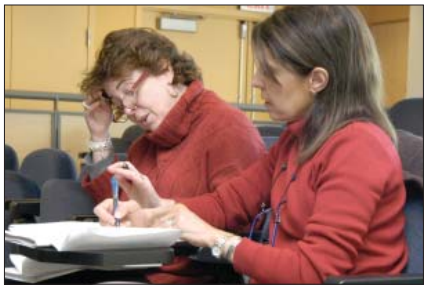
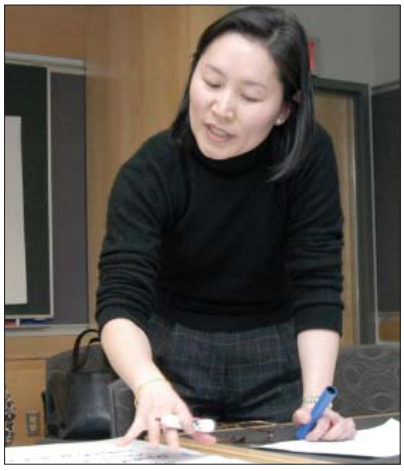
Caring Headlines
February 21, 2008

Coming together to talk about Quality

See story on page 4



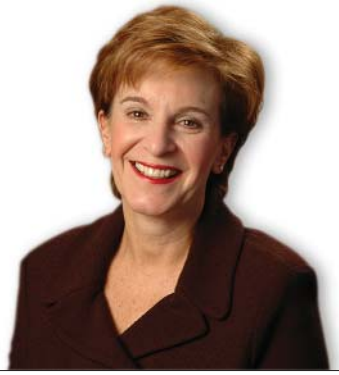
The 2008 Patient Care Services Strategic Planning Implementation Retreat

The newsletter for Patient Care Services
Massachusetts General Hospital

An interview with Keith Perleberg, RN

Recently, I invited Keith Perleberg, RN, director of the Patient Care Services Office of Quality & Safety to share some of his thoughts and impressions with us.

On September 24, 2007, Keith Perleberg, RN, assumed his new role as director of the Patient Care Services Office of Quality & Safety. Following our interview with Gregg Meyer, MD, senior vice president for the MGH Center for Quality & Safety (which appeared in the February 7, 2008 issue of *Caring Headlines*), I invited Keith to share some of his thoughts and impressions with us. Following are excerpts from that interview.



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

Jeanette: Keith, thank-you for talking with us. You've been in your new role for almost six months. Is there anything you'd like to share with staff?

Keith: These first few months have been a time of great excitement and challenge. While quality and safety have always been central to my practice, first as a staff nurse, then as a nursing director, I feel a new and deeper passion for this work in my new position. I hope to engage our patients, families, and staff in ownership (which is different from buy-in) of quality and safety at MGH.

Jeanette: That's an interesting distinction. How do you go about getting others to 'own' quality and safety?

Keith: I start by listening. Staff engage in extensive activities to improve nursing-sensitive indicators, particularly in the areas of fall-prevention and reducing the occurrence of pressure ulcers. I'm learning about evidence emerging from the literature. I've attended a number of conferences including the recent National Database for Nursing Quality Indicators conference in Orlando, Florida. Next month, I'll be attending the Institute for Healthcare Improvement's Patient Safety Officer Executive Training Program. But mostly, I listen to our patients, families, and staff. They are my primary teachers. Recently, I joined my colleague and friend, Gregg Meyer, for an evening with the Cancer Center's Patient-Family Advisory Council where personal stories once again brought life and power to the metrics.

Jeanette: I understand your Office has been working to establish goals for 2008. Can you share those with us?

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As we experience the core values of safety, trust, and respect, our beliefs about what is possible will be transformed. Seeing our contributions valued will lead to sustained actions and outcomes—sustained because each of us will have ownership and accountability.

Keith: In addition to supporting Patient Care Services' strategic plan for 2008 and our journey to Magnet re-designation, our goals include:

- engaging patients, families, and staff in perpetual readiness for demonstrating compliance with regulatory standards
- providing helpful and timely feedback on safety reports
- educating staff about nursing-sensitive indicators (e.g., falls, pressure ulcers, healthcare-associated infections) and supporting their capability to influence outcomes
- developing unit- or practice-based quality and safety resources to help identify, implement, and evaluate performance-improvement initiatives
- renewing and evolving the collaborative governance Quality Committee
- developing a PCS Quality & Safety communication plan that extends across all disciplines and role groups
- improving communication among the groups most closely involved with quality and safety (e.g., ethics committees, Pharmacy, Risk Management, the Office of Patient Advocacy, etc.)
- reviewing and improving the Office of Quality & Safety's training and education from the point of hire throughout employment
- assuming leadership for Magnet re-designation 'forces of Magnetism' pertaining to Quality and Safety
- supporting, defining, and promoting the relationship between the MGH Center for Quality & Safety and the PCS Office of Quality & Safety

Jeanette: That is an impressive and ambitious list.

Keith: It is ambitious. But we're not in this alone. We have the expertise and involvement of all of Patient Care Services. We have a strong relationship with the Center for Quality & Safety. As we work together to achieve these goals, I truly believe we will transform the culture of MGH into one where quality and safety are the central passion of our entire community.

As we experience the core values of safety, trust, and respect, our beliefs about what is possible will be transformed. Seeing our contributions valued will lead to sustained actions and outcomes—sustained because each of us will have ownership and accountability.

