Caring Headlines
April 23, 2009

Occupational Therapy

Helping patients perform daily activities to the best of their ability

Lauren Corbett, OTR/L (left), and Laura White, OTR/L, demonstrate how occupational therapists assess patients' ability to function safely in a kitchen setting.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Anticoagulation management:

a National Patient Safety Goal, a hospital-wide patient-safety priority

Recently, we've begun to develop a new, comprehensive program designed to support not only patients, but the clinicians who manage and coordinate anticoagulation therapy.

Anticoagulation therapy is a high-risk treatment that many patients receive every day. Anticoagulants are among the top five medications associated with adverse drug events. To prevent these adverse drug reactions, standardized treatments and formal guidelines for monitoring compliance are essential. Standard practices for anticoagulation therapy include involving patients in the administration of their medications and in their discharge planning. These simple steps can reduce the risk of adverse drug events associated with anticoagulation management.

At MGH, we have long-standing resources in place for patients receiving anticoagulation therapy, including departmental protocols and guidelines at all levels of care. Recently, we've begun to develop a new, comprehensive program designed to support not only patients, but the clinicians who manage and coordinate anticoagulation therapy.

The new program is multi-faceted involving a number of inter-disciplinary efforts to support patient care. They include:

- a new policy outlining the basic elements required for treating patients on anticoagulants
- updated, disease-based guidelines developed by national and local experts to ensure optimal treatment with anticoagulants
- standardized laboratory testing requirements that select and adjust medication doses to avoid adverse effects

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

- pharmacy standards for supplying the safest available form of anticoagulants. To do this, Pharmacy needs the patient's accurate weight at the time of admission to the hospital
- nursing standards for administering anticoagulation therapy in the safest possible way
- nutritional standards to optimize patients' intake of vitamin K while receiving warfarin
- accurate, standardized patient- and family-education using approved materials to guide a comprehensive education plan
- monitoring compliance and effectiveness of the treatment regimen

The Anticoagulation Management Service delivers best-practice management of outpatient anticoagulation therapy. Through the use of strict protocols, standardized patient-education tools, and a stringent monitoring program, the Anticoagulation Management Service provides essential interventions to ensure

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patient safety. But that's only part of our Anticoagulation Management Program. Every clinician in every setting plays an important role.

The new program is designed to meet the needs of inpatients, outpatients, and patients transitioning home or to other care settings. The new booklet, *A Guide to Taking Warfarin* (available through Standard Register), is the essential tool for instructing patients who will be discharged with a prescription for Coumadin. Specific instructions ensure every patient understands:

- his or her target INR (International Normalized Ratio, a lab measure that reflects the effectiveness of Coumadin treatment)
- who will be managing their anticoagulation therapy after discharge
- where and when their follow-up appointment is

For patients going home on warfarin (also known as the brand name, Coumadin) or enoxaparin (Lovenox), patient-education materials can be found on-line at: Partners Applications –>Clinical References –>MGH Clinical Pathways –>Patient Education –>Patient Discharge Instructions –>Anticoagulation Therapy.

As part of the nurse's initial assessment, The Nursing Dataset Form includes an inquiry in the nutrition section concerning the patient's vitamin K intake. Patients receiving warfarin require specific information about how to maintain a consistent intake of vitamin K, which is found in green leafy vegetables such as spinach, broccoli, kale, Brussels sprouts, etc. Vitamin K is processed by the liver to make clotting factors, and Coumadin reduces the liver's ability to convert vitamin K into blood-clotting proteins. So changes in a patient's dietary intake of vitamin K affect the patient's clotting abilities. Instructing patients on how to maintain a balanced intake of foods rich in vitamin K is an essential part of keeping patients safe.

An anticoagulation problem list has been created to help identify knowledge deficits and guide staff in addressing their patients' needs related to anticoagulation management. The problem list can be found at: http://intranet.massgeneral.org/pcs/Outcome.asp.

In the sense that clinicians 'know' their patients, we are all responsible for ensuring that patients receiving anticoagulation therapy are well informed and knowledgeable about their diet, discharge plans, and other factors affecting their care.

Anticoagulation management is a complex and important issue for many patients. I know some practice changes are going to be announced soon (related to heparin administration), so watch future issues of *Caring Headlines* for updates.

To learn more about the resources available in managing patients receiving anticoagulation therapy, contact Erin Cox at 6-3741; Lynn Oertel at 6-6955; or your unit-based clinical nurse specialist.

In the sense that clinicians 'know' their patients, we are all responsible for ensuring that patients receiving anticoagulation therapy are well informed and knowledgeable about their diet, discharge plans, and other factors affecting their care.

In this Issue

Occupational therapy: helping patients live life to the fullest

—by occupational therapists, Laura White, OTR/L; Stephanie Karban, OTR/L; and Lauren Corbett, OTR/L

Characteristics of Person

- Vision/Hearing
- Pain
- Communication
- Memory/ Concentration
- Balance/Mobility
- Energy/Endurance
- Coping Skills
- Safety Awareness

We all value our ability to participate in the meaningful activities that define us as unique individuals, from getting dressed in the morning, to coaching Little League, to working and leading productive lives. Unfortunately, disability, injury, and illness can alter our ability to perform normal activities. As occupational therapists at MGH, our role on the healthcare team is to assist people facing recent changes in their routines and daily lives. Occupational therapists help people perform their daily activities to the best of their ability. Occupational therapists approach patient care in a holistic manner. We look at the *person* (physical, mental, and emotional capacities), his or her living *environment* (physical surroundings), and his or her *occupations* (life roles, habits, and routines). This approach is referred to as the P-E-O (Person-Environment-Occupation) model. Evaluating a patient's abilities in the broad context of his or her life is one of Occupational Therapy's unique contributions to the medical team. Our input regarding the appropriateness and readiness of a patient to return home is essential in formulating a safe discharge plan.

Making sure patients are living safely and to their fullest capacity is at the heart of what occupational therapists do.

In celebration of National Occupational Therapy Month, we'd like to share some stories that highlight our role and demonstrate the importance of the Person-Environment-Occupation approach when considering a patient's ability to return home safely.

