energy level, and to help him develop trust in our ability to assist him. We successfully transferred him from the bed to the chair, which resulted in a glowing smile from him as he enjoyed the view of the Charles River.

Mr. N's children were both very supportive and involved in his care. They gave me frequent updates on his nutrition, his ability to sleep, and any goals or barriers to his therapy they perceived. I taught Mr. N and his children exercises to build the strength in his legs, and we continued to practice standing and transferring

Heather Markham, PT, physical therapist

to the chair. At the end of my first week caring for Mr. N, I recommended he practice transferring more frequently throughout the day by transferring to the chair for meals.

When I returned on Monday, Mr. N was unexpectedly adamant about not wanting to participate in any therapy that involved standing. I asked why and tried to convey my concern for his well-being. Was he nauseous, in pain? But it became clear my questions just irritated him. I changed course. I told Mr. N I wouldn't try to change his mind. I let him know that if there was anything else I could do to help, I'd be happy to assist. Mr. N mentioned that he'd lost his balance while caregivers were assisting him to transfer, and though he hadn't fallen, he felt it was too risky to try again. We discussed other options of transfer, such as ceiling lifts, which he thought would be an acceptable alternative.

I spoke with Mr. N's nurse about the 'near fall' and about his decision to avoid standing and recommended

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A key element in Mr. N's care during his hospitalization was the communication between Mr. N, his family, and the various team members. The effectiveness of our communication in addressing his concerns, our ability to integrate his children into his caregiving, and the modification of his care plan to meet his changing goals and family dynamics all contributed to a positive experience for Mr. N.

a ceiling lift. She agreed with the plan to change his method of transfer, and satisfied with the outcome, Mr. N wanted to continue to practice mobility during his physical therapy sessions.

Upon reflection, I'm not surprised our conversation took that turn. Mr. N was used to being in an authoritative position in business and politics. Questioning his decisions wasn't part of his culture. By acknowledging his decision and identifying an alternative action, we arrived at a form of communication that was a better fit with his attitudes and beliefs. By changing the style of communication we were able to implement a change in his overall care that better addressed his preferences and needs.

Over the next several weeks, Mr. N experienced more abdominal pain and nausea, which limited his nutritional intake, increased his fatigue, and resulted in frequent episodes of respiratory distress. This limited our ability to progress with physical therapy. From conversations with his medical team, I learned Mr. N did not wish to pursue aggressive treatment, feeling 'at peace' with being near the end of his life. He had difficulty, however, conveying this to his children. After learning there was a difference in what he communicated when his children were present, I stopped by when I knew we could speak about his PT goals one-on-one. He told me he wanted to focus on 'gentle exercises in bed' and felt mobility training was too aggressive.

It was common at the outset of our treatment sessions for his family to encourage him to work on standing and transferring. This resulted in a challenging situation. I wasn't sure how to handle the conflicting messages of Mr. N wanting to 'exercise in bed' and his agreeing to practice standing and transferring when his family was present. I believed that standing and transferring were inappropriate due to the effect they had on his heart rate and respiratory rate. But since this had been the focus of our therapy for several weeks, I wasn't sure how to communicate to his family the need to modify our plan without impacting their hopes for his recovery.

There was one moment when I knew I had managed to address both Mr. N's needs and his daughter's concerns as his caregiver. In response to my suggestion to change the plan and focus on sitting balance and endurance as a step toward improving his standing, Mr. N gave me a smile that literally lit up his face. At the same time, his daughter expressed satisfaction at being recruited to guide him in deep-breathing and relaxation exercises to help him recover between intervals.

One morning, the palliative care nurse practitioner reported that Mr. N's goal for the day was to transfer to a wheelchair so he could spend time in the lounge with his family. Though I thought it was a fantastic plan, I didn't think he'd be able to perform a standing transfer to the wheelchair. Not only did I think it would be challenging for him to perform the transfer, I suspected the energy he would expend in the process would limit his ability to sit in the chair and possibly his ability to enjoy his family due to fatigue from the transfer. I expressed my recommendation to transfer Mr. N using the ceiling lift. The next day, I learned all had gone smoothly with the ceiling lift, and Mr. N had thoroughly enjoyed the time out of his room.

A key element in Mr. N's care during his hospitalization was the communication between Mr. N, his family, and the various team members. The effectiveness of our communication in addressing his concerns, our ability to integrate his children into his caregiving, and the modification of his care plan to meet his changing goals and family dynamics all contributed to a positive experience for Mr. N. This was reflected in his achieving his goal to transfer to a wheelchair to enjoy time with his children outside his hospital room. At a Friday afternoon family meeting, we outlined Mr. N's medical treatment and discharge options and supported him through a candid conversation with his children about his wishes.