We'll know we have arrived when every employee, regardless of role, feels compelled to pick up litter wherever it may be found; when readiness for visits from regulatory agencies is a way of life rather than something we prepare for; and when an apology is freely offered on those rare occasions when we miss the mark. In short, transparency in all aspects of care will be the norm.

Jeanette: Keith, thank-you. I can see we are in good hands as we move forward with this important work. I assure you, you have our full support.

In this Issue

Patient Care Services Strategic Planning Implementation Retreat

Developing, communicating, and implementing a strategic plan throughout the departments of Patient Care Services (PCS) is a complex and multifaceted undertaking. One major step in the process came on Friday, January 25, 2008, when PCS leadership, including executive directors and line managers, came together for a day-long strategic planning implementation retreat. The ambitious agenda focused on quality, safety, and tactics to support implementation of our 2007-2008 strategic goals:

Leadership of various units and departments throughout Patient Care Services brainstorm ideas to support implementation of 2007-2008 PCS strategic goals.

- Seek the patient's voice to improve the care experience
- Achieve and sustain evidence-based quality indicators
- Decrease patient and staff injuries through the use of safe patient-handling practices
- Provide a clean and clutter-free environment for patients and staff
- Enhance teamwork to achieve excellence in care delivery

Richard Bohmer, MD, a physician and professor at the Harvard Business School and an expert in the areas of healthcare quality, organizational learning, and operations management, set the stage with a case study chronicling the care of a patient at a local hospital who was given an accidental overdose of chemotherapy and later died. The interactive session shed light on the complexities inherent in every patient-care situation and provided opportunities to discuss the many challenges facing health care today.

In a subsequent session, Bohmer provided an in-depth overview of the factors involved in managing care, starting with the creation of a viable, effective operating system. Said Bohmer, "It's impossible to develop and execute strategic goals if you don't first have an organizational framework. And to create an organizational framework, certain explicit and deliberate choices must be made."

Bohmer spoke about the importance of aligning an organization's operating system with the organization's values to ensure a common understanding of business and service expectations. He spoke about designing a model of care that will support positive outcomes; about matching the skills and resources of staff with the model of care to ensure optimal outcomes.

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Implementation of strategic goals is a comprehensive process that requires the understanding and participation of every member of Patient Care Services.

There was much discussion about the inter-connectedness of the services offered by any organization. Will services be customized or standardized? What policies will be crafted to support and define those services? What technology will be employed? What will the physical environment look like? Will it support our values, policies, services, etc.?

Bohmer stressed the importance of having systems in place to handle anomalies, and to be able to learn from those anomalies. Every departure from the norm is an opportunity to identify improvements and implement upgrades. Said Bohmer, "We need to learn how to manage and improve simultaneously."

Following Bohmer's presentation, retreat attendees were asked to break into small groups and brainstorm ideas to support each of our strategic goals. Break-out sessions yielded a multitude of suggestions, including:

(Strategic Goal #1: Seek the patient's voice to improve the care experience)

- Conduct more OA/USA/clinical staff training regarding making the hospital more welcoming
- Create more patient-family advisory groups
- Encourage all staff to participate in customer-service activities

(Strategic Goal #2: Achieve and sustain evidence-based quality indicators)

- Study impact of shift length and staffing on patient falls
- Create nursing rounds similar to physicians' M&M rounds
- Promote timely access to accurate data

(Strategic Goal #3: Decrease patient and staff injuries through the use of safe patient-handling practices)

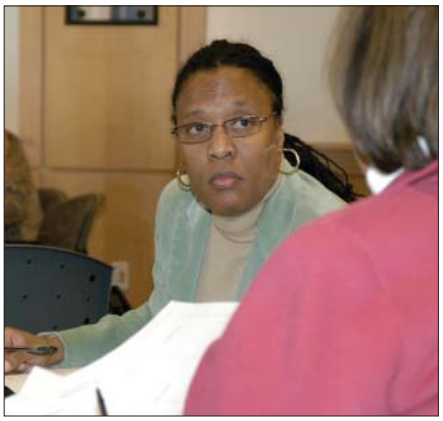
- Train staff on proper use of ceiling lifts
- Issue quarterly reports on injuries reported to Occupational Health
- Make safe patient-handling techniques an annual competency

Strategic Goal #4: Provide a clean and clutter-free environment for patients and staff)

- Have continuity of cleaning staff so relationships can be built
- Articulate industry standards for clean and clutter-free environment
- Utilize 'just-in-time' ordering to alleviate clutter on units

(Strategic Goal #5: Enhance teamwork to achieve excellence in care delivery)

- Standardize unit orientation for house staff
- Create networking opportunities for staff to share best practices
- Create teams co-led by nurses, physicians and other members of the healthcare team to foster teamwork



These are just *some* of the ideas generated during break-out sessions. A list of all suggestions has been compiled, and discussion about tactics is on-going. A follow-up retreat is planned for April.

Implementation of strategic goals is a comprehensive process that requires the understanding and participation of every member of Patient Care Services. For more information about our strategic goals and our plan to implement them, contact Marianne Ditomassi, RN, at 4-2164.

Unit service associates support strategic initiatives

—by Stephanie Cooper, training and development specialist

"Back to Basics," the third session of TEAM USA, provided an opportunity for hands-on practice, information-sharing, and a question-and-answer session regarding such vital tasks as changing cubicle curtains, setting up a cleaning cart, floor-cleaning, and clutter-removal.

