

Caring

Headlines

January 8, 2009

Excellence Every Day Champions Retreat



Scenes from Patient Care Services' Excellence Every Day Champions Retreat, held December 4, 2008. See Jeanette Ives Erickson's column on page 2 for more details.

Excellence Every Day champions

That's why Keith Perleberg and his team in the PCS Office of Quality & Safety are employing a similar model to ensure every person who sets foot in our hospital knows that Excellence Every Day is standard operating procedure at MGH.

MGH was the first hospital in Massachusetts to earn Magnet designation. No one knows better than we do what it takes to provide excellent care to every patient every day. It's easy to engender confidence in our practice when clinicians and support staff are as committed and highly motivated as you all are. That's why our Magnet champion model was so successful. And that's why Keith Perleberg and his team in the PCS Office of Quality & Safety are employing a similar model to ensure every person who sets foot in our hospital knows that Excellence Every Day is standard operating procedure at MGH.

On December 4, 2008, the PCS Office of Quality & Safety held a day-long Excellence Every Day Champions Retreat that brought together champions from inpatient units, peri-operative settings, all the PCS disciplines, certain ambulatory settings, as well as PCS directors, and unit leadership. The retreat was an opportunity to re-affirm our commitment to a culture of shared accountability in providing care that is safe, effective, timely, efficient, equitable, and patient-centered. It was day to take stock of the excellent work we've done and chart a course for the future in which every member of the PCS team understands, embraces, and exemplifies a practice model where the safety and comfort of our patients comes before all else.

And the agenda was ambitious.



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

We heard from Quality & Safety staff specialist, Carol Camooso Markus, RN, who gave an overview of the Joint Commission survey process and reviewed the 2009 National Patient Safety Goals. She walked us through the tracer methodology, customized survey approach, and new scoring process used by the Joint Commission, giving attendees a realistic idea of what to expect in our next survey. She explained each of the National Patient Safety Goals in detail, giving specific examples of how each goal is translated into practice at MGH. Carol's presentation gave rise to some excellent feedback spotlighting areas where a clearer understanding of certain policies and procedures may be needed.

Carol reminded us that there are many instances where MGH standards differ from Joint Commission standards, and in those cases, MGH standards are often more stringent. It's important for staff to know that the Joint Commission expects us to be compliant with the standards we ourselves have established.

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I have no doubt that through the work of our Excellence Every Day champions and our entire MGH workforce, Joint Commission surveyors will have a similar response when they visit in the near future. As we embark on this journey together, let's be bold in conveying our commitment to Excellence Every Day for every patient who comes through our doors.

Lela Holden, RN, patient safety officer, and Ruth Bryan, RN, patient safety staff specialist, for the MGH Center for Quality & Safety, spoke about Universal Protocol and how it should be carried out in a variety of settings and scenarios. Lela described the three primary components of Universal Protocol:

- Pre-procedure verification (correct patient; correct procedure; correct site; correct side)
- Procedure site marking
- Time-out (a hard stop) conducted immediately prior to the start of a procedure

Ruth reinforced the need to document time-outs and explained that the provider performing the procedure must initiate the time-out when all members of the team can actively participate.

George Reardon, director for PCS Clinical Support Services, and David Cohen, project specialist, spoke about fire safety, clutter, supplies, and other issues related to the environment of care. Their take-home message: patient safety is not exclusively a clinical concern. We all play a role. We're all accountable for patient safety.

Quality & Safety staff specialist, John Murphy, RN, led the portion of the retreat where Excellence Every Day champions and their respective leadership teams broke into small groups and brainstormed about how to roll out an Excellence Every Day campaign on their units. He described the Excellence Every Day core curriculum, a multi-week educational program designed to prepare champions to educate, communicate, and motivate as they share lessons learned and best practices with their co-workers.

It is not an exaggeration to say that the enthusiasm in the room that day was palpable. Champions left with a sense of purpose and resolve, eager to implement their own Excellence Every Day strategies. We've already heard from champions throughout Patient Care Services who've developed PowerPoint presentations, posters, and activities to disseminate information and keep staff informed about important compliance issues. We're seeing an incredible level of creativity and support from unit and department leadership.

