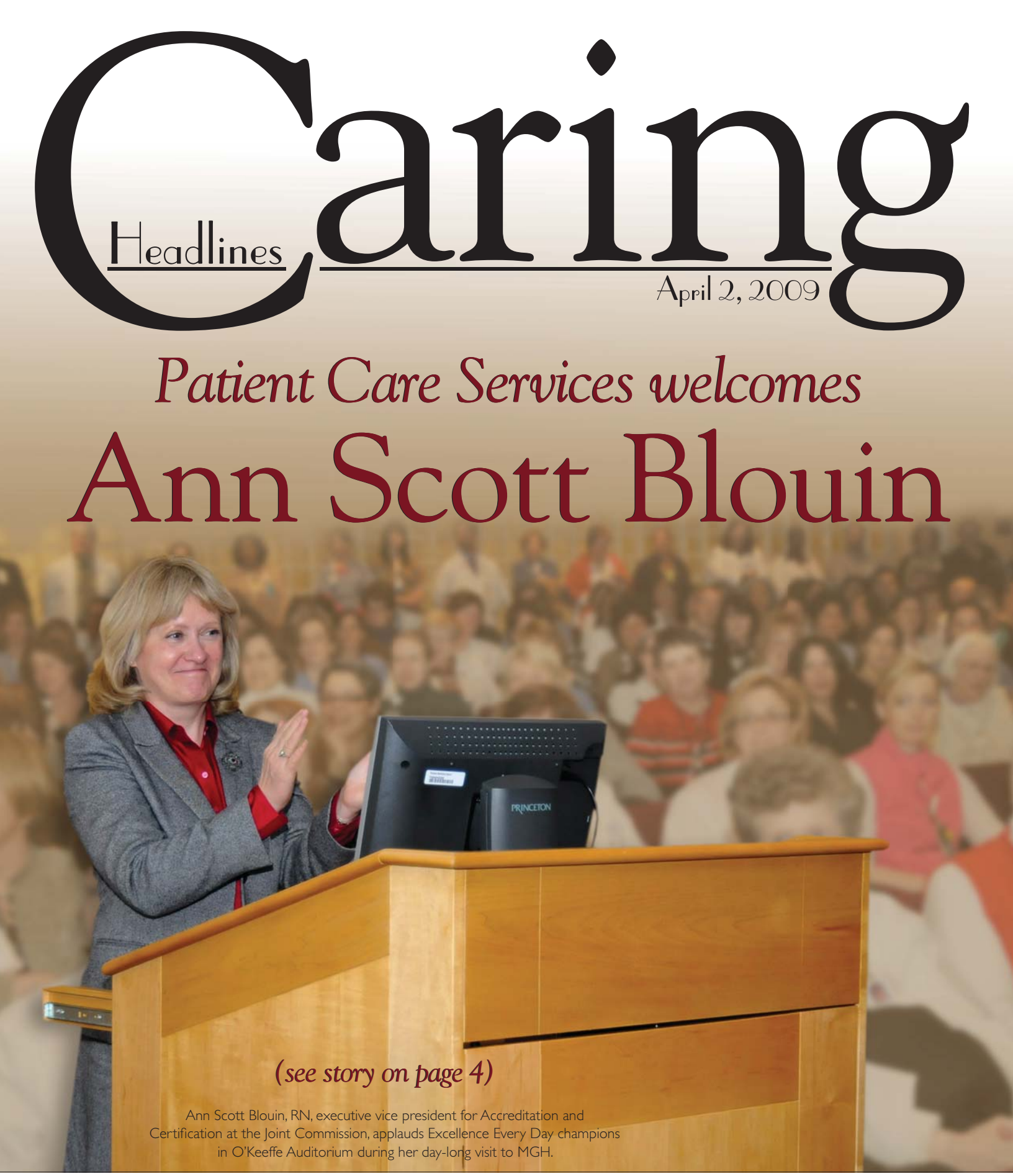
Caring Headlines
April 2, 2009

Patient Care Services welcomes
Ann Scott Blouin



(see story on page 4)

Ann Scott Blouin, RN, executive vice president for Accreditation and Certification at the Joint Commission, applauds Excellence Every Day champions in O'Keeffe Auditorium during her day-long visit to MGH.

The newsletter for **Patient Care Services**
Massachusetts General Hospital

Jeanette Ives Erickson

Universal Protocol

ensuring universal safety for patients undergoing invasive procedures

At MGH, our Universal Protocol Policy is comprised of a number of strategies to be employed before any patient undergoes any invasive procedure or surgery in any setting.

Underlying all the Joint Commission standards and National Patient Safety Goals is the same truth that guides the actions of all caregivers—provide the kind of care you would want for yourself or your loved ones if they were hospitalized. And nowhere is this more apparent than the Joint Commission's standard related to the Universal Protocol. Since July of 2004, Universal Protocol, calling for the prevention of wrong-site, wrong-procedure, wrong-person surgeries, has been a requirement for all Joint Commission-accredited organizations.