One of Patient Care Services' 2008 strategic goals states that we will, "provide a clean and clutter-free environment for our patients and staff." On Wednesday, January 23, 2008, unit service associates (USAs) gathered in Ruth Sleeper Hall to learn more about how they help us achieve this goal every day.

"Back to Basics," the third session of TEAM USA (Training, Education, Awareness, Making a difference for USAs), provided an opportunity for hands-on practice, information-sharing, and a question-and-answer session regarding such vital tasks as changing cubicle curtains, setting up a cleaning cart, floor-cleaning, and clutter-removal. This collaborative project between The Norman Knight Nursing Center for Clinical & Professional Development and Environmental Services offered a number of stations for staff to visit to practice certain tasks.

More than 40 employees from patient care units and the operating rooms attended the two-hour session.

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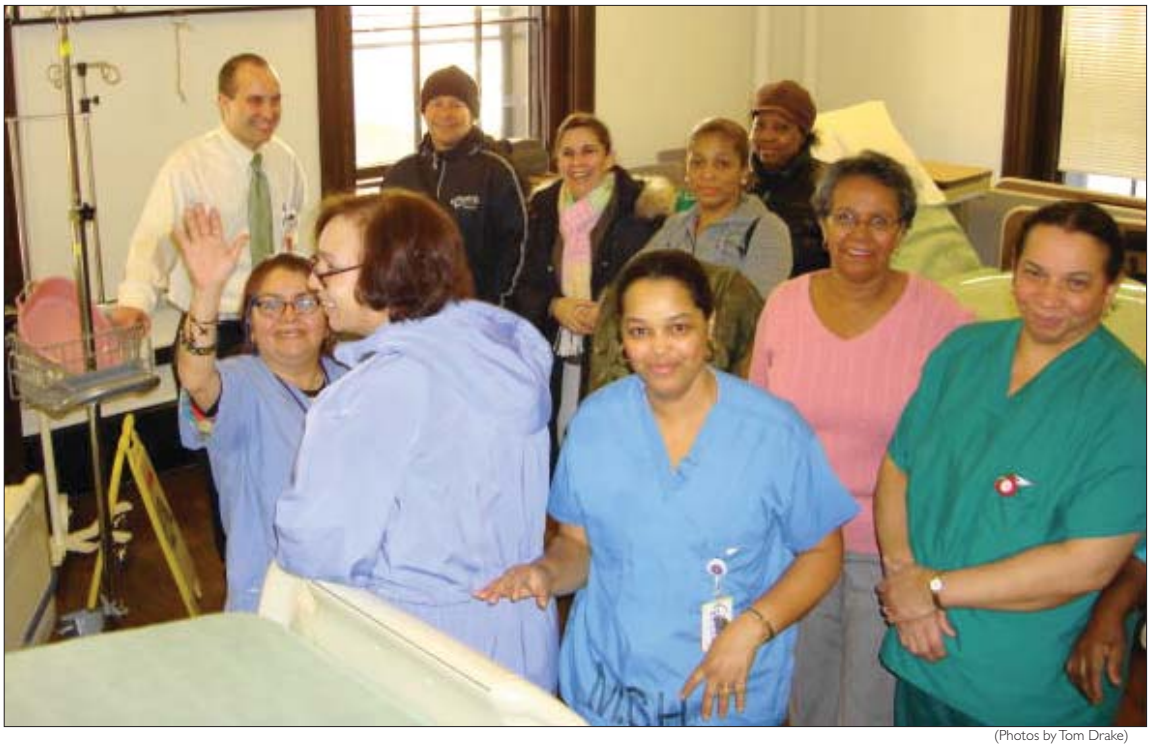


(Photos by Tom Drake)

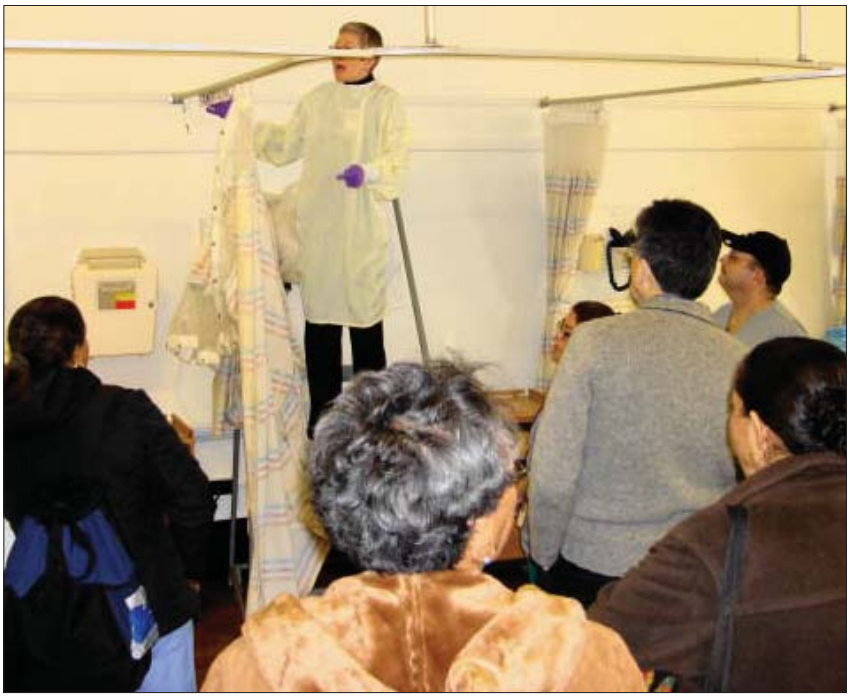
At left: Operations coordinator, Dave Cohen (back left), quizzes unit service associates on strategies to reduce clutter and increase safety on patient care units and in the OR.