On the Monday following the family meeting, I learned Mr. N had passed away the day before. One of Mr. N's primary nurses informed me that his family had left thank-you cards for several of his caregivers, including me and the aide who had assisted us in many of our sessions. Amidst the sorrow, it was nice to open the card and find a picture of him smiling. It was heartwarming to know we had made such a positive impact on him and his family during the final days of his life.

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

How often have we seen patients who approach their health care the same way they approach life. Knowing that each patient's communication style and family dynamics are crucial factors in patient-centered care, Heather recognized Mr. N's need to be in control and not burden his family with worry or concern. She adapted his treatment plan in a way that preserved his dignity and identity. It's a testament to Heather's skill as a therapist and her sensitivity that Mr. N and his family placed so much trust in her judgement.

Thank-you, Heather.

The Norman Knight Clinical Support Excellence Award

—by Julie Goldman, RN, professional development coordinator

On November 20, 2008, Pedro Torres, patient care associate on the White 12 Neuroscience Unit received this year's Norman Knight Clinical Support Excellence Award before a gathering of family, friends, and colleagues in O'Keeffe Auditorium. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, welcomed guests saying, "Today we reflect on and celebrate the contributions of clinical support staff at MGH."

Ives Erickson acknowledged Mr. Knight for his ongoing support of patient care at MGH. Said Ives Erickson, "It's quite fitting that Mr. Knight is one of the founding members of the Hundred Club, whose mission it is to care for those who care for us. We are privileged that he has added nurses and clinical support staff at MGH to his list of benefactors. Mr. Knight's generous spirit and devotion to the development of others is exemplified through his funding of this award."

White 12 patient care associate, Pedro Torres, accepts Clinical Support Excellence Award from senior vice president for Patient Care, Jeanette Ives Erickson, RN.

The Norman Knight Clinical Support Excellence Award recognizes the valuable role of clinical support staff. Criteria for selection are based on three attributes: patient advocacy, commitment to quality patient care, and compassion.

Torres has worked at MGH since 1997. He was nominated by Amy Murphy, RN, staff nurse on White 12. Murphy had the unique opportunity of working with Torres when he was a patient care associate and now as a new-graduate nurse. Says Murphy, "Pedro has a keen awareness of what's going on with his patients and families, and on many occasions he notifies the team when something seems wrong." Many of Torres' co-workers on White 12 expressed words of praise and respect for the care he provides to patients and families. The common thread in each of his nomination letters was compassion, caring, and advocacy for his patients, families, and peers.

White 12 nursing director, Suzanne Algeri, RN, wrote in her letter of support, "I have been continuously impressed by Pedro's ability to know his patients and connect with them. He is mindful of what's important to each individual patient. His compassion, commitment, and passion for nursing are evident every day in his practice."

Torres offered words of thanks saying, "It's both a privilege and a challenge to be honored today. I am motivated to improve my practice and the care I provide to patients and families. I love what I do, and I appreciate the opportunity to be able to practice here at MGH.

For more information about The Norman Knight Clinical Support Excellence Award, contact Julie Goldman, RN, professional development coordinator at 4-2295.

HealthStream: the future of education is closer than you think

—by Mary McAdams, RN, and Kate Stakes, RN

HealthStream is designed to provide convenient access to a variety of Internet-based training and educational programs specific to health care. It can be accessed from anywhere there is Internet access, giving staff the flexibility to decide when and where they want to take advantage of on-line learning.

Working in an increasingly complex healthcare environment makes keeping up with required training and professional development that much more important. To make educational opportunities more accessible for staff, on January 21, 2009, The Norman Knight Nursing Center for Clinical & Professional Development will introduce HealthStream, an easy-to-use, on-line, learning-management system.

HealthStream is designed to provide convenient access to a variety of Internet-based training and educational programs specific to health care. HealthStream can be accessed from anywhere there is Internet access, giving staff the flexibility to decide when and where they want to take advantage of on-line learning. HealthStream employs a combination of learning approaches—PowerPoint presentations, video clips, lectures, etc.—giving users more control over how they meet their learning needs. Users learn at their own pace and have the ability to access additional information about specific topics.

Beginning January 21, 2009, nurses within Patient Care Services will be able to complete post-tests and required training in subjects such as infection control, HIPPA, and general safety. They'll be able to take American Nurses Credentialing Center-approved courses that provide contact hours free of charge. HealthStream will be made available to other role groups in the near future.