At MGH, our Universal Protocol Policy is comprised of a number of strategies to be employed before any patient undergoes any invasive procedure or surgery in any setting. The three major components of the Universal Protocol include:

- Pre-Procedure Verification: making sure you have the correct patient, for the correct procedure, on the correct side, and the correct site, and that any special equipment that may be needed is available and any patient needs are met
- Site Marking: making sure procedure sites are marked with the word, "Yes," prior to the start of the procedure
- A Hard-Stop Time-Out: the entire team pauses prior to starting the procedure to actively confirm correct patient, correct procedure, correct side, and correct site

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

For procedures performed in locations other than the operating room (for instance, at the bedside or in designated procedure areas), the Pre-Procedure Verification process must still be followed. Specific elements of the process may vary depending on the location and the specific procedure being performed.

If staff have questions about whether or when Universal Protocol is required, the following guidelines may be helpful. Universal Protocol is required:

- for any procedure that requires informed consent to be obtained
- for any procedure that exposes the patient to more that minimal risk
- for any invasive procedure involving the 'puncture or incision of the skin, insertion of an instrument, or insertion of foreign material into the body.' (This is the Joint Commission's definition.)

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As with all policies and procedures, questions arise. For more information about Universal Protocol or any of the National Patient Safety Goals, call the PCS Office of Quality & Safety at 3-0140.

In cases of minor procedures that pose minimal risk to the patient, Universal Protocol is not required. For example, the drainage of a cyst discovered during an office visit would not require Universal Protocol. Similarly, Universal Protocol would not be required for:

- venipuncture
- peripheral intravenous line-insertion
- insertion of a naso-gastric tube
- insertion of a urinary bladder catheter
- closed reduction procedures
- dialysis (except for insertion of dialysis catheter)

And of course, every element of Universal Protocol should be documented in the patient's record.

As with all policies and procedures, questions arise. I asked Ruth Bryan, RN, staff specialist in the MGH Center for Quality & Safety, to identify some of the most commonly asked questions about Universal Protocol. I'd like to share some of those with you.

Question: For a bedside procedure such as a PICC-line insertion, what is required by the IV nurse during the Pre-Procedure Verification process?
Answer: The IV nurse should accurately match the correct patient to the correct procedure at the correct site then validate the physician's order for a PICC line. The IV nurse should check labs related to the procedure and confirm that an ultrasound machine is available if needed.

Question: Who is responsible for marking the site?
Answer: The provider directly involved in the procedure is responsible for marking the site. It can be a nurse practitioner, a physician's assistant, the attending physician, or a resident credentialed to perform the procedure.

Question: What if a patient refuses to have the site marked?
Answer: In the event that a patient refuses site marking, an alternate, two-person verification process should be used including a review of documentation that identifies the correct site and confirmation by the provider performing the procedure.

Question: When is the Hard-Stop Time-Out performed?
Answer: The Hard-Stop Time-Out is initiated by the provider performing the procedure after the patient is prepped and draped but before the procedure starts. It should include verbal interaction from the entire team.

Question: If the patient is having two procedures, are two Time-Outs required?
Answer: When two or more procedures are performed on the same patient by separate procedure teams, a Time-Out must be performed before each procedure. (For example a mastectomy followed by re-constructive surgery would require two Time-Outs.)

Question: Is Universal Protocol necessary in emergent situations?
Answer: Universal Protocol is expected in all clinical settings, however, in the event of a patient who is profoundly medically unstable, clinical intervention should be the primary focus and Universal Protocol is not expected.

For more information about Universal Protocol or any of the National Patient Safety Goals, call the PCS Office of Quality & Safety at 3-0140.

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Patient Care Services welcomes Ann Scott Blouin

—submitted by the PCS Office of Quality & Safety

On Tuesday, March 10, 2009, MGH welcomed Ann Scott Blouin, RN, executive vice president for Accreditation and Certification at the Joint Commission. In her role as executive vice president, Blouin oversees the accreditation and certification programs for more than 15,000 healthcare organizations. She is responsible for interpreting standards, managing surveyors, and developing and refining the process for performance reviews. Blouin spent a full day at MGH meeting with staff and leadership throughout the organization.

During her visit, Blouin met with several teams from Patient Care Services, the Quality Oversight Committee, the MGH Operations Team and leaders from other departments throughout the hospital. At every opportunity, dialogue centered around the 'new vision' of the Joint Commission to partner with healthcare organizations to transform health care into a high-reliability industry with safety processes comparable to air travel. Blouin listed the characteristics of a high-reliability organization as:

- continually operating under difficult, unpredictable circumstances, but having fewer than typically expected problems

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Below left: Director of PCS Office of Quality & Safety, Keith Perleberg, RN, offers welcoming remarks. **Below center:** Excellence Every Day champion, Jessica Ranford, OTR/L, occupational therapist, presents her work. **Below right:** staff specialist, John Murphy, RN, helps Excellence Every Day champion, Claire Paras, RN, display her National Patient Safety Goals 'Jeopardy' game board.