I know Keith would want me to remind you that our Excellence Every Day (intranet) website is up and running, and is an excellent resource for staff. The site provides easy access to Joint-Commission-related information. I urge you to visit it frequently for updates, clarifications, and definitive answers to quality and safety questions. You can access the site at: <http://intranet.massgeneral.org/excellenceeveryday/>.

During our Magnet re-designation site visit in February last year, one surveyor observed, "In our meeting with MGH senior leadership, the chairperson of your Board of Trustees shared your mission and values with us. Throughout the site visit, we witnessed your mission and values in action. It was a privilege."

I have no doubt that through the work of our Excellence Every Day champions and our entire MGH workforce, Joint Commission surveyors will have a similar response when they visit in the near future. As we embark on this journey together, let's be bold in conveying our commitment to Excellence Every Day for every patient who comes through our doors.

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Payroll process improved by teamwork and 'trystorming'

—by Dan Kerls, senior project specialist

What do you get when you put nine department of Nursing staff and five process-improvement facilitators in a room for three and a half days? Answer: a standardized payroll process. During the week of October 6, 2008, Patient Care Services facilitated a first-of-its-kind process-improvement engagement, led by change agents recently trained in innovative process-improvement techniques. Nursing leadership provided the team with objectives and support. The objective was to establish a standardized payroll process while maintaining flexibility and using existing technology when possible.

The work began long before the first meeting. The first step was to identify issues requiring improvement. Once an issue was identified, the facilitator did 'pre-work' to validate the need. The department of Nurs-

ing had already requested support around payroll, so Dan Kerls, senior project specialist, along with co-facilitators, Arjun Rao, Ken Scheer, and Suzanne Sokal, worked with Mary Cramer, director of Process Improvement, to gather data. Forty nursing directors and operations managers participated in this phase of the process. Their payroll practices were observed, and it was discovered that every unit had a different method for communicating payroll and payroll changes.

The most critical success factor for a process-improvement engagement is having the right people in the room to ensure that end-users are well represented. This project team was comprised of nursing directors, operations managers, and staff from Financial Management Systems and PCS Information Systems. A cross-section of individuals with different involvement in the payroll process ensures that all perspectives are represented.

The first session was spent mapping out the current

10-step payroll process, during which 71 opportunities for improvement were identified. The group agreed to focus on standardizing payroll codes and communication and providing rec-

Members of the Payroll Process Improvement Team during a workshop session.



(Photo provided by staff)

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Informed consent for PICC-line placement



(Photo provided by staff)

Effective Monday, December 1, 2008, the IV Nursing Team is required to obtain informed consent for all PICC-line insertions. All members of the IV Nursing Team who are competent to place PICC lines have gone through a training program to ensure they understand and can communicate the necessary information to obtain informed consent. Obtaining informed consent for PICC-line placement is a first for IV nurses at MGH. Prior to December 1st informed consent was not required for this procedure.

For more information, contact Janet Mulligan, RN, nursing director for IV Therapy, at 4-7453.

Patient, Meredith Burrows, views ultrasound image of her veins after IV nurses, Patty Awbrey, RN (left), and Deb Guthrie, RN, explain the PICC insertion procedure.

Systems Improvement (continued)

Trystorming is when you try a proposed change, observe how it works, and make the necessary adaptations right away.

ommendations for centralizing payroll operations. Ideas were generated. Then the team engaged in a unique new process called, 'trystorming.' Trystorming is when you try a proposed change, observe how it works, and make the necessary adaptations right away. An example of trystorming is when the group entered payroll information for an unidentified unit using the proposed standardized payroll form, and one member of the team commented, "I can do this department's payroll without knowing any of the nurses on the unit."

The Payroll Process Improvement Team proposed standardized payroll codes to improve the interface between scheduling and payroll and to reduce errors. Two standardized payroll forms are being recommended: a daily staffing sheet and a time card, greatly streamlining the current process. Implementation of these rec-

ommendations will facilitate centralization of data-entry, auditing, and issuing of manual checks. All scheduling, documentation of changes, and verification of payroll remains at the unit level.