At right: Environmental Services manager, Allan Dolinski, solicits feedback from employees about the new mop system.

Below: Unit service associates look on as training and development specialist, Stephanie Cooper, demonstrates the proper way to change cubicle curtains.

Open, two-way communication between attendees and instructors set a comfortable, encouraging tone. Environmental Services manager, Dan Shyne, welcomed USAs to his station by asking, "What do you think of the new cleaning carts?" Opinions were shared, and Shyne assured USAs that he'd bring their comments back to Environmental Services leadership. "Who better to learn from than the people who use this equipment every day," says Shyne.

Senior training and development specialist, Tom Drake, and operations coordinator, David Cohen, 're-created' a patient room that was cluttered with trash, unsecured oxygen tanks, and equipment and asked USAs how they would approach this challenge. "This station served many purposes," says Drake. "We wanted everyone to realize that eliminating clutter not only makes rooms easier to clean but safer for our patients and their families."



Training and development specialist, Stephanie Cooper, instructed unit service associates, including Idalina Tavares of Blake 13, on the correct way to change cubicle curtains. Tavares, wearing personal protective equipment, stood on a staircase ladder and attached the curtain as Cooper asked others in attendance how to determine when cubicle curtains should be changed. Several employees commented that although they had learned these procedures before, the review was very helpful.

Environmental Services manager, Allan Dolinski, was impressed by the number of participants who knew that dry-mopping prior to using a wet mop (with Virex) is key to successfully disinfecting floors. Says Dolinski, "Employees understand how vital they are to our success."

Andrew Riley, USA in the Pediatric Intensive Care Unit, summed it up when he said, "It really takes a team approach to ensure a clean and clutter-free hospital for our patients."

For more information about the TEAM USA sessions and other educational opportunities for support staff, contact Stephanie Cooper, training and development specialist, at 4-7841.

Pediatric nurse tells of competent care, compassion and mentoring

The first admission is crucial in helping a family adjust to an illness. There's so much to learn, and it is of utmost importance that they be well prepared in the care of their child prior to discharge.

My name is Celine Mani, and I have been a nurse on the Ellison 17 Pediatric Unit for 35 years. Our unit is unique in terms of the diversity of our patients' ages and clinical diagnoses, but my passion lies with pediatric oncology. Nothing can be farther from parents' minds than a diagnosis of cancer in their 2-year-old child. Any admission is stressful for a family. But you can imagine the shock, devastation, and fear at being told your young son has stage IV neuroblastoma.

The first admission is crucial in helping a family adjust to an illness. There's so much to learn, and it is of utmost importance that they be well prepared in the care of their child prior to discharge.

Little Max first came to MGH late one evening. We had been notified by Admitting that a 2½-year-old boy with an abdominal mass was coming in. I didn't care for Max that first night, but I could see the strain and fear on his parents' faces as they walked past the nurses' station on their way to his room.

The following evening, I was assigned to care for Max. This is when our relationship began. Max's mother was tearful, expressing much worry over Max's diagnosis. Max was irritable, appropriately very stressed whenever approached by nurses or physicians. Max's father was less verbal, clearly protective of Max, as if he were trying to guard him against the disease as well as our attempts to care for him.

Celine Mani, RN, staff nurse
Ellison 17 Pediatric Unit

My primary goal was to spend time with this family listening to their fears, validating their concerns, and informing them of what to expect. It was difficult for them to comprehend the magnitude of the situation. I assured them that Max would adjust and might even look forward to coming to see his friends at MGH on future admissions.

It's very important to instill in the family a sense of trust and confidence in your care of their child. With my clinical skills and knowledge base, I feel I readily convey this to families. When there are things I don't know or questions I'm not comfortable answering, I don't hesitate to let the family know, and I refer them to the appropriate resources.

My approach with this family, as with all families, was to sit with them every day and focus on how they were doing and what questions they had. When you give families this kind of time, generally a positive, trusting relationship develops.

We took it slow the first few days in order to allow them to comprehend the seriousness of Max's situation and reflect on what was happening. But it was only a

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matter of time before they were ready to learn everything they needed to know.

The relationship we developed from the beginning made it easier to deal with other important facets in Max's care.

Max's parents are not a couple, and frequent bouts of hostility and acrimony between them sometimes challenged our ability to provide the best care. The social worker, oncology nurse practitioner, and I diffused many argumentative situations. I always stressed the need to focus on what was best for Max.

During one teaching session with Max's mother, I had to ask Max's father to leave when an argument broke out between them. She was preparing to give Max an injection, and at the same time they were exchanging unpleasantries. I asked the father to wait in the lounge, and told him I'd come speak to him when we were finished. I didn't want to prolong Max's fear of the injection, nor did I want him to hear their hostile exchange. My discussion with the father was brief. He knew their behavior was inappropriate. Disagreements still occurred, but because I had the respect of both parents, they listened when I said, 'Enough.'

After tests to confirm Max's diagnosis were completed, he had a central line placed, and chemotherapy was initiated.

At this point in Max's care, a novice nurse approached me and expressed an interest in becoming involved in caring for a child with a cancer diagnosis. She asked to be co-primary nurse. I was thrilled with her enthusiasm and motivation. It would be a learning opportunity for her and a welcome challenge for me. As a senior staff nurse, I'm honored that other clinicians respect my knowledge and experience and frequently seek me out as a resource.