- doing the 'right things right' more consistently than expected
- avoiding harm to human beings
- using a series of defense mechanisms or 'checks and balances' to constantly anticipate what might happen, evaluate when something hasn't happened that should have, or imagine the 'unthinkable'

Noting that the three imperatives of a safety culture are trust; the willingness and ability to report safety issues; and having an effective process for translating reported issues into system improvements, Blouin explained that the most common barriers to high-reliability organization include:

- current improvement methods are excessively dependent on vigilance and hard work
- current practice of benchmarking to limited outcomes in health care give clinicians and leaders a false sense of process reliability
- permissive attitude toward clinical autonomy allows for wide and unjustifiable performance variation
- processes are rarely designed to meet specific, articulated reliability goals

According to Blouin's philosophy, a 'little better' isn't enough when it comes to creating a culture of safety. Our goal must be to achieve major, sustainable improvements that we can document and replicate for widespread improvement throughout the organization.

A highlight of Blouin's visit was her interactive session with Excellence Every Day champions in a standing-room-only O'Keeffe Auditorium. Excellence Every Day champions shared examples of their work in disseminating information about National Patient Safety Goals and garnering shared accountability for quality and safety on their units.

Excellence Every Day champions who presented their work were:

- Claire Paras, RN, Phillips House 22
- Abby MacDonald, LICSW, Social Services
- Marie Guerrier, RN, Ellison 12
- Joanne Parhiala, RN, Blake 11
- Jessica Ranford, OTR/L, Occupational Therapy
- Colleen Watters, RN, Ellison 11
- Renee Boudrow, RN, Ellison 11

Each champion had an opportunity to ask Blouin a question, many of which focused on communication and best practices related to sharing information. Blouin answered each question and reinforced her message that the Joint Commission is committed to building alliances with hospitals to advance the cause of safe patient care. Moving forward, the Joint Commission hopes to:

- achieve world-wide convergence on healthcare quality and safety issues
- strike a balance between the evaluative and regulatory functions with increased focus on coaching, teaching, and mentoring functions
- harness global investment to produce generalizable, durable solutions
- spread highly effective interventions throughout the delivery system
- assess institutions for their robust process-improvement activities

Below left: Excellence Every Day champion, Marie Guerrier, RN, displays poster **Below right:** Champions who presented their work (l-r): Claire Paras, RN, Phillips House 22; Jessica Ranford, OTR/L, Occupational Therapy; Joanne Parhiala, RN, Blake 11; Renee Boudrow, RN, Ellison 11; Colleen Watters, RN, Ellison 11; Abby MacDonald, LICSW, Social Services; and Marie Guerrier, RN, Ellison 12.

Future Eagle Scout contributes time and ingenuity to Neuro ICU

Not every boy who joins the Boy Scouts attains the rank of Eagle Scout. Only about 5% of all Boy Scouts go on to become an Eagle Scout, the highest rank in Scouting. To do so, scouts must fulfill certain requirements in the areas of leadership, service, and outdoor skills. That's what Tom Murphy hopes to achieve with his project geared toward helping patients in the Neuroscience Intensive Care Unit.

When Murphy first set foot inside the Neuro ICU, he had no idea that some patients weren't able to speak because of their medical conditions. When he learned clinical nurse specialist, Mary Guanci, RN, wanted to create a tool to help those patients communicate, Murphy was immediately interested. As a member of Boy Scout Troop 2 and a senior at Weymouth High School, Murphy had been looking for the right project to help fulfill his requirement to become an Eagle Scout. Murphy welcomed the opportunity to challenge his leadership and move outside his comfort zone.

Future Eagle Scout, Tom Murphy, presents clinical nurse specialist, Mary Guanci, RN (third from right), with communication board he created to fulfill his Eagle Scout requirement. Associate chief nurse, Jackie Somerville, RN (center), and staff of the Neuro ICU join in the festivities.

Murphy met with Guanci to educate himself on how the tool would work. Guanci envisioned a transparent board on which letters of the alphabet and icons indicating simple requests could be viewed from both sides. When held up between a patient and a caregiver, the patient can focus on a certain letter or icon to communicate his request. Once Murphy had an understanding of what the board would look like, he was ready to get started. To raise money to fund the project, Murphy enlisted the aid of his fellow scouts who helped him rake leaves and do yard work. With the money they earned, they hired a graphic designer who created a number of preliminary designs, and after a series of revisions, Guanci approved a final design.

With the help of troop leaders and his fellow scouts, Murphy secured the appropriate printing and glass-cutting services. It was important to find just the right material, something that was transparent but wouldn't break or crack if dropped. When he delivered the finished communication boards to the Neuroscience ICU, it was the culmination of a six-month journey. Said Guanci, "Tom exceeded all my expectations. The communication boards he made are sturdy, durable, light-weight, and easy to handle. I know they'll make a huge difference for patients who aren't able to communicate verbally."

Patient Safety Awareness Week: "Speak up for Patient Safety"

—submitted by the PCS Office of Quality & Safety

National Patient Safety Awareness Week, March 8–14, 2009, is a national campaign to improve patient safety through education and awareness. Sponsored by the National Patient Safety Foundation, Patient Safety Awareness Week is an effort to involve patients in their own care while building partnerships between patients, their caregivers, and the healthcare community. The theme of Patient Safety Awareness Week at MGH is, "Speak Up for Patient Safety." We want to encourage patients and families to speak up when they have questions or concerns about their care.