Transition of the payroll to a central office will occur in staggered implementation. Staff of the Nursing Support Office will attend payroll training sessions, which will also be available to nursing directors and unit time keepers.

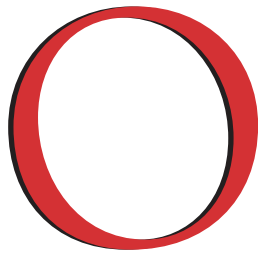
Payroll errors and edits will be monitored every month, and units will continue to be surveyed to ensure we're meeting our goals of reducing time and improving efficiency.

For more information on the work of the Payroll Process Improvement Team, contact Dan Kerls, senior project specialist, at 4-3085.

Patient empowerment through health literacy: a quality and safety issue

—by Sarah Ballard Molway, RN; Elaine Grassa, RN; and Taryn Pittman, RN, for the Patient Education Committee

Health literacy can be described as a person's capacity to obtain, process, and understand basic health information needed to make appropriate health decisions. It is estimated that Massachusetts has a low adult health literacy rate of 40%.



On November 14, 2008, the Patient Education Committee held its Patient Empowerment through Health Literacy: a Quality and Safety Issue conference with keynote speaker, Bob Dickerson, RRT. Dickerson spoke

about patients at risk for low health literacy, how health literacy affects patient safety, and how clinicians can bridge the health literacy gap. His concerns were echoed by a panel from the MGH Cancer Center and MGH Heart Center's Patient-Family Advisory Councils who shared stories about their own challenges in navigating the healthcare system.

Health literacy can be described as a person's capacity to obtain, process, and understand basic health information needed to make appropriate health decisions. It is estimated that Massachusetts has a low adult health literacy rate of 40%. Contributing factors include:

- low general literacy skills
- advancing age
- inexperience with the healthcare system
- unclear information provided by clinicians
- cultural or language barriers
- other distractions such as pain or worry

Many of the printed healthcare materials given to patients exceed the average reading ability of most adults. Often, patients are embarrassed to ask questions, or questions aren't invited by clinicians. It's not uncommon for patients to hide their lack of understanding by answering questions with a simple, "Yes."

Health literacy barriers put patients at risk for medication errors, missed appointments, poor compliance, and/or misinterpreted information. Studies show that patients with low health literacy have higher frequency in Emergency Departments, longer lengths of stay, decreased adherence to care, and increased medication errors, all of which can lead to poor health outcomes and/or mortality.

Low health literacy affects patients of every age, race, socio-economic background, and education level. It's important for clinicians to be able to recognize signs of low health literacy and know how to approach this patient population.

Creating a shame-free, patient-centered environment fosters an atmosphere of helpfulness, caring, and respect. Verbal communication should be clear and easy to understand. Non-verbal communication should convey patience and a willingness to answer questions. Patients should be given easy-to-follow instructions. Appointments, check-in procedures, and referrals should be streamlined and easy to navigate. All staff should play a role in enhancing patients' understanding of their care.

Using 'living-room' language is a good approach when teaching patients. Information should be given slowly and broken down into short sentences. Patient understanding should be checked using a teach-back technique, saying something like, "We've covered a lot of information. In your own words, can you tell me what we talked about?"

Adopting a patient empowerment campaign, such as the National Patient Safety Foundation's "Ask Me

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Three” campaign, is a useful tool in engaging patients. This approach encourages patients to ask their healthcare providers three questions: What is my main problem? What do I need to do? Why is it important to do this?

Other things to consider when creating a shame-free, patient-centered environment are the printed materials we provide. Registration, admission, and insurance forms are often complex and difficult to understand. Patient-education materials are often written at a college level; some consent forms are written at a graduate level, and patients often sign them without reading them.

All printed materials should be patient-friendly, contain conversational language, focus on a few key points, limit medical jargon, be action-oriented, and written at a 6th–8th grade reading level. It’s helpful to minimize information on anatomy and physiology, use short sentences and paragraphs, one- and two-syllable words, and large type.