The family was very happy to have my colleague on the team. They knew she wasn't yet certified to give chemotherapy, but they were comforted that their son would have two nurses administering his medication.

By working closely with me, my colleague was able to see how important it is to follow protocols, policy, and educate the family. She was able to observe me administer chemotherapy and actively assist me. I reviewed side-effects and asked them to let us know if they felt Max was experiencing anything out of the ordinary.

Soon, my colleague and I began to prepare Max and his family for discharge. We provided them with the support and encouragement to learn everything they needed to know to bring Max home. For his mother, who would be the primary caregiver, our education made the tasks understandable and not so terrifying.

Although I performed the majority of teaching with my colleague observing, she was the one to discharge Max after his first admission. She did an excellent job reviewing home-care and follow-up instructions.

Over several hospitalizations, discharge teaching has touched on when to call the oncologist, side-effects of chemotherapy, central-line dressing changes, administration of IV antibiotics at home, and the psychological toll illness can have on Max and the family. They know they have the support of many disciplines to help them deal with any psychosocial issues that may arise.

Max has evolved from a frightened child into an outgoing, playful, socially engaged 2½-year-old. I think the comfort level we helped his parents achieve allowed them to cope more effectively thereby helping Max be less fearful and more relaxed in the hospital setting.

Max has evolved from a frightened child into an outgoing, playful, socially engaged 2½-year-old. I think the comfort level we helped his parents achieve allowed them to cope more effectively thereby helping Max be less fearful and more relaxed in the hospital setting.

Many challenges still lie ahead for this family. Max has tolerated his treatment well with minimal side-effects. He still has a long road ahead including radiation therapy and a double stem cell transplant.

I've already begun to prepare his family. I have been very honest with them, drawing on my past experiences. Both parents are understandably frightened, but they remain positive in their attitude. This will also be an excellent learning opportunity for my colleague. Max and his parents are comfortable knowing that experienced staff will be there to guide her. Her relationship with Max has blossomed. He talks about her at home, and looks forward to seeing her when he comes to MGH.

My colleague says she tries to model her nursing practice after mine. I see her relationship with this family as a reflection on me, but also as a new nurse doing the best she can for her patients. Mentoring this nurse has energized me and made me feel proud that I can share what I love and do best with others.

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

What a wonderful story. Celine recognized the need to let Max's family process their son's diagnosis in their own time. She dealt with the parents' strained relationship openly and honestly and in a way that engendered their trust. Celine's ability to mentor a novice nurse while caring for this family dealing with a new cancer diagnosis will influence that nurse's practice for years to come. This narrative is rich with lessons of compassionate care, nurturing, and mentoring.

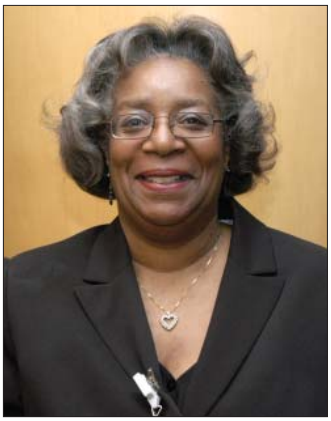
Thank-you, Celine.

Mitchell, Washington, honored by NERBNA

Gwen Mitchell, LPN, of the Gillette Center for Women's Cancers, was named a recipient of the 2008 New England Regional Black Nurses Association's Excellence in Nursing Awards. The New England Regional Black Nurses Association (NERBNA) is a chapter of the National Black Nurses Association incorporated in 1973 as a part of a national effort to unify, educate, and recruit African American nurses.

In her letter of nomination for Mitchell, director of PCS Diversity, Deborah Washington, RN, wrote, "It is with great pleasure that I recommend Gwen for this award. Gwen first came to MGH in 1966. I met her when black nurses at MGH formed the Minority Nurses Recruitment and Retention Committee. She was and remains a committed champion and advocate for patients and employees.

"Gwen is a wonderful teacher, mentor, and care provider. She can be diplomatic with the powerful, and she can set limits, as well. She is able to do this because of her well-known warmth and openness.



Gwen Mitchell, LPN
Gillette Center for Women's Cancers

"Gwen is a knowledgeable and compassionate caregiver. She has kept pace with the demands of the profession in terms of clinical competence and activities outside the workplace. She goes out of her way to meet the needs of patients no matter where they are. A nurse in the truest sense of the word, she has always garnered respect for the profession. Gwen is an authentic representation of Excellence in Nursing."

Mitchell and other NERBNA award recipients will be honored at a special event, Friday, February 22, 2008, at the Copley Marriott Hotel.

Deborah Washington, RN, director of Patient Care Services' Diversity Program was named the 2008 recipient of the New England Regional Black Nurses Association's Presidential Award.

Margaret Brown, RN, president of the New England Regional Black Nurses Association (NERBNA), wrote, "Debbie is an excellent role model for nurses. Her passion for the profession is illuminated daily as she provides service to others. She possesses the skills that set her apart, yet she is still humble."

Washington has served as director of Diversity since 1995, developing the program into one of the most successful, highly-regarded diversity programs in the country. She co-created the Culturally Competent Care Curriculum; established the annual African American Pinning Ceremony, an event that celebrates the contributions black employees have made in creating a positive organizational culture; she was a fellow in the 2007 Robert Wood Johnson Executive Nurse Fellows Program; she helped develop the Hausman Student Nurse Fellowship, designed to expand the diversity of nursing staff; and she recently initiated unit-based cultural rounds as a tool to raise awareness and help educate staff around culturally sensitive issues.