Staffing the educational booth in the Main Corridor are quality and safety representatives (l-r): Millie LeBlanc, RN, staff specialist (center); Linda Akuamoah-Boateng, senior project specialist; and Honor Keegan, RN, staff specialist.

During Patient Safety Awareness Week, the MGH Center for Quality & Safety sponsored information tables in the Main Corridor. Educational materials from the National Patient Safety Foundation and the Blum Patient & Family Learning Center were available. Along with staff from the MGH Center for Quality & Safety, staff from the PCS Office of Quality & Safety and co-chairs of the PCS Quality Committee were on hand to answer questions for patients, staff, and visitors.

The theme, "Speak up for Patient Safety," mirrors the message of our Excellence Every Day campaign to promote understanding of the National Patient Safety Goals at the unit level. National Patient Safety Goal #13 encourages hospitals to involve patients in their care. Materials available during Patient Safety Awareness Week offered guidance to patients on how to ask questions during visits to the hospital, how to document their medications, and how to avoid falling when hospitalized. One visitor commented on the value of the brochure, *Ask Me 3*, which outlines the three most important questions patients should ask when they visit their doctor, nurse, or pharmacist.

One physician commented, "I wish all my patients had these materials and knew how to prepare for an office visit. It would give us more time to talk about the real questions patients have about their health."

Staff who visited the table had an opportunity to play Patient Safety Jeopardy, a fun way to test their knowledge of National Patient Safety Goals.

Patient Safety Awareness Week materials are available in the Blum Patient & Family Learning Center or by contacting Taryn Pittman, RN, patient education specialist, at 4-3822; or Millie LeBlanc, patient safety staff specialist, at 6-8031.

Every patient, every relationship, an opportunity to teach and learn

My name is Lorraine Drapek, I'm a staff nurse in Radiation Oncology. 'Aasha' is a 23-year-old patient, originally from Somalia, who had been diagnosed with rectal cancer. Aasha was going to be receiving radiation to her pelvis and continuous chemotherapy. Many challenges accompany this treatment regimen. Aasha would need an implanted port for continuous chemotherapy and blood draws. She would likely develop diarrhea, vaginal dryness, nausea, decreased appetite, and fatigue. But I soon learned that Aasha did not want to discuss treatment or side-effects.

Aasha told me she was concerned about having more children. She already had two young sons, and her culture valued children. She wanted to be able to get pregnant again. I explained that radiation would affect her pelvis, ovaries, uterus, and vagina, and it would be dangerous for her and the baby to become pregnant at this time. Even if she didn't miscarry, the baby could have severe birth defects or die. Aasha asked if she'd be able to become pregnant after she completed her treatment. I explained there was a good chance she'd no longer be able to have children after radiation treatment.

While reviewing patient information with her, I discovered that Aasha couldn't read. She had memorized all her appointment times. She had declined written teaching materials saying she didn't want her children to see them. When I asked about her next appointment, she couldn't answer. She admitted she'd had very little formal education and couldn't read.

I decided to try to learn more about Somalia. According to Wikipedia (http://en.wikipedia.org/wiki/Somalia) Somalia has been in a state of civil war for more than ten years. Women are often abused and play a subservient role. As many as 97% of Somali women undergo female circumcision, usually before the age of 5. Women aren't allowed to attend school. Marriages are usually arranged, and the strongest cultural values are the Muslim religion and family.

Lorraine Drapek, RN, staff nurse,
Radiation Oncology

I asked Aasha if she had been circumcised. She said she'd been circumcised as a child but didn't want to discuss it. I asked about her education and understanding of English to determine her ability to understand her disease and treatment. She had never been to school in Somalia and couldn't read or write in her native language. Her family had fled the country when she was in her early teens. Her parents had arranged for her to be married when she was 15. That's when she and her husband came to the United States.

Aasha attended school for a brief time in the United States. She felt she had a good understanding of English and consistently declined a Somali interpreter. Aasha did speak English fairly well. She would tell me that she understood our discussions but tended to hide it if she didn't understand something. She pretended to read better than she was actually able.

Aasha is a tall and striking woman. She follows the Muslim tradition of wearing long skirts, long sleeves, and a head covering. She cares very much about her appearance and likes to have coordinated

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accessories. She often spoke on her cell phone. In some ways, she reminded me of my own daughter. She was very concerned about losing her hair. This was one area where I could reassure her. The chemotherapy she was receiving (for more than five weeks) caused limited hair thinning. It was infused through an implanted port. I came up with several ways to keep the pump from being noticed by anyone other than Aasha. I arranged for only female radiotherapists to work with her as there were cultural taboos about being undressed in front of men.

I met with Aasha daily at first, then two or three times a week for the remainder of her treatment. We talked about potential side-effects, and I emphasized the importance of completing the full course of treatment. Aasha expressed fear at having surgery and a colostomy and continued to express concerns about fertility. She would probably require a permanent colostomy as a result of her tumor.