The design and layout of printed materials should include white space and not be text-dense. Information should be presented in ‘chunks’ with headings, sub-headings, and bulleted lists. Headings should be simple

and clear. Invite patients to test written materials and critique them for content and visual appeal.

Panelists at the Patient Education conference noted that healthcare providers deal with health issues every day. Patients are often experiencing them for the first time. They can feel overwhelmed and shut down, rendering them unable to absorb new information. Panelists reminded attendees to be sensitive to individual family dynamics and cultural backgrounds. They encouraged healthcare providers to assume patients have no knowledge about their diagnosis.

Panelists recommended a combination of teaching methods. After assessing a patient or family member for their readiness to learn, present new information in writing, by demonstration, or video, and give them time to absorb the information. Later, discuss the new information and give them an opportunity to ask questions. Using the “Ask Me Three” and teach-back methods together fosters an effective learning environment.

Patients are asked to absorb a lot of information regarding their health. This information is frequently taught in a short period of time. As healthcare providers, we need to give patients tools to overcome low

health literacy so they can understand and manage their diagnosis.

As we begin the new year, let’s make a resolution to empower patients by tackling health literacy. Take the time to assess a patient’s readiness to learn, foster a shame-free learning environment, provide written information in plain language, and encourage patients to demonstrate their new knowledge using the teach-back method.

For more information about health literacy, call patient education specialist, Taryn Pittman, RN, at 4-3822.

Panelists from the MGH Cancer Center and MGH Heart Center’s Patient-Family Advisory Councils (l-r): Teri Fryer; Lynne Graziano-Morin; Denise Mallen; Carole Seigel; and Christine Rice.



(Photo by Michelle Rose)

New nurse cares for medically complex patient and 15 monkeys named Mark

For the next three weeks, I was Joe's primary nurse. I loved caring for Joe and his sister, and with each shift I learned more about them. Although Joe could only comprehend things similar to a 2-year-old, he was fun and loved life.

My name is Elizabeth Whittier, and I am a staff nurse in the Medical Intensive Care Unit (MICU). I first met 'Joe' during his first stay in the MICU early last year. I had completed orientation only a month before. While getting report from the nurse on the unit from which he was transferring, I was nervous because Joe sounded very sick. He had an extensive medical history that included B-cell lymphoma (a type of cancer affecting cells that fight bacteria), multiple cardiac abnormalities, impaired hearing, and broncho-tracheomalacia (mal-formed cartilage in the respiratory tract). Joe was also developmentally challenged. He had been admitted to a general medical unit with recurrent pneumonia and increased abdominal pain. He was placed on BiPap (a non-invasive therapy used to support his breathing) overnight, which he did not tolerate well. Joe was intubated, sedated, and paralyzed prior to his transfer to the MICU.

On arrival in the MICU, Joe was accompanied by numerous physicians, his nurse, and the nursing supervisor. The nursing supervisor informed me that Joe's sister and group-home caregiver were in the waiting room, extremely anxious. After making sure Joe was hemodynamically stable, I asked another nurse to stay with him while I went to the waiting room to speak with his sister. I found Jane crying and very nervous. She wanted to see Joe as soon as possible. I sat with her and reassured her that Joe was stable and comfortable.



Elizabeth Whittier, RN, staff nurse
Medical Intensive Care Unit,

I explained what we do in the MICU, what Joe would look like when she saw him, and what all the machines were for. I told her that Joe would be getting a central line and an arterial line placed for special medications, monitoring, and lab draws. I explained that the oncology team planned to do a bone marrow biopsy soon.

Jane was concerned that Joe was in pain, but I assured her that he was receiving continuous pain medication and a local anesthesia with each procedure. I excused myself to get back to caring for Joe. When all the procedures had been completed, I brought Jane and Joe's group-home caregiver in to see him. Again, I prepared them for what Joe would look like and what medications he was on for his pain.

