Caring Headlines
November 20, 2008

# Respiratory Care celebrates collaborative practice

*See story on page 4*

Respiratory therapist, Gloria Mendez-Carcamo, RRT (second from left), and colleagues (l-r): Danny Nunn, SLP; Laura Gomez, RN; Ashley Rose, RN; and Kelly Macauley, PT, with Ellison 19 patient, Ernest Diorio, or 'Mr. D' as he is affectionately known.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

# Council on Disabilities Awareness seeks to make high-quality care accessible to all

Launched in November, 2003, the Council is committed to addressing the needs of individuals with disabilities beyond the mandates of government compliance to ensure accessibility and a welcoming environment for all.

As we're well aware, a hospital visit can be a stressful time for patients and families. Dealing with unfamiliar health concerns while navigating a complex, medical environment can be a daunting prospect for anyone. But for individuals with disabilities—physical limitations, hearing deficits, sight impairments, cognitive disorders—accessing hospital-based care can present even greater challenges.

For the past several years, MGH has made it a priority to try to identify, understand, and address the needs of people with disabilities who come to our hospital seeking care. This work has been led by the MGH Council on Disabilities Awareness, co-chaired by Carmen Vega-Barachowitz, SLP, director of MGH Speech, Language & Swallowing Disorders, and Oz Mondejar, vice president for Human Resources for Partners Continuing Care. Launched in November, 2003, the Council is committed to addressing the needs of individuals with disabilities beyond the mandates of government compliance to ensure accessibility and a welcoming environment for all.

Every month, Council members from throughout the MGH community meet to address pressing and timely issues. With representation from a number of services and departments—Patient Care Services, Food & Nutrition Services, Social Services, Buildings & Grounds, Human Resources—innovative, patient- and family-centered outcomes are achieved.

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

Partnering with patients and staff with disabilities, the Council has conducted surveys to examine the physical environment at MGH. Members of the Council toured the hospital alongside individuals with hearing and/or visual impairments, speech impediments, and physical limitations. These tours provided a unique opportunity for Council members to see and experience the challenges faced by individuals with disabilities when they visit our hospital. This first-hand, patient-centered approach continues to inform the work of the Council.

Recognizing a need to establish a dedicated position to better address issues related to access, the Council recommended the creation of a disability resource

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The Council is currently in the process of restructuring its membership to better focus on three primary areas: employee awareness, education, communication, and customer service; the physical environment; and patient services and equipment. As we continue to raise the bar around these important issues, our goal remains to ensure safe, high-quality care in an environment that is accessible and welcoming to everyone.

coordinator position. That role is now filled by Betsy Pillsbury, whose primary responsibility it is to review, recommend, and help raise awareness about ways to improve access for patients, families, staff, volunteers, and visitors. I encourage you to contact Betsy with any ideas or concerns you may have related to accessibility. Betsy can be reached at 617-573-2344, Tuesdays, Wednesdays, and Thursdays.

The Council has worked with staff from The Maxwell & Eleanor Blum Patient and Family Learning Center to create an Accessibility Center within the Learning Center. The Accessibility Center will house assistive equipment and resources, such as text-magnification software, JAWS screen-reader software; a Braille translator and printer; transcription software; TTY phone access; and closed-captioned television service.

We have made important advances in assisting deaf and hard-of-hearing individuals to access our services. On the recommendation of the Council, the hospital now employs a full-time American Sign Language (ASL) interpreter and has introduced Communication Access Realtime Translation (CART), a program that allows instant translation of spoken words into text. MGH was the first hospital in the area to launch Sorenson Video Relay Service (SVRS), a free, 24-hour service that enables deaf and hard-of-hearing callers (who use American Sign Language) to conduct video-relay conversations with hearing individuals.

As a way of ensuring patients and visitors with disabilities have a smooth visit to the hospital, the Council has developed a first-of-its-kind 'accessibility website.' People with disabilities and/or their family members can easily find information on the website about shuttle services, handicapped parking, wheelchair accessibility, adaptive devices, and other important services. A link to the accessibility site will appear at the foot of every web page when MGH launches its new web design in December.

The Council is currently in the process of restructuring its membership to better focus on three primary areas: employee awareness, education, communication, and customer service; the physical environment; and patient services and equipment. As we continue to raise the bar around these important issues, our goal remains to ensure safe, high-quality care in an environment that is accessible and welcoming to everyone.

For more information about the MGH Council on Disabilities Awareness, contact Carmen Vega-Barachowitz at 617-724-0762.

## In this Issue

# Respiratory Care Week spotlights teamwork

—submitted by Respiratory Care Services

"Patient care is a team experience; no one person can do it all," says Stephen Safford, RRT, a respiratory therapist with more than 30 years of service. Safford's statement summarizes the collaborative approach to patient care that is the hallmark of practice at MGH. During National Respiratory Care Week, October 19–25, 2008, Respiratory Care Services saluted colleagues in other disciplines as a way to spotlight the teamwork that goes into delivering the highest quality patient care. Respiratory Care Services employs more than 85 registered respiratory therapists who are valued members of the patient-care team throughout the hospital. Multi-disciplinary collaboration is an essential component of respiratory-care practice and one of the leading reasons patient care at MGH is among the best in the nation.

Gloria Mendez-Carcamo, RRT (left), teaches new graduate nurse, Ashley Rose, RN (center), the finer points of caring for a patient with a tracheostomy while preceptor, Laura Gomez, RN, looks on. Patient, Ernest Diorio, enjoys the attention.