Mr. A is a driver and owner of a small delivery business. Mr. A had a stroke. While he was able to move and appeared physically fine, Mr. A couldn't speak or read or understand anything that was said to him. He could no longer buy lunch or ride the elevator without help. He was

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Outpatient occupational therapist, Julie Burke, OTR/L, helps 'patient,' Elizabeth, compensate for her left-sided weakness using adaptive equipment.

(Photo provided by staff)

Characteristics of Environment

- Social/Community Supports
- Home Set-up/Layout
- Pets
- Safety Devices and Adaptive Equipment
- Lighting

Characteristics of Occupation

- Physical and Mental Demands
- Cultural and Social Demands and Rules
- Habits or Routines
- Life Roles
- Values and Priorities

unable to recognize if he needed assistance or to call 911. Mr. A lacked the basic communication skills needed to be a safe *person* at home. He required additional therapy at a rehabilitation center to regain the skills needed before returning home safely.

Mr. B is a husband, father, and computer programmer who enjoyed playing computer games. After falling from a ladder, his life changed forever—he was paralyzed from the neck down. At first, Mr. B thought he could never be left alone due to his inability to call for help if he needed it. However, changes to his *environment* including a voice-controlled computer, a phone-activated emergency system, and a door-opener, allowed him not only to be left alone for extended periods of time, but to return to his favorite activity, working and playing on the computer.

Mr. C lived alone and worked full time. He managed finances, drove, and cared for his 4-month old daughter. He came to MGH with a head injury that had caused confusion, pain, and difficulty walking. He couldn't take care of himself in the most basic ways. It was obvious Mr. C could not safely return to his life roles including parenting an infant. Occupational Therapy's focus on the life occupations Mr. C valued resulted in his acceptance to a rehabilitation facility to best prepare him for a safe return home.

Not only do occupational therapists take person, environment, and occupation into account when examining a patient, we also educate patients toward a safer future. Many resources are available at MGH and in the community to assist people in living safe, independent lives.

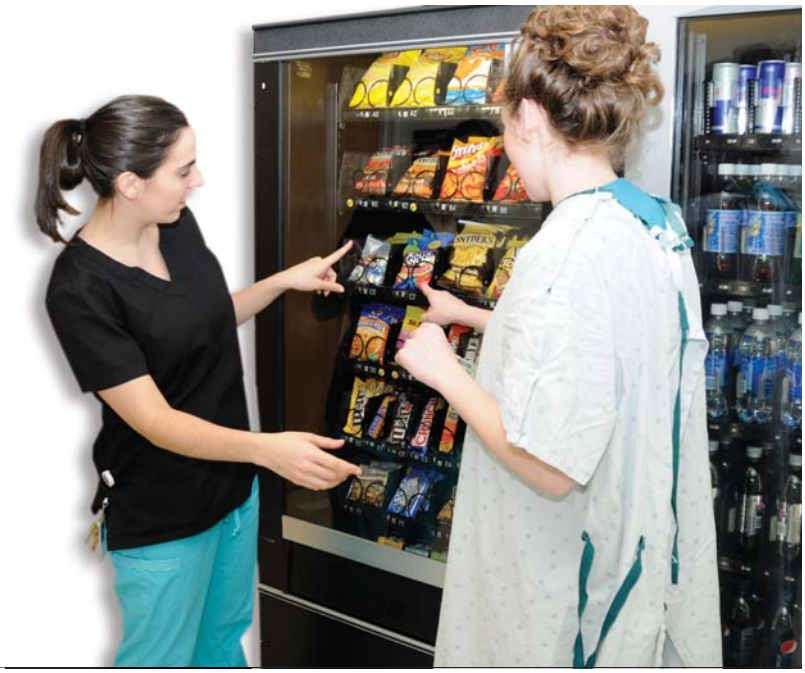
Resources available in the community:

- Meals-on-Wheels
- The RIDE
- Home-delivered medications
- Lifeline, grab bars, shower seats, reaching devices
- Boston Area Agency on Aging, the Alzheimer's Foundation, NAMI, the Brain Injury Association

April is Occupational Therapy Month. At MGH, the department of Occupational Therapy provides care in the inpatient and outpatient settings. Home safety assessments are just one of many services provided to help optimize independence. For more information, call 6-8537.

Occupational therapists, Laura White, OTR/L, and Christopher Richards, OTR/L, demonstrate the importance of following directions during kitchen-based home safety assessment.

Occupational therapist, Stephanie Karban, OTR/L, (left) assesses 'patient,' Kyleen's ability to problem-solve and safely perform everyday activities, such as buying a snack from a vending machine.



Helping children cope in difficult economic times

—by pediatric clinical social workers, Elyse Levin-Russman, LICSW, and Barb Luby, LICSW

'Ken' and his wife, 'Susan,' actually considered themselves lucky. Despite struggling to keep up with monthly bills and dealing with numerous surgeries for their daughter who has a congenital heart disorder, they were still able to keep their heads above water. That is, until Ken lost his 20-year job with a local computer company. Because Susan was a stay-at-home mom with three young girls, not only did they rely on Ken's income but also on his health insurance. Now, having spent their savings and nearing the end of Ken's unemployment benefits, Ken and Susan wonder how they'll get by.

With unemployment and personal debt rising and home foreclosures at an all time high, families are anxious about financial stability... Children know when their parents are worried. They know something's wrong when they have to make changes in their lifestyle or activities.

Unfortunately, Ken and Susan are not alone. *The Boston Globe* reported that in February of 2009, the state's jobless rate hit a 15-year high. And Massachusetts law now requires residents to have health insurance even if they're not working. In Ken's case, he and his family didn't qualify for health-insurance assistance through the state because his unemployment benefits were too high. Yet, according to Families USA, a national consumer advocacy group, the average monthly premium for COBRA (temporary health insurance) for a family in Massachusetts is close to 70% of the monthly unemployment benefit.

With unemployment and personal debt rising and home foreclosures at an all time high, families are anxious about financial stability. Most of us are either directly impacted or know someone who is suffering in this economic crisis. And it affects children, as well. As much as parents try to protect their children from harsh financial realities, children often hear about what's happening in the world. Children know when their parents are worried. They know something's wrong when they have to make changes in their lifestyle or activities.