For the next three weeks, I was Joe's primary nurse. I loved caring for Joe and his sister, and with each shift I learned more about them. Although Joe could only comprehend things similar to a 2-year-old, he was fun and loved life. He had a thing for monkeys. Jane brought in about 15 of his stuffed monkeys, which I learned Joe had all named Mark! I helped Jane decorate the room with pictures, and all the monkeys

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helped reduce Joe's anxiety. I played cards and colored with Joe. He was still intubated and unable to speak so it was difficult for him. One day, I asked the coordinator of the pet therapy program to arrange to have a dog visit Joe. Joe was a little startled by the dog at first, but after a while, he loved him.

Joe had many setbacks including high fevers, low blood counts, and pulmonary edema. Many family meetings were held to talk about a possible tracheostomy, his code status, and goals of care. One weekend when Joe was unstable, Jane decided to change his code status to Limitation of Life-Sustaining Treatment. It was extremely difficult to wean him off the ventilator. After two and a half weeks of intubation, we were unsure if we'd ever be able to extubate him.

I continued to support Jane and answer her questions. During one of our conversations, Jane asked if Joe was going die. I answered her honestly, saying he would if we took him off the ventilator at that time. I explained the options: comfort measures only versus tracheostomy. Jane was tearful. She didn't want Joe to die in the hospital because he had spent so much time in the hospital as a baby. Jane had a hard time making a decision about tracheostomy, because it would mean Joe would need a G-tube for feedings. Joe loved food and eating. If he wasn't able to eat, Jane felt it would affect his quality of life. She hoped a tracheostomy would only be temporary and he'd be able to be weaned off the ventilator and eat normally again.

The Surgical Service was consulted and the tracheostomy scheduled for Sunday afternoon. Joe finally passed a spontaneous breathing trial (SBT) Sunday morning for the first time ever. I was excited and nervous at the same time. Respiratory Therapy conducted a second SBT just to be sure, and Joe passed. I spoke with the pulmonary fellow and junior resident about trying to extubate Joe. I felt we should give him a shot at breathing on his own. We extubated Joe Sunday afternoon, and to everyone's surprise, he did great.

Feeding Joe was our next challenge due to chronic aspiration. Speech, Language & Swallowing Disorders was consulted and worked closely with Joe to prevent aspiration. Joe didn't speak much, mostly communicating with sign language. I learned how to sign many of the words he used. If he pointed outside, it meant he wanted to get out of his room. I would wheel him around the unit during my shifts. He'd carry his monkeys named Mark and wave to doctors and nurses like a king sitting on his throne. Four days after he was extubated, Joe was transferred back to the general medical unit.

During the time I cared for Joe in the MICU and the two months he spent on the general medical unit, I grew close to Joe, his sister, and his group-home caregivers. Before being discharged, Joe underwent surgery to remove his gallbladder and had a short stay in the Surgical ICU. Jane was nervous that he wouldn't be able to be extubated again. I visited him every day when I came in to work.

A few months after he was discharged, Joe was readmitted to the MICU for pneumonia and shortness of breath. We were able to ward off BiPap, treat him with aggressive pulmonary toilet treatments, and transfer him to a general medical unit the next day.

Unfortunately, Joe developed respiratory failure and was transferred emergently back to the MICU for possible intubation. Jane was called in. She wasn't sure she wanted Joe to be intubated again. We did everything we could to keep from intubating him—BiPap, heliox therapy, nebulizers. Despite our efforts, Joe's condition declined. As we prepared to intubate Joe, Jane asked to speak to me and Joe privately. She was crying and torn about what to do. She knew Joe would probably die if he wasn't intubated. I explained that we might not be able to extubate Joe and it might be necessary to consider tracheostomy again. I assured her that whatever she decided to do, we would make sure Joe was comfortable. Jane hugged Joe and asked if he wanted help breathing. He said yes. Jane stayed in the room as we took over Joe's breathing and intubated him.

Over the next four days, nurses and respiratory therapists worked aggressively to optimize Joe's lungs in hopes of extubating him as soon as possible. Joe was successfully extubated and eventually weaned back to his baseline oxygen requirements. He was discharged from the hospital a week later. I remain in contact with Jane, and she updates me on how Joe is doing periodically. When I think about everything Joe and Jane went through, it reminds me why I love being a nurse.