Says Robert Kacmarek, RRT, director of Respiratory Care, "Teamwork is a basic tenet embraced by everyone in Patient Care Services. As a department, we have been fortunate to develop productive, collaborative relationships with staff throughout Patient Care Services and other departments throughout the hospital."

Examples of teamwork abound from the bedside to the conference room. The participation of respiratory therapists in daily rounds along with physicians and nurses is essential in intensive care units as well as the Respiratory Acute Care Unit (RACU). In the Burn Unit ICU, dieticians evaluate the nutritional needs of critically ill, mechanically ventilated patients with the help of data measured by respiratory therapists. When nutritional needs are met, patients recover faster and may be able to breathe on their own sooner. Speech-language pathologists and respiratory therapists follow patients with tracheostomies, and together with nurses, work toward clearly defined goals along the multi-disciplinary clinical pathway. The expertise of speech-language pathologists makes it possible for these patients to use special speaking valves, and in many cases, allows faster removal of the tracheostomy tube. Every day, cystic fibrosis patients receive aerosolized medications and secretion-clearance at the best possible time because respiratory therapists, physical therapists, and patients work together to coordinate therapy schedules.

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Strong multi-disciplinary teamwork sometimes results in creative interventions for patients. Recently, a respiratory therapist and physical therapist partnered to grant the wish of a ventilator-dependent patient to go outdoors. It might seem like a small thing, but it was a meaningful event for this patient who was facing end-of-life decisions. And it came about because a few individuals felt empowered to put their plan into action.

Away from the bedside, Collaborative Governance provides a forum for multi-disciplinary teamwork. Groups such as the Quality Committee, the Patient Education Committee, and others are richer for having viewpoints from across the spectrum of care.

One recent initiative involved teaming up representatives from Patient Care Services with patients and family members to learn about the patient experience and work together to improve aspects of care.

At MGH, teaching, learning, and communication are critical aspects of care-delivery. Sharing knowledge at the bedside is second-nature to clinicians of all disciplines. It happens on every unit, every shift, every day. In The Knight Nursing Center for Clinical & Professional Development, clinicians from Respiratory Care and Nursing developed a mechanical-ventilation curriculum for new graduate nurses in the Critical Care Program. Respiratory therapists have gained knowledge on subjects such as swallowing disorders and pulmonary hypertension through training provided by speech-language pathologists or presentations at Nursing Grand Rounds. These are just a few of the examples of how knowledge is shared among and between disciplines.

Caregivers are increasingly focused on providing a safe environment for patients. Collaboration with Biomedical Engineering allows Respiratory Care to ensure central-alarm annunciation for every mechanical ventilator in use at MGH. The Electronic Medication Administration Process for Patient Safety (EMAPPS) brought nurses, pharmacists, and respiratory therapists together to develop a safer medication-administration processes using bar-code technology (see "Fielding the Issues II" on page 17). Respiratory Care routinely works with the Nursing Practice Committee and other groups to implement the best patient-care practices based on evidence and outcomes.

As we celebrate our 61st year as a department, we take pride in the achievements of Respiratory Care Services. But we are equally proud and appreciative of the multitude of collaborative relationships we enjoy throughout the MGH community. Our expertise combined with the expertise of our clinical partners continues to be our most valuable asset as we strive to be the best we can be.

For more information about the services provided by respiratory therapists at MGH, call Debra Duffy at 4-4493.


Respiratory Care Services staff stand before posters in the Main Lobby celebrating National Respiratory Care Week, October 19–25, 2008.

(Photo by Abram Bekker)

# Physical Therapy Month takes center stage at MGH

—by William Waddell, PT, physical therapist

Physical therapist, Maura Ament, PT, educates visitor on sitting posture at the information booth sponsored by Physical Therapy Services as part of PT Month activities.


Embracing both tradition and change, MGH Physical Therapy Services celebrated National Physical Therapy Month this October with a number of events geared toward sharing professional accomplishments and patient-care experiences with the MGH community. Physical therapists demonstrated their commitment to the communities they serve through educational presentations and fund-raising projects. Under the banner of this year's theme, "It's All about Movement," therapists showcased their work as integral members of the inter-disciplinary healthcare team.

Kicking off activities, Physical Therapy Services fielded a team for the American Heart Association's Boston Heart Walk, held September 13, 2008. Physical and occupational therapists along with students from the MGH Institute for Health Professions participated in a team challenge to raise money for the cause. When all the pledges were counted, Physical and Occupational Therapy had raised $10,822.85 or 17.6% of the total contribution made by MGH to the American Heart Association.

The annual PT recognition dinner was held Tuesday, September 23, 2008, giving therapists an opportunity to celebrate their achievements and reflect on practice. The evening began with an inspiring welcome from director of Physical & Occupational Therapy, Michael Sullivan, PT, followed by comments from Marie Brownrigg, PT; Meaghan Costello, PT; Sofia Devine, PT (see opposite page); and Cynthia Thibodeau, PT, who each shared experiences from their professional journeys. The diversity of stories was a reminder of the unique perspective each therapist brings to the unified team.

On Tuesday, October 21, 2008, therapists from the inpatient and outpatient physical therapy services joined together to staff an interactive information booth in the Main Corridor. This year's focus was on posture and body mechanics. Therapists used models of human skeletons and simulated work stations to demonstrate proper posture and instruct visitors on the importance of ergonomics in daily life. Similar booths were offered at the MGH health centers in Revere, Chelsea, and Charlestown.