Deborah Washington, RN
director, PCS Diversity Program

Said senior vice president for Patient Care, Jeanette Ives Erickson, RN, "Respected by colleagues within and outside of MGH, Deb is a constant source of pride for this organization."

Washington will receive her award at the NERBNA celebration of National Black Nurses Day, Friday, February 22, 2008, at the Copley Marriott Hotel.

Unit-based cultural rounds and holiday heritage posters

Unit-based cultural rounds are being held on patient care units throughout the hospital as a means of promoting discussion about culturally competent care. Cultural rounds started in the fall of 2007, and are scheduled at the request of unit leadership.

Question: I've heard that some units are conducting cultural rounds. What are cultural rounds?

Jeanette: Unit-based cultural rounds are being held on patient care units throughout the hospital as a means of promoting discussion about culturally competent care. Cultural rounds started in the fall of 2007, and are scheduled at the request of unit leadership. Because the day-to-day work on units is unpredictable, rounds are tailored to the individual needs and patient acuity of each unit.

Question: What do cultural rounds look like?

Jeanette: Cultural rounds, led by Deb Washington, our director of Diversity, are conducted using a variety of formats: case presentations, in which staff bring forward scenarios for discussion; chart reviews, where charts are randomly selected to check for documentation of culturally competent care; or conversations of particular events that have occurred that serve as a focus for discussion or education. Some topics covered in rounds include how staff can help families process advanced directives when cultural issues may be a factor, or building rapport with patients and families through a deeper understanding of cultural beliefs.

Question: What outcomes have come from cultural rounds?

Jeanette: Cultural rounds help staff become more aware of the impact culture can have on the quality of care being delivered. They become more culturally informed and familiar with the resources that support culturally competent care. Thinking about cultural issues starts to become a more natural part of how care is delivered.

Question: What is the goal of cultural rounds?

Jeanette: Cultural rounds provide staff with a forum for processing and discussing concerns about their ability to deliver culturally competent care and their ability to function as a multi-cultural, multi-disciplinary team. Rarely do we have an opportunity to step back and reflect on some of the underlying issues and challenges we face in our everyday work. Cultural rounds gives us the opportunity to stop, process, and learn about what we're doing on a deeper level.

Question: How can I schedule cultural rounds for our unit?

Jeanette: Send an e-mail to, or call, Deb Washington at 4-7469.

Question: Speaking of cultural issues, I've heard some discussion about our holiday cultural-heritage posters. Have you gotten any feedback?

Jeanette: Our holiday posters always generate a lot of feedback. We make every effort to incorporate that feedback into future poster designs. Our multi-cultural holiday celebrations are an opportunity to educate and draw attention to various cultural traditions observed around the world and right here at MGH by patients, families, and staff. It's been a great learning experience for everyone.

For more information about any of our diversity initiatives, contact Deborah Washington at 4-7469.

Forging new avenues of communication on the Pediatric Unit

—by Ellen Kinnealey, RN, bedside technology specialist

This was a situation where a challenging patient situation presented itself to clinicians... This innovative solution, spearheaded by clinicians and im plemented by telecommunications experts, resulted in a positive experience for this family

Recently, a team meeting was held to assess the needs of a young boy who would be undergoing an autologous stem cell transplant. One need identified by his primary nurse, Kathy Conley, RN, was that it would be difficult to hear the child behind the double doors if he started to cry. In the past, baby monitors had been used to hear children, but with the implementation of our new monitoring technology, that was no longer an option.

My pager went off and I read: "We have a child who needs a baby monitor and we want to be ready. Please call. Thanks, Kate Stakes."

I am a nurse and the bedside technology specialist for MGH. I called Kate and she told me about her dilemma. I happened to be standing beside Rick Hampton, an Information Services wireless expert, so I asked what he thought. He agreed that baby monitors weren't a good idea due to the lack of wireless security. And he had an excellent suggestion. "Why don't we set up a speaker phone in the baby's room and another dedicated speaker phone at the nurses' station." It sounded like a great solution, but Rick thought it would be wise to check with telecommunications expert, Jim Candida, just to be sure.

A few days later, I received a call from Pam Ambrose, an associate of Jim, saying that Jim wanted to resolve this issue as soon as possible. I reviewed the situation with Pam. There were a lot of questions: was the phone in the room analog or digital? If it was analog, it would have to be replaced with a digital line and so would the dedicated line at the nurses' station. Did nurses on the unit know how to use the hands-free option? And many other questions.

Ellen Kinnealey, RN
bedside technology specialist

I asked Pam to contact Kate Stakes, and I let Kate know that Pam would be contacting her.

The child was due to be admitted. I called Pam, and she told me everything was all lined up. The phones had been installed. A technician had taught nurses how to use the hands-free option and ensured that off-shift staff would receive the same instruction. It was coming together beautifully. Family and caregivers were thrilled.

This was a situation where a challenging patient situation presented itself to clinicians. Pediatric staff were determined to do the very best for this family, making sure that if the child began to cry, a nurse would be at his bedside immediately. This innovative solution, spearheaded by clinicians and implemented by telecommunications experts, resulted in a positive experience for this family. This is a perfect example of how different departments at MGH work together to achieve common goals.