She found this possibility overwhelming. I offered to find someone with a colostomy to speak with Aasha. I offered to have the stoma nurse see her. She declined these interventions. She didn't want to know and would wait until surgery.

As time went on, Aasha became less concerned with fertility and more concerned that she might die as a result of her cancer. I reminded her she had two children who needed their mother. She declined a visit from an MGH chaplain, saying she could talk to someone at her mosque. She would become tearful but didn't want to see a psychiatrist. I was the person she chose to talk to about her fears. I listened and reassured her that she was doing well. When she spoke about discontinuing treatment, I reminded her that her family needed her and helped her see that this was her best chance of being cured. As time went by, she became more positive.

Aasha didn't have family in the area. Her husband drove a truck and was on the road a lot. His mother stayed with Aasha to assist with child care.

In time, Aasha came to understand the importance of taking care of herself during treatment. She developed pain in the area of her tumor but it was easily managed with medication. As she got closer to completing radiation, and surgery loomed, she became more anxious. Though we talked about her surgery, Aasha stayed awake nights afraid of what would happen if her cancer couldn't be cured. Sleep medication helped. And again, she refused to speak to a psychiatrist or social worker. She had suffered in a country torn apart by war. Her coping skills involved leaving the past behind and moving ahead.

Aasha completed her treatment without significant side-effects. The day she finished, she gave me a big hug. This meant a lot to me as Aasha had boundaries and didn't allow unnecessary touching. I called Aasha a few weeks before her surgery to check on her. She had recovered well and was ready for surgery.

Aasha did require a permanent colostomy. I visited her after her surgery. She was disappointed but not surprised. She was just glad the surgery was over and the "cancer was out."

When I first met Aasha, I doubted she'd be able to comply with her chemo/radiation treatment. Her oncologist had selected a regimen that involved continuous IV chemotherapy throughout her radiation treatment believing it would help Aasha be compliant. I believe if Aasha hadn't wanted to comply with treatment, she wouldn't have let a chemotherapy pump stand in her way.

At one point, she was going to discontinue treatment because she believed the tumor could be removed the same way a hemorrhoid is removed. I explained the importance of completing treatment, finally explaining that if she didn't complete treatment there was a very real possibility she could die. It was the only time I ever saw her cry. After that, she never spoke of stopping treatment again.

I learned as much from Aasha as she learned from me. Though we were very different in culture and age, the language of trust between us helped us on this journey. And the language of parenthood helped us find common ground. Being a mother was what mattered most to Aasha.

I've always thought of myself as a good communicator. But I realize there are always new ways to grow, learn, and be creative in communicating effectively. Learning about the Muslim and Somali culture was a valuable experience. Though I had read about the war in Somalia and child soldiers, I hadn't fully understood the coping skills of someone who has lived through such a horrific experience. Aasha's inner strength was evident throughout her course of chemo/radiation. It taught me a great deal about the human spirit and the ability to survive.

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

What a lovely story of nursing presence and culturally competent care. Two people from very different cultures. Lorraine listened to Aasha. Got to know her. Took it upon herself to learn more about Aasha's country of origin. Found out what was important to Aasha as a person, as a woman, as a mother. Lorraine acknowledged the challenges Aasha had had to overcome in her young life—war, circumcision, emigration, and a devastating cancer diagnosis. Lorraine became a constant, reliable presence for Aasha throughout her treatment regimen, someone she could trust, someone to guide and support her through her rigorous treatment. Wouldn't everyone like to have their own personal Lorraine!

Thank-you, Lorraine.

One step closer to EMAPPS

Tuesday, March 17, 2009, was an historic day at MGH. White 6 and Blake 13 became the first units to convert to the new Electronic Medication Administration Record (eMAR), one part of the larger Electronic Medication Administration Process for Patient Safety (EMAPPS). Nurses on these two units now confirm the 'five rights' of medication administration with scanning technology that matches bar-coded medications with bar-coded patient wristbands. This initiative is intended to help prevent medication-related adverse events by linking the electronic systems clinicians use to order, dispense, and administer medications. EMAPPS will be implemented in two phases, from March 17th through July 5, 2009, and from mid-summer through November, 2009. To help facilitate the transition, specially trained coaches are available 24 hours a day, seven days a week for the first two weeks of implementation. These coaches, members of Nursing and Information Systems, have received intensive training in EMAPPS and will be available to answer questions as clinicians transition to the new system.

Patients may have questions about EMAPPS, too. A pamphlet has been created to help educate patients and families about this new system. The pamphlet will be distributed on inpatient units prior to implementation. EMAPPS coaches are available to help staff address any issues that may arise.

For more information about EMAPPS, contact Rosemary O'Malley, RN, at 6-9663.

Above left: EMAPPS coaches (l-r): Meaghan Devlin, RN; Marjorie Noone, RN; Patricia Meyer, RN; and Stefanie Michael, RN.
Above right: EMAPPS coach, Ellen Kinnealey, RN (right), works with staff nurse, Wendylee Baer, RN, to scan medication.
At right: Baer scans patient, Catherine Barrett's, wristband to ensure she is receiving the correct medication.