As clinical social workers we're often called upon to assist families in crisis. We're asked to help families find resources and community supports. As families' needs increase, communities struggle to meet those needs. Reduction in government programs, the closure of philanthropic foundations, and a decrease in charitable giving combine to create a difficult financial climate for many families.

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Children may have their own reactions to these challenges. It's important to keep in mind the ways children may be impacted.

- Children may become anxious. This may become evident in behaviors at home or at school.
- Children may recognize conflicts that occur because of financial problems. Heightened stress between parents or arguments about money may arise.
- Children may perceive parents as being more irritable toward them.
- Families may need to make changes that directly impact children. Some may have to give up their home and move in with relatives. Children may have to move away from friends and school.
- Children may have to make sacrifices as their family adapts to fewer resources. New toys and clothes may be put on hold. Older children may have to leave a private college to attend a state or community college.
- Families may feel embarrassed by their financial difficulties. Children may feel shame and not know how to share this with anyone.

While the current economic crisis may be challenging for some families, opportunities can be created for positive outcomes. Children and families can learn to appreciate what is most important—their love for each other, good health, and the support of friends and family.

While there are many challenges for children in difficult times, there are also things that we as parents and professionals can do to help.

- Recognize stress in children. This is the first step in helping childred deal with their feelings. Some children develop headaches, stomach aches, or have difficulty sleeping. There may be changes in their appetite. Their grades may fall. Other children may withdraw from activities with their friends. Some may become angry or irritable. Be on the look-out for different behavior that may signal a problem.
- Don't underestimate how stressful this can be for a child. Whether your child is personally affected or knows someone who is, he or she is likely to be worried. Help children share their feelings. Validating children's feelings is a powerful way to help them feel understood.
- Talk with your child in age-appropriate terms. Young children need repeated assurance. School-aged children can understand more complicated information while teens may be interested in discussing issues related to the global economy.

Be aware that children may be reluctant to share their worries for fear it will be an added burden for the parents. Extra time and encouragement may be needed.

- Keep the lines of communication open. If your family is in trouble, sit down with your children and let them know what's going on. It's better they hear it from you. Prepare your child the best you can for any changes that may occur, and include them in the decision-making, if appropriate.
- Reassure children about their safety and well-being. Let them know that while it might be a difficult situation, the adults are handling things.
- Give children tools to deal with their stress. Problem-solve with them around healthy coping. This might include physical activity, talking with friends, or learning relaxation exercises.
- Realize when stress has become problematic enough that professional guidance might be helpful. Mental health professionals can help children and parents talk about issues and strengthen their coping abilities.

While the current economic crisis may be challenging for some families, opportunities can be created for positive outcomes. Children and families can learn to appreciate what is most important—their love for each other, good health, and the support of friends and family.

Parents can be role models in helping children focus more on what they do have and less on what they don't. It's an opportunity for children to learn compassion for friends who may be experiencing difficult times. Hardship can strengthen families and encourage us to care for one another, cherish our relationships, and forge closer bonds.

For more information, call the MGH department of Social Services at 6-2640.

Developing cultural empathy:

the journey from awareness to action in social work

Some speakers start off slow and work up to the important stuff. Not Sheila Thorne, president and CEO of Multicultural Healthcare Marketing Group, this year's guest lecturer at the annual Social Work Month presentation in O'Keeffe Auditorium, Thursday, March 26, 2009. Thorne's tour de force speech was a non-stop cavalcade of insights from the very first sentence. "Unless you're a full-blooded Native American," said Thorne, "you, your parents, and most likely, your ancestors have immigrant blood in your veins."

President and CEO of Multicultural Healthcare Marketing Group, Sheila Thorne, speaks at this year's annual Social Work Month event in O'Keeffe Auditorium.

Thorne, a diversity advocate and activist, shared her thoughts and ideas as well as a wealth of data and statistics in making her point that awareness of diversity issues isn't enough. Action is needed—including the need for underserved populations to get out and vote!

Thorne cautioned listeners about using the word, 'minority' in describing individuals and populations, saying the word has come to have a pejorative connotation. She recommends referring to individuals as African Americans, Latinos, Asians, etc. Or better yet, identify them by their country of origin. And most importantly, don't make assumptions.

According to Thorne, *every* interaction is a cross-cultural interaction, and thereby an opportunity to learn. We live in a 'global village' nowadays, a village whose demographics are 82% persons of color; 8% people whose primary language is English; 60% Asian, and 49% female.

Thorne suggested learning another language, or at least 'the basics' of another language to convey to patients that you're making an effort. Said Thorne, it's a sign of respect when you try to communicate with someone in his or her own language. Not to mention the sense of comfort that's established when someone hears a familiar word or phrase in their native tongue. It's worth the effort.

The over-arching message in Thorne's presentation was that cultural competence is a journey, not a destination. It's a process, not a single learning experience. And it's a strategic *imperative* for healthcare organizations—not an option. Quoting African American comedienne, Jackie 'Moms' Mabley, Thorne reminded us, "If you always do what you always did, you'll always get what you always got."

Thorne urged social workers and all clinicians to move away from the 'old' way of thinking about cultural competence as a technical skill or technique. She advised healthcare practitioners to use their knowledge and communication skills to build on their cultural awareness and move toward cultural sensitivity, cultural safety, and cultural sensibility.

For information about the services offered by social workers at MGH, call 4-0062.

The Norman Knight Visiting Scholar Program

—by Mary Ellin Smith, RN, professional development coordinator

On Tuesday, March 31, 2009, Patient Care Services welcomed Judy Murphy, RN, as this year's Norman Knight visiting scholar. The Knight Visiting Scholar Program, was created to support professional development, creativity, and innovation in clinical practice. Each year, a nationally recognized nurse leader, scientist, or scholar is invited to MGH to share his/her knowledge and expertise through consultations, teaching, mentoring and research.