The Symposium on Evidence-Based Nursing Practice

—by Liz Johnson, RN, clinical nurse specialist

Evidence-based nursing practice is the integration of best-available evidence, nursing expertise, and the values and preferences of patients to provide quality care. In providing care, nurses seek evidence to guide clinical decision-making, create evidence to communicate practice, and document evidence to advance professional knowledge. Many definitions of evidence-based nursing practice exist, but all seek to illuminate how nurses utilize knowledge and inquiry to support nursing practice and challenge established precedents that may be based on questionable scientific rationale. Nurses are increasingly aware of the power of evidence-based practice to the extent that it is becoming a core value of clinical practice.

On October 26, 2007, the Symposium on Evidence-Based Nursing Practice was held to share information about the state of the science and about specific projects being implemented by MGH nurses. Dorothy Jones, RN, director and senior nurse scientist of The Munn Center for Nursing Research, gave the keynote address, in which she discussed the growth of evidence-based practice, its importance to the profession, and concepts such as knowledge-based practice and research translation. Jones addressed the growing recognition of the inter-relationship between research and clinical practice and how clinical documentation both impacts, and is impacted by, clinical investigation. Documentation is of particular concern to nursing because nursing interventions are sometimes 'invisible' resulting in nursing's contributions to patient outcomes remaining unknown, unacknowledged, and/or misunderstood.

Panelists discuss their experiences implementing evidence-based nursing inquiries. (L-r): Emily Olson, RN; Leah Gordon-Rowe, RN; Marian Phipps, RN; Peggy Settle, RN; Marian Jeffries, RN; Barbara Roberge, RN; and moderator, Barbara Blakeney, RN.

Liz Johnson, RN, clinical nurse specialist
Bigelow 7 Gynecology-Oncology Unit

Following Jones' address, a number of nurses shared information about their evidence-based projects. The symposium concluded with a panel discussion moderated by Barbara Blakeney, RN, director of The Center for Innovations in Care Delivery. Discussion focused on motivators, challenges, and rewards associated with implementing an evidence-based project.

The Symposium on Evidence-Based Nursing Practice was presented by the Evidence-Based Resource Group with the support of the Nursing Research Committee and The Norman Knight Nursing Center for Clinical & Professional Development. The Evidence-Based Resource Group is a partnership of PCS nurses and Treadwell librarians dedicated to promoting evidence-based nursing practice at MGH. Members include: Catherine Griffith, RN; Deborah Jameson, medical librarian; Elizabeth Johnson, RN; and Carolyn Paul, medical librarian.

For more information about the Evidence-Based Resource Group or the Symposium on Evidence-Based Nursing Practice, call 4-4118.

Announcements

Make your practice visible: submit a clinical narrative

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.

The MGH Blood Donor Center

The MGH Blood Donor Center is open for whole-blood donations:
Tuesday, Wednesday, Thursday, 7:30am – 5:30pm

Friday, 8:30am – 4:30pm

Platelet donations:

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

Friday, 8:30am – 3:00pm

Call 6-8177

Abstracts wanted for Clinical Research Day

The Clinical Research Program invites investigators from throughout MGH to submit abstracts for Clinical Research Day, Thursday, May 22, 2008.

A poster session will showcase clinical research at MGH. Prizes include:

Team award: $5,000
Translational research award: $1,500
Individual awards: $1,000
A number of departmental prizes also will be awarded.

Submissions due March 20, 2008

Submit abstracts online at: http://crp.abstractcentral.com

For more information, call 6-3310

Seminar Series MGH Center for Global Health

"Key Issues in Achieving Global Child Health in the 21st Century"

Monday, February 25, 2008,
5:00 – 6:30pm
O'Keeffe Auditorium

Speaker:
Charles F. MacCormack
president and CEO
Save the Children

All are welcome

For information, call 3-0067

Path-Breaking Advanced Practice: Development of the NP Role

Karen Anne Wolf, RN
associate director, Graduate Program in Nursing MGH Institute of Health Professions

March 5, 2008
8:00–9:00am
Haber Conference Room
1 contact hour

For more information, call 6-3111.

Nursing Career Expo

Anticoagulation Management Services

Experienced staff nurses come learn more about the management of anticoagulation patients or explore a career in the Anticoagulation Management clinic.

Wednesday, March 5th, 2008
1:00–3:00pm
Haber Conference Room

Light refreshments will be provided
Please RSVP to mandrews3@partners.org.

LGBT Reception

Attend a reception of the lesbian, gay, bisexual, transgender community

Wednesday, February 27, 2008,
4:00–6:00pm
Yawkey 2-210

Socialize with colleagues and learn more about upcoming events. For information, call 6-0169

2008 Holy Week Services

All services held in the MGH Chapel

Saturday, March 15, and Sunday, March 16
4:00pm
Palm Sunday Roman Catholic Mass

Monday, March 17, Tuesday, March 18, and Wednesday, March 19
12:15 and 4:00pm
Ecumenical service
(Roman Catholic Mass will take place as regularly scheduled)

Thursday, March 20
12:15pm
Ecumenical prayer service
4:00pm
Roman Catholic Mass

Friday, March 21
12:00 – 3:00pm
Good Friday service of music, reflections, readings and prayer
4:00pm
Roman Catholic service

Saturday, March 22
7:00pm
Roman Catholic Easter Vigil Mass

Sunday, March 23
12:15pm
Ecumenical Easter service
4:00 Pm
Easter Sunday Roman Catholic Mass