MGH mourns the loss of veteran nurse, Miriam 'Mim' Huggard

The MGH community was saddened to learn of the passing of Miriam 'Mim' Huggard, RN, who died March 10, 2009, at the age of 99. Huggard graduated from the MGH School of Nursing in 1931, was a staff nurse in the Baker Building for 11 years until she became supervisor of the Phillips House Nursing Service. She became director of the service in 1965 and served in that role until she retired in 1976.

(Photo provided by staff)

Above: Gino Chisari, RN, director of The Norman Knight Nursing Center for Clinical & Professional Development, points to 'Mim' Huggard in picture of the 1931 graduating class of the MGH School of Nursing, currently hanging in the Alumnae Conference Room on Founders 3

Below: Huggard (second from right) is pictured with fellow alumnae (l-r): Linda Lass-Orrell, RN; Carolyn Thayer, RN; and Mary Caira, RN.

Huggard was an active member of the MGH Nurses' Alumnae Association for many decades. She lived on Beacon Hill, within walking distance of the hospital. Even after she retired, she continued to volunteer in the MGH Flower Shop and in the Alumnae Office. The Alumnae Association presented her with an Unsung Hero Award, and at its 125th anniversary celebration she was given the Alumnae Association Achievement Award for excellence, innovation, and dedication to the practice of nursing.

At age 95, Huggard was featured in a *New York Times* article entitled, "These Days, 'Retirement Living' Can Mean Many Things." The piece described her participation in a virtual retirement community that provides services to older residents living in their own homes.

The Board of the MGH Nurses' Alumnae Association has establish a scholarship in Huggard's honor. The scholarship will be given each year to a student in the BSN program at the MGH Institute of Health Professions School of Nursing to cover the cost of his/her final semester. One criteria for the scholarship will be prior employment at MGH because MGH was such an important part of Huggard's life. Final criteria are being developed.

Said Barbara Dunderdale, RN, long-time friend and former colleague of Huggard, "It is an extraordinary joy when you meet an individual whose core values are palpable in her daily work and personal life. Such a woman was the beloved Mim Huggard. She was a committed nurse devoted to her patients and a committed leader dedicated to her nurses. Throughout her career, Mim exemplified all that embodies nursing. As a teacher and mentor she passed on a legacy to countless MGH nurses who hold her in the highest regard to this day. I'm sure I speak for the entire MGH Nurses' Alumnae Association in paying tribute to this remarkable person."

Professional Achievements

Lanckton certified

Rabbi Ben Lanckton, MGH Chaplaincy, became a board-certified chaplain by the National Association of Jewish Chaplains, on February 2, 2009.

Robbins elected

Christopher Robbins, RN, staff nurse, Endoscopy Unit, was elected to the Nominations and Elections Committee, Society of Gastroenterology Nurses and Associates for the 2009–2010 term February 5, 2009.

Nurses certified

Staff nurses, Susan Croteau, RN, Sharon Kelly-Sammon, RN, and Regis MacDonald, RN, became certified ambulatory perianesthesia nurses by the American Board of Perianesthesia Nursing Certification, in February, 2009.

Connors publishes

Patricia Connors, RN, clinical nurse specialist, Obstetrics, authored the chapter, "Complications of Pregnancy," in *Maternal-Child Nursing Care: Optimizing Outcomes for Mothers, Children and Families*, by Susan Ward, in January, 2009.

Somerville earns doctorate degree

Jacqueline Somerville, RN, associate chief nurse, received her doctorate degree from Boston College, for her dissertation, "The Development and Psychometric Evaluation of Patients' Perceptions of Feeling Known by their Nurses' Scale," on February 26, 2009.

Banister presents

Gaurdia Banister, RN, executive director, The Institute for Patient Care, presented, "Our Work Isn't Finished Yet," at the Excellence in Nursing Awards, New England Regional Black Nurses Association reception, February 22, 2009.

Washington recognized

Deborah Washington, RN, director of PCS Diversity, received the inaugural Arnold Z. Rosoff Change Agent Award from The Ad Club of Boston and the Greater Boston Chamber of Commerce, March 23, 2009.

Capasso presents

Virginia Capasso, RN, clinical nurse specialist, presented, "The Importance of Writing in my Career as a Nurse" to the 4th grade class at Downey Elementary School in Westwood, February 4, 2009.

Vora presents

Ruchita Vora, PT, physical therapist, presented, "Factors Affecting Adherence to Osteoporosis Medications: a Focus Group Approach Examining Viewpoints of Patients and Providers," at the American Physical Therapy Association Combined Sections Meeting in Las Vegas, in February, 2009.

Multi-disciplinary team publishes

Janice Heavey, RN; Patricia Olsen, RN; Michelle Picard, RN; Janey Pratt, MD; and Nancy Sceery, RD, authored the abstract, "The Effectiveness of Urinary Urea Nitrogen as an Evidence-Based Tool" in the February/March, 2009, *Nutrition in Clinical Practice*.

Curley presents

Suzanne Curley, OTR/L, occupational therapist, presented, "Extensor Tendon Injuries," at Tufts University, February 9, 2009.