Among the features offered by HealthStream, staff will be able to complete courses, tests, and evaluations on-line; view transcripts of completed HealthStream courses; print certificates for completed courses; and browse and enroll in elective courses. Moving forward, HealthStream will provide a platform for MGH-developed courses, such as continuing education, department-specific courses, and in-service education to be offered on-line.

Look for the following opportunities to familiarize yourself with the HealthStream approach:

- a "Show Me How" module—a five-minute, self-directed, on-line program to introduce you to HealthStream step by step
- The HealthStream Student User Guide—a comprehensive, on-line resource that provides easy-to-follow directions and access to additional resources
- Facilitator-led super user sessions—60-minute sessions facilitated by Knight Center staff to orient staff to serve as unit-based HealthStream resources
- Facilitator-led introductory sessions—45–60-minute sessions designed for nurses with minimal computer skills.

For more information about HealthStream, contact Thomas Drake, senior educational development and project specialist, at 6-9148, or Mary McAdams, RN, clinical educator, at 6-1607.

Early detection a key factor in stroke survival

— by Jessica Wiggins, RN

Jessica Wiggins, RN, staff nurse, Cardiac Interventional Unit

My name is Jessica Wiggins, and I am a staff nurse on the Ellison 11 Cardiac Interventional Unit. Though most of our patients come to our unit to await cardiac procedures, I have learned to expect the unexpected. Every patient is unique. It's important to remain alert to what patients are communicating. This became especially evident one evening when I learned in report that my patient, Mr. G, an 82-year-old-man, was feeling anxious as he awaited triple cardiac bypass surgery.

Mr. G anticipated needing surgery on his carotid artery due to a severe blockage. As I assessed Mr. G and prepared to administer his medications, he complained of blurriness in his right visual field. His systolic blood pressure had risen to 170, which was high for him. I completed my assessment paying particular attention to any other possible stroke symptoms. Mr. G. was alert and oriented; his speech was clear; he showed no weakness in his arms or legs and didn't complain of a headache. But I remained concerned about the sudden change in his vision. Mr. G had a history of TIAs, or 'mini strokes,' so I alerted the cardiology fellow who agreed to see Mr. G. In the meantime, I held Mr. G's medications until I was sure what was happening.

When I re-examined Mr. G, his right pupil was fixed and dilated. He complained that when he was watching television, it appeared as if, "someone had pulled a shade down over my eye." When the fellow arrived, I reported the symptoms and asked if it could be a TIA or a stroke. He agreed it was a significant change, so I called for the Acute Stroke Team to be paged and prepared to accompany Mr. G for a CT-scan. I measured his blood glucose level because hypoglycemia can confuse the exam by mimicking signs of a stroke. His blood sugar was normal.

Knowing Mr. G was already anxious, I told myself to remain calm. I focused on reassuring him that he was safe and we were going to help him. As members of the Stroke Team arrived, the room quickly became crowded. The nursing supervisor asked what I had noticed and when. The IV nurse placed an IV line and sent labs. The pharmacist awaited arrival of the stroke kit, which contained necessary medications. The fellow and I provided Mr. G's history, recent lab values, symptoms the patient had displayed, and his weight to the stroke fellow. Within minutes, the stroke fellow arranged to bring Mr. G to the Emergency Department CT scanner. I quickly connected Mr. G. to a portable monitor, grabbed a manual blood-pressure cuff, and we were off to CT scan.

After transporting Mr. G, the nursing supervisor stayed with me in Radiology. She guided me while Mr. G was in the CT scan to prepare to administer thrombolytic tPA or 'clot-busting medication.' I continued to monitor Mr. G and measure his blood pressure every five minutes. It remained at about 170 systolic. The stroke fellow worried that if his blood pressure went any higher we might need to lower it with intravenous medication. Though Mr. G's blood pressure remained high, it didn't increase any further. I held Mr. G's hand and explained we would be leaving him alone in the scanning room for a few minutes but would be right on the other side of the window.

After the scan, I heard the stroke fellow say, "There's no hemorrhage. Let's get the tPA ready." As the pharmacist mixed the tPA, I explained to Mr. G that his radiology test was done and we would be moving him across the hall for an MRI. I was glad we had caught his stroke symptoms in time to administer thrombolytic medication.