Judy Murphy, RN, Norman Knight visiting scholar and vice president for Information Services at Aurora Health Care in Milwaukee

Murphy, vice president for Information Services at Aurora Health Care in Milwaukee, oversees all software supporting clinicians and patient care. She has authored more than 20 articles in nursing and information-technology journals and has lectured internationally on systems methodologies, automated clinical documentation and the use of technology to support evidence-based practice.

Murphy met with staff and leadership involved with our acute care documentation project. She applauded the conversion to an automated system saying it will allow patients' stories to be understood more readily. One benefit of automated systems is standardization since there are no longer any hard-copy 'work-arounds.' She spoke about the need to focus not on work flow, but thought flow, the critical thinking, planning, interventions and outcomes essential to patient care.

Murphy discussed evidence-based practice in her visit to the Bigelow 7 Gynecology Unit. She told members of the Evidence-Based Practice Task Force that the key to successfully integrating evidence into practice is the involvement of clinicians from the beginning. She noted that our soon-to-be-implemented acute-care documentation system will allow clinicians to have easy access to evidence-based interventions simply by entering a patient problem or diagnosis.

Murphy met with nurses, pharmacists, and representatives from IS who are working to implement our EMAPPS system.

Her visit ended with the Norman Knight Visiting Scholar Lecture. Gaurdia Banister, RN, executive director of The Institute for Patient Care, thanked Mr. Knight for his generosity and contributions to MGH Nursing before introducing Murphy. Murphy's presentation was entitled, "The Copernican Shift: the Patient as the Center of the Universe." She discussed the many opportunities that exist to use technology to empower patients through on-line scheduling, electronic results-reporting, and health education. She noted that with technological advances, it's important not to lose sight of the patient and the patient's experience as a person. She urged all hospitals to embrace the Planetree model of care, which recognizes the patient as a partner in care and focuses all systems on the efficient, timely, compassionate treatment of patients and families.

Murphy's visit was a great success and especially timely with our implementation of EMAPPS and the roll-out of acute care documentation on the horizon.

Compassion and empathy at the heart of clinical social work

Lisa Lovett, LICSW, clinical social worker

My name is Lisa Lovett, and I have been a social worker on the Ellison 12 Neuroscience Unit for three years. 'Enzo' was a 28-year-old, undocumented immigrant from Central America. I came to know him quite well over the course of many admissions. Enzo had a history of HIV and Progressive Multifocal Leukoencephalopathy (PML), a rare, usually fatal viral disease characterized by progressive damage and inflammation to the white matter of the brain. It occurs almost exclusively in patients with severe immune deficiency. Unfortunately, Enzo's PML caused frequent seizures, so he was often admitted following an increase in seizure activity. Enzo also had what we believe was an undiagnosed developmental delay.

Enzo's frequent seizure activity was due in part to poor medication compliance. During his first few admissions I met with his father and brother and educated them on the importance of medication compliance. I voiced concern that Enzo needed reminders and supervision around his medication regimen.

When Enzo later returned to Ellison 12, his situation had drastically changed. His father had returned to his native country, and he had lost contact with his brother. Enzo had spent the past few months in various shelters. He stayed briefly with an uncle who confirmed he'd allowed Enzo to stay in a 'small, dark room' in his basement for a week or so. For fear of 'catching HIV,' Enzo was not allowed in the common areas of the home. He slept in the basement. Each morning he had to leave the home and was not allowed to return until nightfall.

It was apparent that Enzo needed a structured, supportive environment. Given his undocumented legal status and consequent lack of insurance, I knew this would be a difficult task.

It was apparent that Enzo was in need of a structured, supportive environment. Given his undocumented legal status and consequent lack of insurance, I knew this would be a difficult task.

One challenge was communicating my concerns to the team. Some members of the team thought he should be sent to a shelter. His case manager and I believed Enzo's situation was not typical. His limited cognition placed him at the age level of a child. He couldn't effectively problem-solve, he had limited insight into his illness, and limited understanding of medication-management. He had no money, no source of income, no insurance, and no family support.

I spent time researching appropriate housing options. My interactions with Enzo focused on building a safe, trusting environment for him. Enzo had been abandoned by his family. He had only one friend, Rafael (who lived 20 miles away), and virtually nowhere to direct his feelings. Once Enzo felt comfortable, he started to talk about his family (He had taught himself to speak English). He had endured years of physical

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and verbal abuse. His father had abused him and his mother. Enzo was concerned for his mother's safety. He worried his fathers' return home would lead to more domestic abuse. Enzo desperately wanted to contact his mother. He carried her phone number in a small diary. I tried contacting his mother via Interpreter Services several times to no avail. The person on the other end of the phone would hang up after I introduced myself. Enzo was disappointed, but he seemed to understand why I wasn't able to reach his mother.

Although Enzo sometimes had difficulty expressing himself, he was able to communicate feelings of happiness, sadness, and anger. Thoughts of his mother made him sad, and thoughts of his father made him angry. Simple things such as orange juice, ice cream, and clean clothes made him happy. His nurses made sure Enzo always had access to orange juice and ice cream.

His friend, Rafael, brought him second-hand clothing. This thrilled Enzo as he loved to groom himself and put on clean clothes.

I was well aware that washing a patient's clothes was not part of my job description, but I also knew this simple act would mean a great deal to Enzo. Also, having a routine of washing clothes helped give structure and consistency to Enzo's life. So every few weeks I would help Enzo wash his clothes at the laundromat. He would spend hours folding his laundry and putting his clothes away. In addition to his diary and bible, they were his only possessions.

I had learned Enzo was connected with the Cambridge Health Alliance and PACT. The PACT program is an Adherence Support Program, and Enzo had been assigned a case worker there named Anna. Because Anna realized Enzo didn't have the ability to administer his medications properly, Anna had entered him in a pilot study. The study allowed Anna to follow Enzo's progress as long as he resided in the Boston area. Anna had lost contact with Enzo when he became homeless. She was so relieved to hear he was safe at MGH and started visiting him on a regular basis.

Although PACT could not provide housing for Enzo, they did express a commitment to treat him as long as he resided locally. This was valuable as it allowed me to consider independent housing for Enzo.