Mulligan presents

Janet Mulligan, RN, nursing director, IV Therapy, presented, "Using Quality Initiatives for Catheter Selection," at the quarterly meeting of the Massachusetts Chapter of the Association for Vascular Access, February 5, 2009.

McCormick-Gendzel appointed

Mary McCormick-Gendzel, RN, clinical instructor, IV Team, was appointed, president of the New England Chapter of The Infusion Nurses Society, March 10, 2009.

Heavey, Olsen and Sceery present

Janice Heavey, RN; Patricia Olsen, RN; and Nancy Sceery, RD, presented their poster, "The Effectiveness of Urinary Urea Nitrogen as an Evidence-Based Tool" at Clinical Nutrition Week 2009 in New Orleans, February 1–4, 2009.

Mulligan and Dreher present

Janet Mulligan, RN, nursing director, IV Therapy, and Denise Dreher, RN, clinical nurse specialist, IV Therapy, presented, "The ABCs of VADs: Care and Maintenance of VADs (Vascular Access Devices)," via teleconference to the medical and nursing staff of the King Edward VII Memorial Hospital in Bermuda, January 30, 2009.

Coakley and Ghiloni publish

Amanda Coakley, RN, staff specialist, and Carol Ghiloni, RN, clinical educator, authored the article, "A Study of How a Summer Fellowship Program Prepares Students for Employment as New Graduate Nurses in Oncology Nursing," in the February 15, 2009, *Creative Nursing*.

Nurses publish

Beth Nagle, RN, clinical nurse specialist; Jeanne McHale, RN, clinical nurse specialist; Gail Alexander, RN, clinical educator; and, Brian French, RN, manager, Knight Simulation Program, authored the article, "Incorporating Scenario-Based Simulation into a Hospital Nursing Education Program," in *The Journal of Continuing Education in Nursing*, in January, 2009.

Steiner presents

Linda Steiner, PT, physical therapist, presented, "Take Control with Exercise," and "Service Learning as a Tool for Building Effective Partnerships between Academic Institutions, National Organizations, and Urban Elder Communities," at the American Physical Therapy Association Combined Sections Meeting in Las Vegas, in February, 2009.

Burchill presents

Gae Burchill, OTR/L, occupational therapist, presented, "Hand and Upper Extremity Rehabilitation II: Management of Flexor Tendon Injuries," at Tufts University, February 2, 2009.
Burchill presented, "Flexor and Extensor Injuries and Splinting: a Lab," at Tufts, February 16, 2009, and "Hand and Upper Extremity Rehabilitation II: Splinting for Flexor and Extensor Tendons," at Tufts, February 23, 2009.

A reminder from Infection Control: what we need to know about norovirus

To reduce the risk of infection, family and caregivers should perform thorough hand-washing with soap and water after close contact with patients, their vomit, or stool. Always wash hands after using the bathroom and before preparing food.

Question: What is norovirus?

Jeanette: Noroviruses are a group of viruses that cause diarrhea and vomiting. Norovirus is often mistakenly called, 'stomach flu,' but it's not related to the flu (influenza), which causes respiratory illness.

Question: What are the symptoms of norovirus?

Jeanette: Common symptoms include nausea, diarrhea, vomiting, and stomach cramps that usually begin one or two days after exposure to the virus, but can occur as quickly as 12 hours after exposure. Some people may develop low-grade fever, chills, headache, muscle aches and fatigue. Illness can come on suddenly. Sometimes people with norovirus experience no symptoms at all but can still pass the illness on to others.

Question: How long does it last?

Jeanette: Most people recover in one or two days. Sometimes people are unable to drink enough fluid to replace what they've lost from diarrhea and vomiting, which can cause dehydration. This is more likely to occur in very young children, the elderly, or those with weakened immune systems.

Question: Where does it come from?

Jeanette: People become infected with norovirus by:

- eating food or drinking liquid contaminated by infected persons
- eating uncooked shellfish harvested from contaminated waters
- touching contaminated surfaces or objects then touching their mouths or eating without washing their hands
- having close contact with infected persons, their vomit, or stool

Question: What is the treatment?

Jeanette: Drink plenty of fluids to prevent dehydration, wash hands often, and contact your healthcare provider if you have any concerns (especially if you don't recover quickly or are at risk for dehydration).

Question: How do we protect patients?

Jeanette: Patients with symptoms of norovirus may be placed on special isolation precautions that include gowns and gloves and the use of a bleach product for room-cleaning. Affected staff may not return to work until 72 hours after their symptoms subside.

Question: How is infection prevented?

Jeanette: To reduce the risk of infection, family and caregivers should perform thorough hand-washing with soap and water after close contact with patients, their vomit, or stool. Always wash hands after using the bathroom and before preparing food.

Announcements

Jean M. Nardini, RN, Nurse of Distinction Award

The Jean M. Nardini, RN, Nurse of Distinction Award recognizes a clinical staff nurse who consistently demonstrates leadership and excellence in clinical practice. Recipient receives $1,000.
Nominees must be clinical staff nurses within Patient Care Services.