Physical Therapy Month was a great success for the department and the MGH community, as therapists demonstrated their commitment to the highest level of patient care, health and wellness, public education, and service to the community.

For more information about the services provided by the MGH Physical Therapy department, visit our website at www.mghphysicaltherapy.org.

## One physical therapist's journey

—by Sofia Devine, PT

I came to MGH as an inpatient therapist in 1995. I was a bright-eyed, bushy-tailed, new graduate eager to learn. My intention was to learn as much as I could in two years and move on. After 13 years, here I am. Why am I still here? I continue to have excellent opportunities to develop as a professional. MGH is an environment rich with professionals who share their thirst for knowledge and excellence; rich with opportunities to grow personally and professionally; and rich with resources to overcome the challenges that come with those opportunities.

One of my first experiences at MGH was working in the ICU and step-down units as an inpatient therapist. I had to overcome my fear of performing invasive interventions, particularly, "blind suctioning." At the time, I was unaware that physical therapists performed invasive procedures, and I was uncomfortable with the idea that I would have to do it.

Fortunately, our department provides a tremendous amount of training and mentorship. With practice and guidance from my mentors, I was able to overcome my fear and become adept at blind suctioning.

Sofia Devine, PT, physical therapist

After a year of treating patients in the inpatient setting, I was given the opportunity to work in the outpatient setting. I went through some growing pains, but it was an invaluable experience in my development as a therapist.

I soon realized I needed to improve my critical-thinking skills. With the help of mentors, graduate courses at the IHP, and countless electronic resources (OVID, Micromedex, Up-to-date, Refworks, etc.) I was able to develop into a more proficient, evidence-based clinician. Assistance with continuing education and tuition-reimbursement helped me hone my data-reading skills and improve my analytical abilities.

In 2001, another opportunity presented itself when I was given the chance to work in the MGH Chelsea HealthCare Center. This change in demographics offered a new challenge. Only about 5% of my patients on the main campus had been Spanish-speaking; in Chelsea it rose to 80% with patients from Central and South America and the Caribbean; all with very different dialects.

Most recently, I had an opportunity to work with the Chelsea Diabetes Management Program, a collaborative, multi-disciplinary program that tries to empower patients to successfully manage their diabetes.

Our challenge is to provide culturally competent care and minimize any disparities that may exist between different demographic groups. We brainstorm regularly among disciplines to find new ways to bridge this gap. The MGH Disparities Solution Center, the Physicians Organization, and various grants have supported us in meeting these challenges.

These are only some of the opportunities and resources I've been able to tap in this rich environment. They are the reason I've stayed for 13 years. And I look forward to the opportunities and challenges that still lie ahead.

**At left:** Mike Gillespie, executive administrative director for the department of Medicine, thanks the departments of Physical and Occupational Therapy for their participation in the AHA fund-raising walk. **At right:** Physical therapists enjoy some quality time at annual PT Recognition Dinner under the Bulfinch Tent.

Speakers at the PT Recognition Dinner (l-r): Garth Savidge, PT; Marie Brownrigg, PT; Karen Waak, PT; Meaghan Costello, PT; and Cindy Thibodeau, PT.

(Photos by Abram Bekker)

# Reduce, re-use, recycle

## *an update from the Forms and Office Supplies Tiger Team*

—By Jamie Breed, Jennifer Daniel, and Jennifer Lassonde

Patient Care Services is the largest single service at MGH and one of the hospital's biggest consumers of goods and services with more than 3,800 employees throughout the inpatient units. As a hospital, we have a responsibility to ensure safe, efficient, effective operations with minimal waste. Not only does this make financial sense, it fosters a clean environment and helps preserve resources.

Over the past few months, the Forms and Office Supplies Tiger Team has looked at supply-utilization throughout PCS to identify opportunities to eliminate waste, improve efficiency, and reduce expenses. This proved to be a far-reaching and illuminating undertaking.

The team reviewed the needs and ordering practices of all 44 inpatient units and found sharp contrasts in the prices of supplies. For example, the cost of copy paper from the same manufacturer differed by as much as $13 per case from unit to unit. By standardizing copy paper across all units, we will save nearly $36,000 per year. Patient care units order 4,000 pens of varying styles and prices. Establishing BIC medium-point pens as the standard will save approximately $11,000 per year.

Currently, inpatient units use 2,752 cases of paper each year (that's seven reams of paper per employee). If half this paper were recycled, it would save the equivalent of 330 trees, trees that if let grow would absorb 4,854 pounds of carbon per year. We need to think about ways to re-use and recycle paper to eliminate this unnecessary waste. We need to think about ways to re-circulate paper so both sides are used, and about not printing hard copies if we don't need to.

The team looked at the 364 forms available through Standard Register and developed recommendations for eliminating waste without adversely affecting patient care. For example, moving to on-line Annual Competencies and Training would save $69,000. Eliminating color ink on Progress Notes, Flow Sheets, and Procedure Consents would save more than $13,000. These changes along with improvements in inventory-management will save money, open valuable storage space, and reduce the amount of paper that is wasted.

The Forms and Office Supplies Tiger Team has identified numerous opportunities to eliminate waste, but there is still more to do, and we each have a role to play. We're asking every employee to look for ways to reduce, re-use, and recycle. Share your ideas with unit leadership, and look for more information about these and other suggestions to make MGH a greener, more efficient, more cost-effective work place.