One of our HIV social workers suggested contacting the Latin American Health Institute in Boston knowing they had resources for illegal immigrants living with HIV. I contacted them and one of their housing specialists told me it could take months or years before an appropriate match could be found for Enzo. But it was the first glimmer of hope in finding him housing. I made an appointment to meet with the specialist the following week. Enzo and I were going on a field trip.

The day of the appointment, Enzo was excited to leave the hospital for a few hours. After our appointment it started to rain, which gave me an opportunity to witness Enzo's developmental limitations firsthand. He was so thrilled to be outside despite the pouring rain. With childlike abandon, he skipped along the sidewalk then darted into the street. Thankfully, I was able to catch him and guide him back to the sidewalk. I held his hand, and we hailed a cab back to MGH.

Enzo was soon transferred to the North End Nursing Home where I visited him every other week. He was brought back to MGH on two occasions due to seizures. His final seizure brought him to the ED where, unfortunately, he went into cardiac arrest.

Enzo died in the ED. He was 28 years old. His family was devastated to hear of his death. They asked that his body to be sent home but didn't have the means to pay for it. I was instantly aware of feelings of countertransference toward this family. Why had they turned their backs on Enzo when he was alive? I tried to focus on my belief that Enzo would want to return home, especially to his mother. I found a funeral home that would fly Enzo home for a reduced fee, and through a fund-raiser organized by Rafael and Anna, we raised enough money to pay for the flight. Enzo returned home a month after he died.

When I reflect on this case, I'm proud of my work. Enzo required a great number of clinical interventions. I worked closely with him, the inter-disciplinary team, and external professionals. Despite many hardships, Enzo stayed positive and appreciative. His belief in God helped him cope with an extraordinary situation. His story grounds me whenever I'm on the verge of losing sight of the many blessings I have in my own personal and professional life. I will never forget Enzo, and I pray he is now home and at peace.

When I reflect on this case, I'm proud of my work. Enzo required a great number of clinical interventions... Despite many hardships, Enzo stayed positive and appreciative... His story grounds me whenever I'm on the verge of losing sight of the many blessings I have in my own personal and professional life.

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

This narrative is a lesson in the power of advocacy and compassion and the importance of preserving a person's dignity. Lisa believed that with the right support, Enzo could find appropriate housing. In so many ways (doing laundry, trying to contact his mother, visiting him in the nursing home) Lisa helped restore Enzo's personhood. She gave him her time, her interest, and her attention. She protected him. And she made the last months of his life a positive, peaceful time.

Thank-you, Lisa.

Stephanie Macaluso, RN, Excellence in Clinical Practice Award

—by Mary Ellin Smith, RN, professional development coordinator

On Thursday, March 26, 2009, members of the MGH community gathered in O'Keeffe Auditorium to recognize four clinicians whose exemplary practice is caring, innovative, guided by knowledge, built on a spirit of inquiry, and based on a foundation of leadership and entrepreneurial teamwork. This year's recipients of the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award were: Ruth Burrows, RN, of the Bigelow 7 Gynecology Unit; Ann Haywood-Baxter, MDiv, chaplain; Colleen Lowe, OTR/L, occupational therapist; and Jennifer Mello, CCC-SLP, speech-language pathologist.

Macaluso Award recipients (l-r): Ann Haywood-Baxter, MDiv; Jennifer Mello, CCC-SLP; Colleen Lowe, OTR/L; and Ruth Burrows, RN; with director of the Chaplaincy, Michael McElhinny, MDiv, and senior vice president for Patient Care, Jeanette Ives Erickson, RN (right).

In her welcoming remarks, Jeanette Ives Erickson, RN, senior vice president for Patient Care, noted that the Macaluso Award has been a coveted honor by MGH clinicians since its inception because of its focus on excellence in clinical practice. She invited director of the MGH Chaplaincy, Michael McElhinny, MDiv, to share his thoughts on this auspicious occasion.

McElhinny read a fable entitled, *The Greatest Deed*, in which a contest was held to decide which wizard could perform the greatest deed. Each wizard demonstrated miraculous talents such as the ability to speed up time, or change night to day. But the townspeople couldn't decide which wizard performed the greatest deed. So they turned to Jeanette Ives Erickson who, of course, brought her considerable Maine common sense to the deliberations. In the context of the fable, Ives Erickson asserted that, indeed, Stephanie Macaluso had performed the greatest deed because she, "used her talents as part of a team to help others develop into the people and clinicians they were meant to be. Stephanie remained true to her knowledge, her intuitive skills, her ability to coach her peers and teach her patients with empathy. Her caring practice acknowledged our shared humanity and was a gift to her patients."

"That," agreed McElhinny, "is the greatest deed."

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"Stephanie Macaluso remains with us in spirit in the exceptional care delivered by these clinicians and all clinicians who provide first-rate care to our patients."

Introducing each recipient, Ives Erickson read from their letters of nomination. Burrows was nominated by her colleague, Anne Donnelly, RN, who wrote, "The most important part of Ruth's practice is her ability to mentor new nurses. She has become my mentor and the person I go to with my most difficult patient and professional questions. Ruth has helped me form my own thought processes around patient care. She always gave me her full attention when I was a new nurse struggling with how best to care for my patients. Not only did she listen attentively, she gave me more than just a yes or no answer."

Haywood-Baxter was nominated by Patricia O'Malley, MD, director of Pediatric Emergency Services, who wrote, "Ann's example remains an inspiration for me in providing a ministry of presence. I learned from her how to empower families and children by listening, reflecting, wondering with them, and by witnessing her accompany them, even into some of the darkest territories a suffering or dying parent or child might have to penetrate... It takes a certain amount of courage to show up, let alone speak up, as a chaplain on medical rounds. But her patience and courage have paid off richly. Because she shows up regularly and her contributions are so valuable, Ann has become a recognized, respected, and sought-after resource to the medical team."

Lowe was nominated by colleague, Suzanne Curley, OTR/L, who wrote, "Colleen has brought wisdom, caring, knowledge, and passion to our clinic and to all the clients she treats. While her expertise is significant, her most impressive trait is that she constantly seeks to increase her knowledge. Colleen begins to observe patients the moment they enter the clinic to see if they hike their shoulder, put their arm in a protected position, or use their affected arm for daily tasks. She listens to patients to truly understand what their functional difficulties are and why they came to her for help."