Deadline for nominations is April 9, 2009

For more information, contact Julie Goldman, RN, at 4-2295

Chapel Schedule for Holy Week 2009

All services held in the MGH Chapel on Ellison 1

Saturday and Sunday, April 4 and 5
4:00pm: Palm Sunday Roman Catholic Mass

Monday, Tuesday, Wednesday, April 6–8
12:15pm: Ecumenical Service and
4:00pm: Roman Catholic Mass

Thursday, April 9
12:15pm: Ecumenical Prayer Service
4:00pm: Roman Catholic Mass

Friday, April 10
11:00am: Second Day Passover/ Shabbat Service
12:00pm: Good Friday Service
4:00pm: Roman Catholic Service

Saturday, April 11
7:00pm: Roman Catholic Easter Vigil Mass

Sunday, April 12
12:15pm: Ecumenical Easter Service
4:00pm: Easter Sunday Roman Catholic Mass

Wednesday, April 15
10:00am: 7th Day Passover Service

For more information, call Rabbi Lanckton at 4-3228.

Elder care discussion group

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

Next session:
April 14, 2009
12:00–1:00pm
Yawkey 7-980

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

Sexual Assault Awareness Month

Please join the Domestic Violence Working Group, MGH Men Against Abuse, the Employee Assistance Program, HAVEN, and Police & Security to "Help MGH Blow the Whistle on Sexual Assault."

Wednesday, April 8, 2009
11:00am–1:00pm
in the Main Corridor

For more information, call 6-7674.

Come hear the findings of the SPPPE Survey

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, will present the findings of the Staff Perceptions of the Professional Practice Environment Survey to the PCS community in two open forums:

April 10, 2009
9:00–10:00am
Haber Conference Room

April 13, 2009
7:30–8:30am
Thier Conference Room

For more information, call 4-3534

Partners in Excellence Awards reception re-scheduled

All members of the MGH community are invited to the re-scheduled 2008 Partners in Excellence Awards reception:

April 15, 2009
3:00–4:00pm
Bulfinch Tent

Employees will be honored for their contributions to the Partners community. For more information, call 4-9743.

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

Next Publication
April 23, 2009

Educational Offerings – 2009

April 7

Building Relationships in the Diverse Hospital Community: Understanding our Patients, Ourselves, and Each Other

Founders 325
8:00am–4:30pm
Contact hours: 6.8

April 7

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

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

April 8

BLS/CPR Certification for Healthcare Providers

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

April 8

Pediatric Simulation Program

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

April 8

Nursing Grand Rounds

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

April 9

BLS/CPR Re-Certification

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

April 10

On-Line Electronic Resources for Patient Education

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

April 10

PALS Re-Certification

Simches Conference Room 3110
7:45am–4:00pm
No contact hours

April 13

CPR Mannequin Demonstration

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

April 13 & 14

Oncology Nursing Society Chemotherapy Biotherapy Course

Day 1: Yawkey 2-220
Day 2: Yawkey 7-920
8:00am–4:30pm
Contact hours: TBA

April 13

Boston ICU Consortium Continuing Education Pharmacology Update

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

April 14

BLS AED Certification Program

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

April 14

New Graduate RN Development Program

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

April 14

PCA Preceptor Course

Founders 325
1:00–3:00pm
No contact hours

April 14

Chaplaincy Grand Rounds:

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

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

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

National Healthcare Decisions Day

raising awareness about advance care planning

—by Cynthia LaSala, RN; Sharon Brackett, RN; and Taryn Pittman, RN

For more information about advance care planning efforts at MGH, contact: Cynthia LaSala at 3-0481, Taryn Pittman at 4-3822, or Sharon Brackett at 6-2314.

On April 16, 2009, National Healthcare Decisions Day, the PCS Ethics in Clinical Practice Committee and the Patient Education Committee will co-sponsor their annual Advance Directive information booth in the Main Corridor from 8:00am–3:00pm. The goal of this national initiative is to encourage patients to express their wishes about their healthcare decisions, to increase awareness among healthcare providers and facilities about respecting those wishes, and to emphasize the importance of providing information related to advance care planning for patients, families, and staff.

MGH joins 72 national and more than 322 state and local organizations in this concerted effort to highlight the importance of advance healthcare decision-making. For the past four years, the Ethics in Clinical Practice and Patient Education committees have co-sponsored this information booth to provide counseling and brochures to raise awareness about the importance of written advance directives. MGH clinicians certified as advance care planning facilitators through the Respecting Choices Advance Care Planning Facilitator Program will be on hand to answer questions and counsel patients and staff about the advance care planning process.

Committee members hope this event will encourage more people to have thoughtful conversations about their healthcare decisions, to appoint a willing and informed healthcare agent, and to complete a reliable advance directive making their wishes known. With increased awareness, healthcare providers are better prepared to address advance care planning issues before a crisis arises and more apt to appreciate the need to honor a patient's wishes when the time comes to do so.

For more information, contact: Cynthia LaSala at 3-0481, Taryn Pittman at 4-3822, or Sharon Brackett at 6-2314. For more information about National Healthcare Decisions Day visit: www.nhdd.org.

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