If you have ideas about how to reduce, re-use, or recycle forms and office supplies, please contact Jennifer Daniel, RN, staff specialist, at 6-6152.

# Perioperative Nurse Week

## *an opportunity to share and educate*

—By Maureen Hemingway, RN, and Alan Goostray, RN

During the week of November 9–15, 2008, operating-room nurses showcased their practice with hands-on displays in the White Corridor in celebration of Perioperative Nurse Week. Educational booths offered information on laser technology, care of pediatric patients, minimally invasive surgery, auto-tansfusion therapy, orthopaedic joint replacement, cardiac percutaneous-valve replacement, and the Ventricular Assisted Device (VAD) program.

On Wednesday, November 12th, Scott Farren, RN, clinical service coordinator, presented, "A Portrait of Perioperative Nursing," at Nursing Grand Rounds, sharing some of his professional experiences as a perioperative nurse.

On Thursday, there was a discussion on the MGH based perioperative nursing program hosted by Charlene O'Connor, RN, Cathy O'Malley, RN, Laurie Lynch, RN, and alumni of the program.

The perioperative nursing service wishes to thank Jeanette Ives-Erickson RN, senior vice president for Patient Care, and Dawn Tenney, RN, associate chief nurse, for their continued support of our nursing practice.

Operating-room nursing is an exciting career opportunity. For more information, please call Karen Jarosz at 4-3554, or Lisa Morrissey, RN, at 3-0191.


Nurses from the various perioperative services staff an educational booth in the Main Corridor during Perioperative Nurse Week.

# Proactive learning helps physical therapist treat patient with BPPV

'Mae' was a 66-year-old woman who had been referred by her primary care physician for neck pain two weeks after falling and hitting her head.

My name is Julie Bosworth, and I am a physical therapist. Prior to coming to MGH 15 months ago, I worked as an outpatient therapist in an Orthopaedic setting for two years. During that time, dizziness was not a symptom I thought I could affect with physical therapy. In a discussion with Eileen Collins, PT, clinical specialist, soon after I came to MGH, Eileen mentioned cervicogenic dizziness (CD) as a possible explanation for a patient's unsteadiness. With my interest piqued, I decided to join the PT department's cervicogenic dizziness special interest group.

Over the next months, I participated in case discussions, practiced techniques with my colleagues, and co-treated patients with a number of therapists who had expertise in this area. I became more confident in performing vestibular assessments, teaching balance exercises, and educating patients about dizziness.

'Mae' was a 66-year-old woman who had been referred by her primary care physician for neck pain two weeks after falling and hitting her head. CT scans and X-rays were negative. Mae presented with painful neck rotation, which was likely superimposed on cervical arthritis given her past history of neck pain and prior X-rays. Mae also reported feeling, "a little light-headed and fuzzy," with a vague sense of movement. This was brought on almost immediately when she rose from a lying position, bent over, or lay on her back—the latter two, in particular, caused symptoms of nausea and spinning that lasted about five minutes. Mae could avoid dizziness by holding her head in certain positions when she performed activities. She also revealed that she'd been sleeping on five pillows since having hip-replacement surgery a year ago.

Julie Bosworth, PT, physical therapist

Mae's history suggested she might have a condition called Benign Positional Paroxysmal Vertigo (BPPV). Her symptoms were short-lived, positional, and involved a sense of spinning. While BPPV can arise idiopathically, it could also have resulted from her head trauma. And having slept on so many pillows for so long could have sensitized her to those positions, strengthening her symptoms. My exam revealed that Mae's neck ligaments, eye motion, and eye reflexes were all normal. Time did not permit me to test specifi-

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The next week, I guided Mae through the appropriate maneuver. Afterward, she left feeling dizzy and unwell, but based on prior experience, I knew that wasn't uncommon... She e-mailed me two days later saying, "I believe the treatment you gave me Monday helped. While I'm not 100%, I feel the symptoms have significantly improved."

cally for BPPV, which was just as well, as the Dix-Hallpike maneuver, the gold-standard in testing for BPPV, often provokes symptoms, and Mae had to return to work that afternoon.

I suggested we inform Mae's primary care physician of these symptoms and the potential for BPPV so we could further evaluate and treat it. I explained that research indicates about 85% of people with BPPV respond to a repositioning maneuver, but that sometimes BPPV resolves on its own. Since the test often provokes symptoms, I proposed doing the test at a time when she didn't have to go right to work. Mae agreed.

A busy schedule prevented Mae from having the Dix-Hallpike test at either of her next two appointments. During that time, she reported her dizziness was "much improved," so we put off any more talk of a Dix-Hallpike test. Mae's physical therapy included massage, joint mobilization, and active exercise. In theory, none of these treatments would affect BPPV. While I still believed BPPV was the cause of Mae's symptoms, I knew there could be an element of cervicogenic dizziness (CD) present given her favorable response to treatment. I couldn't rule CD in or out because I hadn't ruled out BPPV. Mae's injury, neck pain, decreased motion, neck osteo-arthritis, and presentation of immediate dizziness with painful motion, all pointed to CD.

Each week, the intensity of Mae's dizziness decreased, but she still reported the same pattern of symptom-provocation. While I wanted to test for BPPV, I respected her wish to continue with the status quo because her pain and dizziness were improving to where they would diminish quickly after a position change. In retrospect, I believe this may have been Mae's brain learning to adapt to the dizziness.