I conferred with the pharmacist about the dose of tPA Mr. G. would receive. The neurology resident would give the initial 10% bolus, then I would start the infusion of the remaining dose. The Neuro-

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Davis inducted into American Academy of Nursing

Sheila Davis, RN, nurse practitioner in the MGH Infectious Disease Unit, faculty member at the MGH Institute for Health Professions, and associate in the MGH Center for Global Health, was inducted as a fellow into the American Academy of Nursing at their annual meeting, November 8, 2008. Patient Care Services held a reception in her honor here at MGH on Tuesday, December 2nd.

(Photo provided by staff)

Sheila Davis, RN, recent inductee into the American Academy of Nursing, with Alex Johnson, provost and vice president of Academic Affairs at the MGH Institute for Health Professions.

Among her many accomplishments, Davis and colleague, Chris Shaw, RN, participated in the Nursing Partners AIDS Project, a joint undertaking with the Partners AIDS Research Center, spending two years providing humanitarian assistance in South Africa in areas hardest hit by the AIDS epidemic.

The approximately 1,500 fellows of the ANN are leaders in nursing education, management, practice and research. They include: university presidents, chancellors, and deans; state and federal political appointees; hospital chief executives and vice presidents for nursing; nurse consultants; and researchers and entrepreneurs. The MGH community congratulates Davis on this prestigious honor.

Stroke Response (continued)

science Intensive Care Unit nurse arrived and double-checked the dose with me before I started it. I was a little nervous because I'd never administered tPA. With the initial dose given, I primed the tubing and started the thrombolytic infusion. As soon as Mr. G. was in the MRI scanner, I gave report to the ICU nurse.

With the ICU nurse now responsible for Mr. G's care, I thanked the nursing supervisor and returned to Ellison 11. In my first quiet moment to reflect, I realized I had felt a bit overwhelmed, but I had been so supported throughout the process, I was just happy I had been there for Mr. G.

A couple of days later, I was thrilled to learn that Mr. G. had fully regained his eyesight. It had, in fact, been a blood clot that occluded the artery to his eye.

It was gratifying to know I had played a central role in identifying and responding to early signs of a stroke. I not only detected Mr. G's stroke symptoms as part of my exam, but I played a role in getting Mr. G. to Radiology and treatment with tPA. With the quick response of the Stroke Team and guidance from the nursing supervisor, I was able to see beyond my own anxiety and support Mr. G through a very crucial 30 minutes in his care.

It was gratifying to know I had played a central role in identifying and responding to early signs of a stroke.

Announcements

Call For Nominations

Stephanie M. Macaluso, RN, Excellence In Clinical Practice Award

The Stephanie M. Macaluso, RN, Excellence in Clinical Practice award recognizes direct-care providers throughout Patient Care Services whose practice exemplifies the expert application of values reflected in our vision. Nominations are now being accepted for recipients who will be named in March, 2009. Staff nurses, occupational therapists, physical therapists, respiratory therapists, speech-language pathologists, social workers and chaplains are eligible.

- To nominate a direct caregiver, complete a nomination form, which can be found in patient care areas, department offices, and in the Gray Lobby
- Nominations are due by January 12, 2009. Nominees will be notified of their nomination and invited to submit a portfolio for consideration
- The review board is comprised of previous award recipients, administrators, and MGH volunteers

Recipients will receive $1,000 to be used toward a professional conference or course of their choosing. They will be acknowledged at a reception, and their names will be added to the plaque honoring Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award recipients.

For more information or assistance with the nomination process, contact Mary Ellin Smith, RN, professional development coordinator, at 4-5801.

Call for Abstracts

Nursing Research Expo 2009

Submit your abstract to display a poster during Nursing Research Expo 2009

Categories:

- Original research
- Research utilization
- Performance-improvement

For more information, contact Laura Naismith, RN; Teresa Vanderboom, RN; or your clinical nurse specialist.

To submit an abstract, visit the Nursing Research Committee website at: www.mghnursingresearchcommittee.org

The deadline for abstracts is January 15, 2009.

MGH unveils new Intranet

The MGH Public Affairs Office officially launched the re-designed MGH Intranet, a useful resource for the hospital community.

Available at http://intranet.massgeneral.org, the site features an easy-to-navigate format and timely content, including links to employee resources, events, news, and more. Updates will be posted regularly; staff are encouraged to check the site for the latest employee information.

For more information or to share feedback about the new site, contact Therese O'Neill at 4-2753.