Friday, April 25
11:00am
Passover service

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

Next Publication
March 6, 2008

Educational Offerings – 2008

February 27

New Graduate RN Development Seminar II

Training Department
8:00am – 12:00pm
Contact hours: TBA

February 27

Pediatric Simulation Program

Founders 335
12:30 – 2:30pm
Contact hours: TBA

February 28 & 29

Oncology Nursing Society Chemotherapy Biotherapy Course

Yawkey 2220
8:00am – 4:30pm
Contact hours: TBA

February 28

Intermediate Arrhythmia

SRC 3120
8:00 – 11:30am
Contact hours: 3.5

February 28

Pacing Concepts

SRC 3120
12:15 – 4:30pm
Contact hours: 3.75

February 28

Nursing Grand Rounds

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

February 29

Heart Failure: What Healthcare Providers Need to Know

O'Keeffe Auditorium
7:30am – 3:30pm
Contact hours: TBA

March 3

BLS/CPR Certification for Healthcare Providers

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

March 3 & 17

ACLS Provider Course

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

March 4

BLS/CPR Re-Certification

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

March 5

Cardiac/Vascular Nursing Certification Preparation Course

Simches Research Center
Room 3120
8:00am – 4:00pm
Contact hours: TBA

March 10

Understanding Addiction in the Perinatal Setting

O'Keeffe Auditorium
8:00am – 3:30pm
Contact hours: TBA

March 11

BLS/CPR Re-Certification

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

March 11

Chaplaincy Grand Rounds: "An Inter-Disciplinary Case Presentation"

Call for location (6-2220)
11:00am – 12:30pm
No contact hours

March 12

New Graduate RN Development Seminar I

Training Department
8:00am – 12:00pm
Contact hours: TBA

March 12

Simulated Critical-Care Emergencies

POB 448
1:00am – 3:00pm
Contact hours: TBA

March 12

Nursing Grand Rounds

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

March 12

OA/PCA/USA Connections

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

March 12

Nursing Research Committee's Journal Club

Yawkey 7-980
4:00 – 5:00pm
Contact hours: 1

March 12

Ovid/Medline: Searching for Journal Articles

Founders 334
10:00am – 12:00pm
Contact hours: 1

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

Professional Achievements

Forbes certified

Lauren Forbes, RN, became certified as a medical-surgical nurse, by the American Nurses Credentialing Center, in December, 2007.

Nurses publish

Marian Jeffries, RN; Rechelle Townsend, RN; and Emily Horrigan, RN, authored the article, "Helping Your Patient Combat Lung Cancer," in the December, 2007, issue of *Nursing*.

Mulgrew, Squadrito present

Physical therapists, Jackie Mulgrew, PT, and Alison Squadrito, PT, presented, "Management of the Acute Care Patient," at St. Edwards Hospital in Naperville, Illinois, December 7–8, 2007.

Inter-disciplinary team publishes

Diane Carroll, RN; Teri Lundgren, RN; Yoshimi Fukuoka, RN; Sally Rankin, RN; Bruce Cooper; and Yvonne Munn, RN, authored the article, "Cluster Analysis of Elderly Cardiac Patients Pre-Hospital Symptomatology," in the December, 2007, issue of *Nursing Research*.

Harker elected

Jane Harker, RN, endoscopy staff nurse, was elected a member of the Board of Directors of the Society of Gastroenterology Nurses and Associates, for the 2008–2010 term.

Bell and Muller publish

Aaron Bell, RN, and Anne Muller, RN, Blake 8, authored the article, "Electrolyte Update: Potassium, Chloride, and Magnesium," in *Nursing 2008 Critical Care*, in January, 2008.

Burchill presents

Gae Burchill, OTR/L, occupational therapist, presented, "Flexor Tendons: Anatomy and Physiology," at Tufts University, on January 28, 2008.

Multi-disciplinary team presents

June Williams, SLP, speech-language pathologist; Neila Altobelli, RRT, respiratory therapist; Susan Gavaghan, RN, clinical nurse specialist; and Marian Jeffries, RN, clinical nurse specialist, presented their poster, "Multi-disciplinary Tracheostomy Quality Team in the Acute Care Setting," at the American Speech-Language and Hearing Association's 2007 convention, in November, 2007.

Dorman appointed

Robert Dorman, PT, physical therapist, was appointed a member of the Education Committee of the American Physical Therapy Association of Massachusetts for 2008.

Levin, Morris publish

Barbara Levin, RN, and Nancy Morris, RN, authored the chapter, "Complications in Orthopaedics," in the December, 2007, issue of *Core Curriculum for Orthopaedic Nursing*.

Bazazi recognized

Kathleen Bazazi, cosmetologist, CMF, MGH Images Boutique, received the 2007 Massachusetts, Look Good Feel Better Sunrise Award from the American Cancer Society, November 8, 2007

Lapierre presents

Ann Lapierre, RN, Cardiac Arrhythmia Service, presented, "The Patho-Physiology of Atrial Fibrillation," at the second annual Atrial Fibrillation Symposium for Allied Health Professionals, on January 17, 2008.

Clinical Recognition Program

The following clinicians were recognized December 1, 2007–February 1, 2008:

Advanced Clinicians:

- Catherine Cleary, RN, Cardiology
- Debra Shaw-Davis, PT, Physical Therapy
- Hilary Levinson, RN, Emergency Department
- Andrea Hennigan, RN, Obstetrics

Clinical Scholars:

- Kelly Hartnett, RN, Interventional Radiology
- Rachel Bolton, RN, Radiation Oncology
- Julie McCarthy, RN, Post Anesthesia Care Unit
- Betty Ann Burns-Britton, RN, Medicine

Caring Headlines
February 21, 2008

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