After five treatments, Mae's neck motion had returned to normal. She had no pain and was able to perform home exercises independently. Mae felt her dizziness wasn't bothersome enough to warrant treatment. But she did have chronic lower-back pain and wanted to start treatment for that. Following an evaluation, I reviewed proper posture with her and taught her some stretches and core-strengthening exercises.

One evening, Mae came to physical therapy and asked if we could pursue treatment for her dizziness because it was limiting her ability to lie on the floor and do her back exercises. I performed the Dix-Hallpike, which provoked symptoms on both her right and left sides, but abnormal eye motion was only present on the right side. Based on the timing and duration of symptoms and the direction of eye movement, this indicated that Mae had a right-sided positional problem. At this point, Mae was feeling very dizzy and had had enough. She wanted to go home.

I was now confident Mae had BPPV. However, since, it had taken three months for her to feel comfortable enough to seek treatment because of her fear of becoming more symptomatic, I decided to wait until her next appointment to start treatment.

The next week, I guided Mae through the appropriate maneuver. Afterward, she left feeling dizzy and unwell, but based on prior experience, I knew that wasn't uncommon. Mae wasn't scheduled for a follow-up appointment for another week, but she e-mailed me two days later saying, "I believe the treatment you gave me Monday helped. While I'm not 100%, I feel the symptoms have significantly improved." At the next appointment, Mae had a negative Dix-Hallpike test on both sides, and more significantly, tolerated a 20-minute treatment while lying on her back with only two pillows.

The following week, Mae e-mailed me to cancel her appointment, saying, "I don't think I need to reschedule as I'm feeling much better. I slept on my side for half the night last night, which was a nice change of pace."

While I believe it's impossible to always 'know what you don't know,' I now have a much better grasp of what I know with respect to dizziness. I effectively applied what I had learned and helped Mae become more functional and able to manage pain while taking into account her goals and values and my own limitations.

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

Julie's narrative demonstrates the critical importance of staying current with clinical research and knowing the patient—the person—her goals, values, and willingness and ability to participate in her own care. Julie understood Mae's trepidation and respected her need to put off intervention until Mae felt she was ready to pursue treatment for her dizziness. It's not just knowing *what* to do, it's knowing how and when to do it.

It is telling that Julie proactively sought knowledge and information about cervicogenic dizziness, honed her assessment skills, and practiced treatment techniques well before meeting Mae. She consulted clinical experts in the field and took full advantage of the resources available to help Mae overcome her pain and dizziness.

Thank-you, Julie.

# Grand Rounds looks at cross-cultural care

—by Laurene Dynan, RN, case manager

On October 23, 2008, MGH Case Management hosted Nursing Grand Rounds. "Thinking Outside the Box: a Practical Framework for Cross-Cultural Care," was presented by Alexander Green, MD, associate director of the Disparities Solution Center at MGH. Green shared that according to the 2000 United States Census Report, 47 million US residents speak a language other than English in their homes, and 51% of Americans have limited functional health literacy. Green defined cultural competence as more than just our attitude toward various cultures, ethnicities, and races or knowing about different customs, values, and health beliefs. Cultural competence is having the skills to communicate with any patient to explore his or her individual customs, values, and beliefs. We need to listen to what patients are telling us about their beliefs, as belief systems hold important cues about barriers to disease-management and compliance. Quality-improvement interventions that emphasize cultural competence are necessary to help eliminate disparities in health care.

Alexander Green, MD, associate director of the Disparities Solution Center at MGH, presents at Nursing Grand Rounds, hosted by Case Management

One intervention Green described was the ESFT Model (E=Explanatory model; S=Social barriers; F=Fears and concerns; and T=Therapeutic contracting). Other interventions included case-based teaching and Healthcare Employees ResCUE Model that teaches healthcare professional how to better interact with persons of diverse cultural backgrounds.

The Disparities Solutions Center at MGH is dedicated to developing and implementing strategies to eliminate racial and ethnic disparities in health care locally, regionally, and nationally. For more information, contact Laurene Dynan at 4-9879, or Alexander Green at the Disparities Solution Center, 4-7658.

# Second annual Care of the Patient with Vascular Disease Conference

—By Carol Ghiloni, RN, staff specialist

On Monday, October 20, 2008, and Monday, October 27, 2008, the MGH Vascular Center in collaboration with The Norman Knight Nursing Center for Clinical & Professional Development and MGH vascular nursing staff co-sponsored the second annual Care of the Patient with Vascular Disease Conference. The two-day conference was well attended by staff from medical, surgical, neuroscience, vascular, cardiac, and intensive care units as well as outpatient areas, and community health clinics.


Vascular clinical nurse specialist, Erin Cox, RN, presents at second annual Care of the Patient with Vascular Disease Conference.

Day one of the conference provided a general overview of the vascular system, common risk factors, peripheral arterial disease, aortic aneurysms, the clotting cascade, implications related to long-term anticoagulation, and diagnostic imaging. Day two focused on vascular trauma, renal vascular disease, ischemic and phantom pain, cerebral circulation, acute stroke care, carotid stenting and an update on interventional procedures.