Mello was nominated by colleague, Tessa Goldsmith, CCC-SLP, who wrote, "In her quiet, unassuming way, Jenn is a fierce patient advocate. She stops at no barrier in the hierarchy to make sure the patient receives rehabilitation either as an inpatient or outpatient. She is not afraid to raise difficult issues, be they around team dynamics or ethical concerns. I was privileged to know Stephanie Macaluso and I cannot help but be reminded of her gentleness, advocacy, thoughtfulness, and concern as well as her unique clinical expertise—all qualities I see in Jenn."

Recipients spoke of their gratitude to their colleagues who mentored them, their families, and their patients who have taught them so much.

Haywood-Baxter read her narrative chronicling her involvement with a family who struggled to give their infant just the right 'blessing.' McElhinny helped unbundeled the narrative to share lessons learned.

Said Ives Erickson, "Stephanie Macaluso remains with us in spirit in the exceptional care delivered by these clinicians and all clinicians who provide first-rate care to our patients."

For more information about the Macaluso Awards, call Mary Ellin Smith, RN, at 4-5801.


Ives Erickson


Burrows


Haywood-Baxter


Mello


Lowe

National Patient Safety Goals: What patients and families need to know

—by Joan Gallagher, RN; Jane Reardon, RN; and Taryn Pittman, RN,
for the Patient Education Committee

The Joint Commission began issuing National Patient Safety Goals in 2002... Many National Patient Safety Goals include a component of patient- and family-education.

The Joint Commission began issuing National Patient Safety Goals in 2002 to help accredited organizations address specific areas of concern regarding patient safety. Many National Patient Safety Goals include a component of patient- and family-education.

Fall Reduction

This goal states that hospitals must have a fall-reduction program that educates patients and families and includes individualized fall-reduction strategies. MGH nurses have crafted evidence-based assessment tools that include a patient- and family-education component. Many factors impact a patient's risk for falling. Patients with a history of falling often fall again. Patient- and family-education and involvement in care are critical in preventing falls. Well informed patients are more willing to alert staff of their needs. A brochure entitled, *Preventing Falls in the Hospital and at Home*, is available through Standard Register (Item #84157), and a video entitled, *Fall Prevention*, is available on-demand via the patient-education television channel (Video #104).

Organization Identifies Safety Risks

This National Patient Safety Goal applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals. The goal states that hospitals provide information, such as a crisis hotlines, to individuals at risk for suicide. It may not be apparent upon admission that a patient is at risk for suicide. Motor vehicle accidents and drug and alcohol abuse may indicate an underlying risk for suicide in teens and adults. Clinicians are in a position to recognize the risk for suicide. A combination of hopelessness and access to a means to commit suicide, a history of previous suicide attempts, or suicidal thoughts are indications an individual may be at risk. Maintaining a safe environment for those at risk is critical. (National Suicide Prevention Lifeline: 1-800-273-TALK/8255; http://www.suicidepreventionlifeline.org)

Patients Actively Involved in Care

Hospitals are required to identify ways patients and families can report safety concerns and encourage them to do so. This includes educating patients and families on the various methods available for reporting concerns related to care, treatment, and safety. Clinicians should introduce patients and families to resources such as nursing directors; The MGH Office of Patient Advocacy (6-3370); The MGH Center for Quality & Safety (6-9282); and the PCS Office of Quality & Safety (3-0140).

This National Patient Safety Goal includes a requirement that patients and families be educated in infection control, hand hygiene, respiratory hygiene, and isolation precautions as necessary. This information is to be discussed with patients and families upon admis-

continued on next page

National Patient Safety Goals were developed to ensure that patients are cared for in a safe healthcare environment. All clinicians play a role in educating patients and families. We need to integrate these goals into our patient-education practices and plans of care.

sion or as soon as possible thereafter. The patient's understanding of this information must be evaluated and documented. A hand hygiene video is available on-demand via the patient-education television channel (Video #201 in English) (Video #200 in Spanish). Staff should inform patients and families about the importance of hand hygiene, using CalStat, and hand-washing; about respiratory hygiene, including covering their mouths when coughing, disposing of Kleenex tissues, and using respiratory masks if appropriate. Patients on isolation precautions need to be educated about their respective precautions and the protective garments required when entering the room.

For surgical patients, staff must describe the measures we take to prevent adverse events in surgery, such as patient identification practices, infection-prevention practices, and marking the procedure site. The patient's understanding must be evaluated and documented.

Rapid Response

Hospitals are required to develop suitable methods to request assistance from specially trained individual(s) when a patient's condition worsens. This includes educating and encouraging patients and families to seek assistance when there's a change in the patient's condition. MGH has a number of resources in place, including the code team, the airway team (RICU consult), the stroke team, the rapid response team, and others. When calling the Code/STAT number (6-3333) staff should indicate whether they need the adult or pediatric team. Patients and families are encouraged to raise their concerns with the primary nurse. Notices are being placed on patient care units that read: "During your hospital stay, we encourage you to ask questions if there is anything you don't understand about your or your loved one's care. Let staff know if you're concerned about any changes in your or your loved one's condition."

Anticoagulation Management

This goal highlights the importance of providing education about anticoagulation therapy to prescribers, staff, patients, and families emphasizing follow-up care, dose-adjustments, dietary restrictions, and the potential for adverse drug reactions. To help patients understand these safety issues, the user-friendly, *Guide To Taking Warfarin*, is available through Standard Register (item #85474). The booklet outlines correct discharge doses, how current lab values relate to anticoagulation, and when and where their next blood test will take place. The *Guide To Taking Warfarin* includes important information on managing diet, altering lifestyles (if indicated), and the importance of consistency when taking anticoagulation medication. A Warfarin Dosing Calendar (item #85475) accompanies the guide to help patients track their labs and dosages. An array of videos related to anticoagulation are available (Coumadin: video #230; Lovenox: English video #188 and Spanish #189; Fragmin: English video #097 and Spanish #096). Print materials for Lovenox and Fragmin are available in the *Partners Handbook* under Patient Education Information/MGH Discharge Documents/Anticoagulation.