MGH Chaplaincy Holiday Schedule

Chanukah service as part of pre-Shabbat services
11:00am
December 26, 2008

One People, Many Candles
The Modern Movements of Judaism candle-lighting in the MGH Chapel
4:00pm each evening
December 21st: Reform
December 22nd: Orthodox
December 23rd: Conservative
December 24th: Reconstructionist
December 25th: Jewish Renewal

Christmas day Christian service
December 25th
12:15pm
MGH Chapel
All are welcome

Roman Catholic Masses in the MGH Chapel

- Mass at 4:00pm on Christmas Eve, December 24th, and Christmas day, December 25th
- Mass at 4:00pm on New Year's Eve, December 31st and New Year's Day, January 1st

The Chaplaincy invites individuals of all faiths and spiritualities to attend any and all services in the MGH Chapel, located off the Ellison Corridor across from the Gift Shop.

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All stories should be submitted to: ssabia@partners.org
For more information, call: 617-724-1746

Next Publication
January 8, 2009

Educational Offerings – 2008–2009

December 23

CPR Mannequin Demonstration

Founders 325
Adults: 8:00am and 12:00pm
Pediatrics: 10:00am and 2:00pm
No BLS card given
No contact hours

January 5 & 6

Intra-Aortic Balloon Pump

Day 1: NEMC
Day 2: Founders 311
7:30am–4:30pm
Contact hours: TBA

January 6

BLS/CPR Certification for Healthcare Providers

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

January 9

PALS Instructor Class

Simches Conference Room 3120
7:30am–4:00pm
No contact hours

January 9

Assessment and Management of Psychiatric Problems in Patients at Risk

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

January 9, 13, 14, 22, 27, 28

Greater Boston ICU Consortium Core Program

MAH
7:30am–4:30pm
Contact hours: TBA

January 12

BLS/CPR Re-Certification

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

January 14

Nursing Grand Rounds

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

January 14

OA/PCA/USA Connections

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

January 14

Nursing Research Committee's Journal Club

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

January 20

Ovid/Medline: Searching for Journal Articles

Founders 334
10:00am–2:00pm
Contact hours: 2

January 21

BLS/CPR Certification for Healthcare Providers

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

January 21

BLS/CPR Certification for Healthcare Providers

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

January 22

BLS/CPR Re-Certification

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

January 22

Phase I Wound-Care Education Program

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

January 22

Nursing Grand Rounds

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

January 26

Oncology Nursing Concepts

Yawkey 2-220
8:00am–4:00pm
Contact hours: TBA

January 26

CPR Mannequin Demonstration

Founders 325
Adults: 8:00am and 12:00pm
Pediatrics: 10:00am and 2:00pm
No BLS card given
No contact hours

January 27

BLS Heartsaver Certification

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

January 27

PCA Educational Series

Founders 325
1:30–2:30pm
No contact hours

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

Reducing waste through efficient use and storage of clinical supplies

Question: I've noticed that a lot of clinical supplies are thrown away when patients are discharged. Is there anything we can do to reduce this waste?

Jeanette: We know there are opportunities to reduce waste in some of our practices related to clinical supplies. In talking with staff to better understand the situation, the Clinical Products Tiger Team has identified some variations in practice around discarding clinical supplies. On many units, when a patient is discharged, the supplies that were in the patient's room are throw away. This creates an undue burden on the unit's budget and has an adverse effect on the environment by increasing the amount of trash we generate. Not all supplies need to be discarded when a patient is discharged.

Question: Is it safe to keep clinical supplies after a patient has been discharged?

Jeanette: Infection Control tells us it's safe to keep clinical supplies when:

- they've been handled with clean hands
- they haven't been in contact with contaminated surfaces or equipment (such as the patient's bed, bedside table, window sill, sink, or counter)
- they've been kept in a clean, dry, dust-free storage place (such as supply bins, carts, drawers, or shelves)
- the packaging remains unopened, dry, and intact

Question: Has the Tiger Team looked at what supplies are being given to patients to take home?

Jeanette: Because there are no established guidelines, a variety of supplies are being given to patients to take home. Recent analysis of five patient care units found that more than $30,000 worth of supplies were sent home with patients (on those units) in a single year. If other patient-care areas follow this pattern, we could be giving away hundreds of thousands of dollars per year. Clearly, we need to establish some criteria around what supplies are given to patients and when it is or isn't appropriate. This will be part of our future discussions.

Question: What can we do to help reduce waste when it comes to clinical supplies?

Jeanette: We want to continue to support the storage of clinical supplies at the bedside because it increases efficiency. Ideally, each unit should set guidelines to identify clean, safe, locations for supplies and limit in-room supplies to only those items that will be used in a 12-hour period.

As with any process-improvement initiatives, we welcome your thoughts and ideas. If you have suggestions related to practices around clinical supplies, please contact Jennifer Daniel, RN, staff specialist, at 6-6152.

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