Faculty was comprised of many nationally and internationally recognized vascular experts. Among the distinguished presenters were: Mary Amatangelo, RN, senior stroke researcher at MGH and BWH and president of the Boston chapter of the American Association of Neuroscience Nurses; Richard Cambria, MD, chief of Vascular and Endovascular Surgery at MGH; Alice Gervasini, RN, nurse director of the MGH Trauma & Emergency Surgery Program and instructor of Surgery at Harvard Medical School; Kathleen Hannon, RN, technical director of the MGH Vascular Diagnostic Laboratory and president of Greater Boston Vascular Technologists; Michael Jaff, DO, medical director of the MGH Vascular Center; and Lee Schwamm, MD, vice chairman of the MGH department of Neurology and director of MGH TeleStroke & Acute Stroke Services and assistant program director for the combined MGH-MIT General Clinical Research Center Program.

Other faculty included: Paul Arnstein, RN; Erin Cox, RN; Jean Fahey, RN; Bernard Khor, MD; Lynn Oertel, RN; Johnny Pryor, MD; Teresa Vanderbloom, RN; Drena Root, RVT; Kenneth Rosenfield, MD; and Jacqueline Somerville, RN. The Planning Committee would like to thank all who contributed to the success of this year's conference.

# Nursing research opportunities abound

## *Checking in with The Yvonne L. Munn Center for Nursing Research*

—Submitted by The Yvonne L. Munn Center for Nursing Research

The Center serves as a platform for clinically focused nursing research that advances nursing practice. By providing opportunities to challenge current thinking and identify new ways to shape and influence nursing practice, we enhance patient care and promote health and wellness.

Throughout her long and distinguished career, Yvonne L. Munn, RN, associate general director and director of Nursing at MGH from 1984–1993, promoted patient-focused, evidence-based practice. Her commitment to collaborative practice and consensus-building enabled her to influence the practice of nursing and the delivery of patient care.

The Yvonne L. Munn Center for Nursing Research was established to build on existing research initiatives including the annual lecture and awards program, doctoral nurse forum, the Norman Knight Visiting Professor Program, and postdoctoral fellowships. The Center serves as a platform for clinically focused nursing research that advances nursing practice. By providing opportunities to challenge current thinking and identify new ways to shape and influence nursing practice, we enhance patient care and promote health and wellness. To date, 21 research awards and six postdoctoral fellowships have been awarded through the Munn Nursing Research Program.

The Yvonne L. Munn Nursing Research Awards are presented annually to MGH staff to fund research studies. Each year, research studies are initiated by staff to advance nursing knowledge around the care of patients and families. A doctorally-prepared nurse serves as consultant and mentor for each research team, and completed studies are featured during Nurse Week on Research Day, through poster presentations, and other Nurse Week activities.

Applicants seeking an Yvonne L. Munn Nursing Research Award must be members of the MGH clinical nursing staff. Each research team must include a doctorally-prepared nurse mentor who has agreed to provide support and guidance for the duration of the study. All approved Munn research proposals must be approved by the MGH IRB, although approval is not required at the time of an award submission. Recipients must submit a progress report to the Munn Center every six months until the research is completed. Awards are granted for $1,500.

Important milestone dates:

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| December 15, 2008: | Letters of intent and nursing director support are due |
| January 15, 2009: | Proposals are due for the 2009 funding cycle |
| January 22, 2009: | Feedback is given to applicants following internal review |
| February 2, 2009: | Final proposals are due |

For more information about the Munn Nursing Research Awards, contact Paul Arnstein, RN, at 4-8517; Marion Phipps, RN, at 6-5298; or Elaine Cohen, RN, at 6-1989.

The Yvonne L. Munn Post-Doctoral Fellowship in Nursing Research supports the development of nurse researchers seeking to advance research and scholarship at MGH. The fellowship provides nurse researchers with time and resources to develop their programs of study and formulate proposals in promising areas of nursing inquiry.

The fellowship subsidizes 400 hours of practice time and related expenses up to $2,500 to give fellows an opportunity to develop a research proposal. At the end of the fellowship, fellows share the proposal with the Post Doctoral Fellowship Committee and present their research to the MGH nursing community.

The deadline for applications to receive a Munn Post-Doctoral Fellowship in Nursing Research is February 6, 2009.

For more information, contact Diane Carroll, RN, at 4-4934, or Mandi Coakley, RN, at 6-5334.

# Glove use: separating fact from fiction

*Proper glove use plays a vital role in preventing the spread of infection. Following are some common misconceptions about glove use and the corresponding facts to help dispel misunderstandings about this important hand-hygiene practice.*

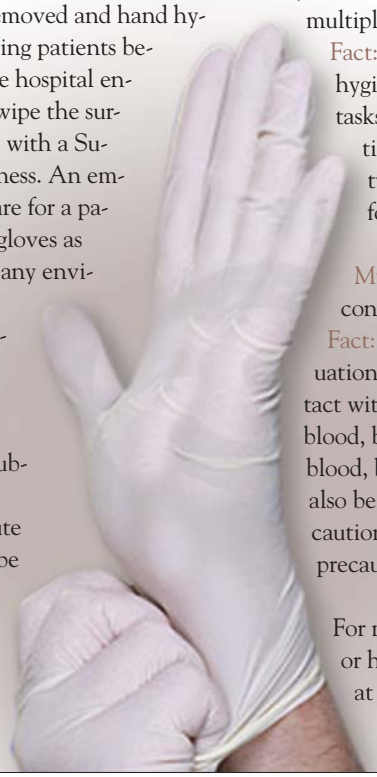
Myth: It's okay to wear gloves in public areas.
Fact: Gloves should not be worn in public areas such as elevators and hallways. Some exceptions apply, such as unit service associates who wear gloves while working in public areas, but these employees should change gloves and practice good hand hygiene when moving from task to task.