Medication Reconciliation

When a patient is admitted to the hospital, the physician, admitting nurse, and patient create a Pre-Admission Medication List or PAML. This list of medications is constructed from patient reports and electronic sources and is compared to what the patient is currently taking. At discharge, the list is reviewed, adjusted, and explained to patients and their families. Short-term medications, such as antibiotics and post-operative pain medicines should be discussed with the patient and reviewed along with a list of ongoing medications to be used to treat the patient's clinical condition. Reinforcing the rationale for current medication regimens and explaining proper doses and side-effects to patients and families helps ease anxiety and allows patients to participate in their care. Healthcare providers must work as a team to help patients manage their medications at home. An accurate medication list increases a patient's compliance and understanding and reduces hospital admissions from adverse reactions. A tool that can be used to assist patients in learning about their medications is a Medication Schedule, found in the *Partners Handbook* under Patient Education Information/MGH Discharge Documents/Medication Schedules.

National Patient Safety Goals were developed to ensure that patients are cared for in a safe healthcare environment. All clinicians play a role in educating patients and families. We need to integrate these goals into our patient-education practices and plans of care. For more information about any of the National Patient Safety Goals, call the PCS Office of Quality & Safety at 3-0140.

The Orren Carrere Fox Award

—by Mary Ellin Smith, RN, professional development coordinator

If you had walked into the Newborn Intensive Care Unit (NICU) on March 26, 2009, you would've had a hard time picking out the NICU graduate in the standing-room only crowd of family, friends, and clinicians. Because today, Orren Fox is a tall, good-looking, award-winning photographer, chicken farmer, and exemplary student—a far cry from the fragile newborn who came to the NICU 12 years ago.

(Photo by Paul Batista)

Award recipient, Cheryl Slater, RN (second from right), with Orren Fox (third from left), nursing director, Peggy Settle, RN (center back), and members of the Fox and Slater families.

Orren's parents, Henry and Libby Fox, established the Orren Carrere Fox Award for Newborn Intensive Care Unit Caregivers to recognize a NICU caregiver who provides the highest caliber, family-centered care. This year's recipient was staff nurse, Cheryl Slater, RN. In presenting the award to Slater, nursing director, Peggy Settle, RN, said, "Thanks to the generosity of the Fox family, this award brings awareness of the important work we do in the NICU and our unwavering commitment to providing family-centered care. The consistently high number of nominations we receive each year shows that staff recognize and celebrate those attributes in one another." Settle spoke of Slater's ability to inspire parents to have the confidence they need to care for their child and to create the time and space for that care to occur.

Slater thanked the Fox family, her own family, and her colleagues for their support, saying it was a privilege to work in a unit so committed to family-centered care.

On behalf of the Fox family, Henry Fox spoke of their love for Orren and their pride in his many accomplishments. He expressed gratitude for the care they received when Orren was a patient, saying, "Not a day goes by that we don't think about all of you."

For more information about the Orren Carrere Fox Award for Newborn Intensive Care Unit Caregivers, call Mary Ellin Smith, RN, at 4-5801.

Fall reduction: it's everyone's responsibility

Question: The Joint Commission made fall-reduction a National Patient Safety Goal for 2009. What are we doing at MGH to reduce patient falls?

Jeanette: At MGH, we have a comprehensive Fall Reduction Plan that includes assessing each patient's risk for falling and immediately implementing interventions to minimize that risk. The plan focuses on each patient and the environmental factors that need to be in place to prevent falls. The Fall Reduction Plan includes staff- and patient-education. We must monitor falls closely and learn from every incident in order to prevent falls from occurring in the future.

Question: We use the Morse Falls Scale (MFS) in our risk assessment. Why did we choose this tool?

Jeanette: Janice Morse's assessment tool has been in use longer than any other falls scale. The MFS has proven reliable and valid in identifying patients at risk for falling. It was created to guide nurses in rating a patient's fall risk using measureable subscales. The tool enables nurses to consistently agree on a fall-risk assessment and develop an appropriate plan for each patient.

Question: Is keeping the patient safe from falls solely the nurse's responsibility?

Jeanette: Absolutely not. A team approach is essential in reducing patient falls. Consideration must be given to the patient's medication regimen, cognitive and physical abilities, cleanliness of the environment, and the patient's ability to travel safely off the unit for tests. So, physicians, pharmacists, therapists, transporters, support staff, and clinicians from all disciplines play a part in keeping patients safe.

Question: I completed my patient's Morse Fall Scale assessment and found she had no identified fall risks. Is that all I have to do?

Jeanette: No. All patients are at some degree of risk for falling even if they have no identified fall risks on the MFS. You should implement Universal Interventions for Fall Prevention for these patients, which includes orienting them to the room, inspecting each room for hazards that could lead to falling, explaining how to call for assistance, and educating the patient and family to the risk of patients falling while hospitalized. (See The Patient at Risk to Fall Problem List at http://intranet.massgeneral.org/pcs/Outcome.asp.)

Question: I had a patient who felt weak while ambulating with assistance. He needed to be assisted to the floor. Is that considered a fall?

Jeanette: Yes. We would ask that you report that using our on-line Safety Reporting system. A fall is defined (by the National Database of Nursing Quality indicators) as any un-planned descent to the floor, with or without injury, during the course of hospitalization.

Question: What's next in our efforts to reduce patient falls?

Jeanette: We are increasing our focus on patient- and staff-education, as well as creating a communication strategy to heighten awareness for patients at risk for falling. For more information, call the PCS Office of Quality & Safety at 3-0140.

Announcements

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.

Games for Health Conference

Registration now open for the 2009 Games for Health Conference

June 11–12, 2009
Hyatt Harborside Hotel

Event will include more than 40 sessions covering a wide range of 'exergaming' and health games, including health training and disease-management. Pre-conference sessions held on June 10th will focus on individuals with physical disabilities and virtual worlds in health games. Conference will provide exhibition areas and opportunities to network.