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

This narrative beautifully captures Elizabeth's ability to relate to Joe, become part of his world, and provide individualized care to both Joe and his sister. Elizabeth made sure Jane understood all the ramifications of Joe's care and made sure Joe's voice was heard. The trust and confidence Elizabeth elicited enabled Jane to make informed decisions on her brother's behalf. Joe's medical needs were complex, but Elizabeth's care and presence were unwavering.

Thank-you, Elizabeth.

Over the next four days, nurses and respiratory therapists worked aggressively to optimize Joe's lungs in hopes of extubating him as soon as possible. Joe was successfully extubated and eventually weaned back to his baseline oxygen requirements. He was discharged from the hospital a week later.

Comfort and Support after Loss Memorial Service

—by Leslie Kerzner, MD, staff neonatologist

Courage and strength. These are the words that resonated at the 17th annual Pediatric, Neonatal and Obstetric Memorial Service, November 2, 2008, sponsored by the MGH Comfort and Support after Loss Committee. The service is dedicated to MGH families who've experienced the death of a child, from infancy through adolescence, including miscarriage or stillbirth. Many families return year after year to participate in this event that is so meaningful for families and staff.

Family member hangs memento during Pediatric, Neonatal, and Obstetric Memorial Service.



(Photo by Michelle Rose)

Kathryn Beauchamp, RN, clinical nurse specialist in the Pediatric Intensive Care Unit, moderated the service. Heartfelt comments were offered by Ronald Kleinman, MD, chief of Pediatrics, Patricia O'Malley, MD, director of Pediatric Emergency Services and Palliative Care, and Janet Madden, RN, clinical nurse specialist in the Newborn Intensive Care Unit. Gloria Ciccone, MD, of Newborn Services welcomed Spanish speaking guests, and Reverend Ann Haywood-Baxter offered non-denominational prayers. Some families shared stories and poems of remembrance. Music therapist, Lorrie Kubicek, along with Kimberly Khare and Claudia Eliaza, provided soothing music throughout the afternoon.

Parents, families, and friends were invited to participate in a naming ceremony; daffodil bulbs and pewter hearts were given to families in memory of their children. Many families hung decorated fabric memorials, which will be made into a scrapbook.

Immediately following the service, a reception was held in the East Garden Room where families had a chance to re-connect with their children's care providers and mingle with other families. Memorial quilts from 1998–2002 were on display outside the General Store, and scrapbooks from past years were available for viewing during the reception.

Members of the Comfort and Support After Loss Committee include: Fredda Zuckerman, LICSW; Kathryn Beauchamp, RN; Natalie Cusato, LCSW; Denise DuChainey, LICSW; Ann Haywood-Baxter, MDiv; Genevieve Gonzales, LICSW; Leslie Kerzner, MD; Elyse Levin-Russman, LICSW; Janet Madden, RN; Joyce McIntyre, RN; Brenda Miller, RN; Heather Peach, CCLS; Lisa Scheck, LICSW; Kate Stakes, RN; and Eileen White.

Chisari named director of Center for Clinical & Professional Development

Chisari is a familiar and friendly face to many in the MGH community. He began his nursing career at MGH as a staff nurse in the Neuroscience Intensive Care Unit.

The Institute for Patient Care has appointed Gino Chisari, RN, as director of The Norman Knight Nursing Center for Clinical & Professional Development. Chisari most recently served as deputy executive director for the Massachusetts Board of Registration in Nursing (MARN), where he managed and coordinated regulatory and policy decisions around implementation of laws governing the practice and education of nurses in the Commonwealth. In his position as deputy executive director for MARN, Chisari influenced trends related to new and emerging standards of nursing practice, particularly as they related to the legal scope of nursing practice.

Chisari is a familiar and friendly face to many in the MGH community. He began his nursing career at MGH as a staff nurse in the Neuroscience Intensive Care Unit. He later became a clinical nurse specialist in General Medicine. And as a key member of the unit-based management team, he co-led the development of two start-up units: Bigelow 9 and Bigelow 11.