Myth: It's okay to wear gloves when transporting patients.
Fact: Gloves should always be removed and hand hygiene performed before transporting patients because gloves can contaminate the hospital environment. Transporters should wipe the surfaces of stretchers or wheelchairs with a Super Sani-Cloth to ensure cleanliness. An employee who is providing direct care for a patient during transport may wear gloves as long as he or she does not touch any environmental surfaces such as doors or elevator buttons. Another employee should be designated to touch surfaces in this situation.

Gloves are never a substitute for hand hygiene, which should be performed both before gloves are worn and after they are removed.

Myth: Gloves can be used as a substitute for hand hygiene.
Fact: Gloves are never a substitute for hand hygiene, which should be performed both before gloves are worn and after they are removed.

- Gloves can be contaminated by unclean hands
- Gloves are not 100% effective in preventing contamination
- The warm environment inside gloves can promote the growth of germs
- Gloves can contain imperfections invisible to the naked eye
- Hands can become contaminated as gloves are removed



Myth: The same pair of gloves can be worn for multiple patients or tasks.
Fact: Gloves should be changed and hand hygiene performed between dirty and clean tasks, even when working with the same patient. Gloves should also be changed between patients, with hand hygiene performed both before and after contact.

Myth: Gloves must be worn for all patient contact.
Fact: Gloves are required only in certain situations, such as if an employee anticipates contact with non-intact skin, mucous membranes, blood, body fluids or items contaminated with blood, body fluids or excretions. Gloves may also be required if a patient is on Contact Precautions, Contact Precautions Plus or other precautions.

For more information about proper glove use or hand hygiene, contact Judy Tarselli, RN, at 6-6330.

# An update on construction of B3C

*Question:* What's going on with the Building for the Third Century (B3C)? Where are we in the construction process?

*Jeanette:* As you may know, the first phase of construction for B3C was the construction of the slurry wall. A slurry wall is the concrete barrier that establishes the perimeter of the excavation area for the underground floors. With completion of the slurry wall in late October, the project met its first construction milestone.

*Question:* Will construction continue over the winter?

*Jeanette:* Absolutely. The next phase of construction, the erection of the steel frame, began in early November. After years of intense planning by a number of multi-disciplinary teams, we will soon start to see the shape of the Building for the Third Century.

*Question:* As construction progresses, should we expect to feel vibrations or hear excessive noise from the construction site?

*Jeanette:* From time to time, we may feel vibrations or hear construction noises. But the Noise, Vibration, and Particulate Team (NVP) was developed to anticipate and deal with any construction-related issues. Should you or your patients have any concerns about noise, vibrations, or any other construction-related issues, call Buildings & Grounds at 6-2422.

*Question:* How will this phase of the construction impact pedestrian traffic?

*Jeanette:* During this phase of construction, trucks and heavy equipment will continue to travel to and from the construction site. It is imperative that patients, employees and visitors continue to use the Yawkey Path when traveling between buildings.

Patients should make use of the on-call shuttle when traveling between buildings. To access the on-call shuttle, patients can go to the information desks located in the Cox, Gray, or Yawkey lobbies and ask an information associate to call for the shuttle bus. The bus will drive patients from these hospital lobbies directly to the MGH buildings where their appointments are scheduled. Staff and volunteers will continue to be available to assist patients in reaching their destinations.

For information on these services call one of the following information desks: (White Main Lobby: 6-2281; Wang Lobby: 6-2700; Yawkey Lobby: 3-1133; Gray Lobby: 4-7724, and Cox Lobby: 4-2927).

*Question:* Where can we find more information on the Building for the Third Century?

*Jeanette:* Visit the The Building for the Third Century website at http://www.massgeneral.org/building3c/.

# Look for EMAPPS in March, 2009

*Question:* I've heard we're implementing a new electronic medication system. Can you tell us more about that?

*Jeanette:* The new Electronic Medication Administration Process for Patient Safety (EMAPPS) is a quality and safety initiative. In an effort to reduce medical errors, The Institute of Medicine (IOM), has recommended both a computerized Provider Order Entry System (POE) and a bar-coded medication-administration system to ensure accuracy in medication-delivery. POE addresses potential errors in ordering medications. EMAPPS ensures accuracy in medication transcription, distribution, administration, and documentation.

*Question:* How will the new system work?

*Jeanette:* Medication orders will flow electronically from POE to the Pharmacy information system (Sunquest) to the new electronic medication administration record (eMAR), eliminating the need for manual transcription by operations associates into the paper Medication Administration Records (MARs). Medications for each individual patient will be populated by eMAR. Nurses and respiratory therapists will be able to view ordered medications and the time they're due. After retrieving the medications, the nurse or respiratory therapist will scan the medication and the patient's identification band with a bar-code reader in the patient's room. If the system confirms it is the correct medication, dose, and route, the clinician is given the okay to administer the medication. If there is a discrepancy between the order and the scanned medication, the clinician will receive an alert indicating a mis-match. Once the error is rectified and the correct medication confirmed, the clinician will enter his or her password to document administration. This will automatically document the time the medication was administered and the name of the clinician who administered it.

*Question:* Who was involved in developing this project?

*Jeanette:* Staff from inpatient units have been involved and will continue to participate in EMMAPS team meetings. The Nursing Practice and Pharmacy Practice committees have also been involved.