Games and game technologies that emerge from Games for Health Conference help individuals achieve better health outcomes, empower patients to manage chronic diseases, and hone the skills of providers to deliver better care. The Games for Health 2009 conference is hosted in partnership with the Robert Wood Johnson Foundation's Pioneer Portfolio.

For more information visit: www.gamesforhealth.org.

Elder care discussion group

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

Next session:
May 12, 2009
12:00–1:00pm
Yawkey 7-980

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

Save the Date

Boston Health & Fitness Expo

Partners HealthCare and Channel 7 NBC/CW present the third annual Boston Health & Fitness Expo

June 27 and 28, 2009
10:00am–5:00pm
Hynes Convention Center

More than 70,000 adults and children are expected to attend the Expo, which is free to the public.

For more information, visit: www.bostonhealthexpo.com.

Support Service Employee Grant

Applications available

Looking for financial assistance as you pursue your academic goals? Applications for the Support Service Employee Grant are now available. The grant is open to eligible, non-exempt employees in clinical, technical, service, and clerical positions.

Applications are due by June 12, 2009. For more information, go to: http://is.partners.org/hr/New_Web/mgh/mgh_training.htm, or call 4-3368.

Sponsored by MGH Training & Workforce Development

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.

2009 MGH College Fair

Employees are invited to attend the 2009 MGH College Fair

April 29, 2009
12:00 – 3:30pm
under the Bulfinch tent

Fair will provide one-stop shopping to explore healthcare professions and administrative tracks in healthcare administration, policy, and business-management. Come and compare undergraduate, graduate, and certificate offerings.

A number of local colleges and universities will be represented

Sponsored by the MGH Office of Training & Workforce Development. For more information, e-mail: mghtraining@partners.org, call 4-3368, or visit: http://is.partners.org/hr/new_web/mgh/mgh_training.htm.

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

Next Publication
May 7, 2009

Educational Offerings – 2009

April 15

Simulated Bedside Emergencies for New Nurses

POB 419
7:00am–2:30pm
Contact hours: TBA

April 15

Congenital Heart Disease

Haber Conference Room
7:30am–12:30pm
Contact hours: TBA

April 17

PCA Educational Series

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

April 21

Intermediate Arrhythmia

Simches Conference Room 3-120
8:00–11:30am
Contact hours: 3.5

April 21

Pacing Concepts

Simches Conference Room 3-120
12:15–4:30pm
Contact hours: 3.75

April 23

Preceptor Development: Learning to Teach, Teaching to Learn

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

April 23

Nursing Grand Rounds

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

April 27

Boston ICU Consortium Core Curriculum: Day 1

VABHCS
7:30am–4:30pm
Contact hours: TBA

April 28

BLS/CPR Re-Certification

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

April 29

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
7:00–11:00am
Contact hours: TBA

April 30

Management of Patients with Complex Renal Dysfunction

Founders 311
8:00am–3:30pm
Contact hours: TBA

May 4

CPR Mannequin Demonstration

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

May 4 & 18

ACLS Provider Course

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

May 4, 12, 14, 15 & 22

Boston ICU Consortium Core Curriculum: Days 2–6

VABHCS
7:30am–4:30pm
Contact hours: TBA

May 5

BLS/CPR Certification for Healthcare Providers

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

May 5

Pediatric Simulation Program

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

May 5 & 6

Intra-Aortic Balloon Pump

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

May 11

BLS/CPR Re-Certification

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

May 12

Chaplaincy Grand Rounds

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

May 13

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
7:00–11:00am
Contact hours: TBA

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

Nurse Recognition Week

May 3–8, 2009

Sunday, May 3, 2009
7:00–9:00am, Trustees Room
Staff Nurse Breakfast

Monday, May 4, 2009
7:30–8:30am, O'Keeffe Auditorium
"The Wisdom of Experience," presented by Barbara Mackoff, psychologist and author of *Nurse Manager Engagement* and *The Inner Work of Leaders*

10:00–11:00am, O'Keeffe Auditorium
"The Effect of Therapeutic Touch on Bio-Behavioral Stress Markers in Vascular Surgical Patients," presented by Amanda Coakley, RN, principal investigator, and Ellen Mahoney, RN, mentor

1:30–2:30pm, O'Keeffe Auditorium
"The Wisdom of Experience" (repeated session; see above)

4:00–5:00pm, O'Keeffe Auditorium
"Patients' Perceptions of Feeling Known by their Nurses," presented by Jackie Somerville, RN, associate chief nurse

Tuesday, May 5, 2009
10:00–11:00am, O'Keeffe Auditorium
"The Effects of a Music Intervention on Patients Undergoing Cerebral Angiography for the First Time: a Pilot Study," presented by Teresa L. Vanderboom, RN, principal investigator, and Patricia Arcari, RN, mentor

2:00–3:00pm, O'Keeffe Auditorium
"The Institute for Patient Care: the Critical Link to Transforming Patient Care," presented by Gaurdia Banister, RN, executive director, The Institute for Patient Care, in conjunction with the Institute team

Open House immediately following on Founders 3

Wednesday, May 6, 2009 (Research Day)
10:00am–12:00pm, O'Keeffe Auditorium Lobby
Interactive Nursing Research Poster Display

1:30–3:00pm, O'Keeffe Auditorium
15th Annual Yvonne L. Munn Nursing Research Lecture followed by presentation of the 2009 Yvonne L. Munn Nursing Research Awards

"Pursuit of Quality," presented by Linda Aiken, RN, Claire M. Fagin leadership professor in Nursing, and director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing

Afternoon tea immediately following in the Trustees Room

Thursday, May 7, 2009
7:00–9:00am, Trustees Room
Staff Nurse Breakfast

1:30–2:30pm, O'Keeffe Auditorium
Chief Nurse Address, presented by Jeanette Ives Erickson, RN, chief nurse

Reception immediately following in O'Keeffe Auditorium Lobby

Friday, May 8, 2009
10:00–11:00am, O'Keeffe Auditorium
"Making the 'Authentic Connection' in Service," facilitated by Vanessa McClinchy, of ZYM Consulting
A thought-provoking interactive session exploring strategies for building healing, collaborative, culturally-sensitive relationships with patients, families and colleagues

Caring Headlines
April 23, 2009

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