*Question:* What is the time frame for roll-out of EMAPPS?

*Jeanette:* The first unit will roll out in March of 2009, and two or three more units will be rolled out every two weeks through October of 2009.

*Question:* How will clinicians be educated and supported during the roll-out?

*Jeanette:* Prior to roll-out, staff nurses and respiratory therapists will attend a 4-hour class that will include simulated medication-administration. During roll-out, there will be 24-hour, unit-based coverage by project trainers and Information Systems staff. Project trainers will assist staff in using the application to administer and document medications. Project trainers are now being hired. They will participate in the roll-out through the end of October, then return to their units where they'll serve as expert resources to their peers. This is a great opportunity for nurses to help advance quality and patient-safety. For more information on becoming a project trainer, contact Rosemary O'Malley at 726-9663.

# Announcements

## Elder care discussion group

Elder care monthly discussion groups are sponsored by the Employee Assistance Program.

Next session:
December 9, 2008
12:00–1:00pm
Yawkey 7-980

All are welcome. Bring a lunch.
For more information,
call 6-6976.

## Rapid Response Nursing Team

### Name change

Effective immediately, the Rapid Response Nursing Team is changing its name to the Central Resource Nursing Team.

The name change is to avoid confusion with the hospital-wide Rapid Response Team, which will be introduced In January 2009. The new Rapid Response Team will function as part of our overall Emergency Response.

The Central Resource Nursing Team (CRNT) will continue to provide access to nursing support for increased workload, patient transports, and emergency situations. Staff can access the Central Resource Nursing Team through the Clinical Nursing Supervisor (pager #2-5101), the CRT Office (6-6718) or the page operator.

For more information,
call 6-3201

## 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.mghnursingresearch committee.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.

## 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.

## 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.

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For more information, call: 617-724-1746

**Next Publication**
December 4, 2008

# Educational Offerings – 2008

*November*
**24**
Creating a Healing and Therapeutic Environment

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

*November*
**26**
On-Line Electronic Resources for Patient Education

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

*December*
**1**
BLS/CPR Re-Certification

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

*December*
**1**
Management of the High-Acuity Trauma Patient

O'Keeffe Auditorium
8:00am – 4:30pm
Contact hours: 6.5

*December*
**2**
BLS/CPR Certification for Healthcare Providers

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

*December*
**2**
Ovid/Medline: Searching for Journal Articles

Founders 334
9:00 – 11:00am
Contact hours: 2

*December*
**3&4**
PALS Certification

Charles River Plaza
Day 1: 8:00am – 5:00pm
Day 2: 7:450am – 3:00pm
No contact hours

*December*
**5**
How do I Know when I Need IRB Approval? Plus: Writing Research Poster Abstracts

Blake 8 Conference Room
12:00 – 1:00pm
Contact hours: TBA

*December*
**5**
BLS/CPR Re-Certification

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

*December*
**9**
New Graduate RN Development Program

Founders 311
8:00am – 4:30pm
Contact hours: TBA

*December*
**9**
Chaplaincy Grand Rounds

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

*December*
**10**
Nursing Grand Rounds

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

*December*
**10**
OA/PCA/USA Connections

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

*December*
**12**
Managing Medical Emergencies Related to Cancer

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

*December*
**15**
Diabetic Odyssey

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

*December*
**17**
Intermediate Arrhythmia

Simches Conference Room 3120
8:00 – 11:30am
Contact hours: 3.5

*December*
**17**
Pacing Concepts

Simches Conference Room 3120
12:15 – 4:30pm
Contact hours: 3.75

*December*
**18&19**
Oncology Nursing Society Chemotherapy Biotherapy Course

Yawkey 2-220
8:00am – 4:30pm
Contact hours: TBA

*December*
**18**
Workforce Dynamics: Skills for Success

Charles River Plaza
8:00am – 4:30pm
Contact hours: 6.5

*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

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

# Excellence in Action Award goes to ED social worker

On November 5, 2008, MGH president, Peter Slavin, MD, paid a visit to the department of Social Services to present an Excellence in Action Award to Nancy Leventhal, LICSW. This recognition was triggered by a letter sent by Police, Security & Outside Services manager, Joe Green, who wrote: "I would like to express my respect and admiration for MGH social worker, Nancy Leventhal, who works the evening shift in the Emergency Room. As you may know the ED social worker on evenings responds throughout the hospital assisting with a number of complex situations. As evening manager of Police, Security & Outside Services, I often have the opportunity to see Nancy's compassion and her ability to give of herself to others. One night recently, as I was leaving the hospital at 12:45am (Nancy was probably scheduled to leave at 11:00pm), I watched the parents of an employee who had just lost their son hugging Nancy, thanking her for the comfort she had given them. As I drove home, all I could think about was the touch of humanity Nancy had given that couple who were living a parent's nightmare, the sudden unexpected death of a child. Although this was amazing to see, I wasn't surprised, as I have observed Nancy support, assist, and give to others very often before. This letter does not do justice to Nancy, but I hope it gives you a sense of my respect and appreciation for her efforts."

At reception honoring Excellence in Action Award recipient, Nancy Leventhal, LICSW (center), are (l-r): director of Social Services, Ann Daniels, LICSW; Police, Security & Outdoor Services manager, Joe Green; Leventhal's husband, Chuck Silverston; daughter, Lily; MGH president, Peter Slavin, MD; and Mr. and Mrs. Silverston.

(Photo by Abram Bekker)

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