He has held faculty appointments at several area nursing programs, including the MGH Institute for Health Professions, Northeastern University, Emmanuel College, and Massachusetts Bay Community College. He is an accomplished presenter and writer and has been actively involved in a variety of professional



Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development

activities. In 2006, he was elected to the Board of Directors for the National Council of State Boards of Nursing.

Chisari earned his diploma from the Shepard-Gill School of Practical Nursing of the Massachusetts General Hospital, and his bachelor of Science degree in Nursing from the Massachusetts College of Pharmacy & Allied Health in Boston. His master's degree in Nursing is from Salem State College.

Patient Care Services and the MGH community welcome Chisari back in his new role as director of The Norman Knight Nursing Center for Clinical & Professional Development.

Pin Week celebrates volunteer service

—by Meghan Fitzgibbons, project specialist, and Kathy Clair-Hayes, LICSW, volunteer coordinator

Each December, the volunteer community celebrates Pin Week to recognize the efforts of volunteers and honor hourly milestones. It's Ether Day for volunteers. This year, the department celebrated the accomplishments of more than 150 individuals who gave more than 64,770 combined hours to MGH. Norris Branscombe, who received his 5,000-hour pin, said, "Being a volunteer is not something you do, it's something you are. I'm grateful to MGH for giving me a place to learn and grow."

Said Marguerite Hamel- Nardozzi, LICSW, "Norris has shown a rare dedication and devotion to MGH and the Cardiac Intensive Care Unit. The driving force behind Norris' devotion to service is best expressed in his own words: 'I've had the opportunity to spend 5,000 hours helping people. That's what matters most to me.'"

Among volunteers honored this year were (l-r): Virginia Needham, (2,000 hours); Priscilla Farias-Monge, (1,000 hours); Sanford Evans, (100 hours); Eloisa Garcia, (100 hours); Natalia Kuzmina, (100 hours); and Norris Branscombe, (5,000 hours).

One draw for many volunteers is the ability to interact with a variety of patients and families. Charlie McCarthy and Margaret Wilkie, who received their 4,000-hour pins, are long-time volunteers in the Cancer Center Infusion Unit. Says Wilkie, "I feel like I get a lot more out of it than I give."

Says McCarthy, "It's gratifying to help people. Volunteering is so rewarding. I love talking with patients. I believe they're the reason my health is so good."

The MGH Volunteer Department supports 1,200 volunteers, more than 650 who fill weekly shifts. Many serve as patient escorts, others work in the Same Day Surgery Unit, Emergency Department, Gray Family Waiting Area, Cancer Center, Pediatrics, Newborn and Family Units, the Inpatient Psychiatric Unit and the Patient Education Centers. Volunteers visit patients with the book cart, serve as Eucharistic ministers through a collaborative effort with Chaplaincy. No matter where volunteers are found, they help staff create a more welcoming and caring hospital for patients and families.

MGH volunteers come from all walks of life: high-school students, college students, working adults, and retirees. Some are considering careers in Nursing or Medicine. Others have been patients themselves or have had family members hospitalized and want to give something back. Many are motivated by a desire to make a difference in a way that connects with people. Says Paul Bartush, co-director of the MGH Volunteer Department, "I am constantly reminded of the power of simple acts—serving a meal to someone who's hungry, assisting those who can't help themselves. These acts may seem simple by themselves, but as a whole they make a monumental difference."

For more information about volunteering at MGH, contact Meghan Fitzgibbons at 617-643-4344.



(Photo by Paul Batista)

HealthStream: the 'wave' of the future

Question: I've heard about a new, on-line learning system. Can you tell us a little bit about that?

Jeanette: This month, The Norman Knight Nursing Center for Clinical & Professional Development is introducing HealthStream, an on-line learning system that will give staff access to a variety of educational offerings 24 hours a day, 365 days a year. The service is web-based, so staff can use the system whenever and wherever they have Internet access.

Question: When will HealthStream be available?

Jeanette: HealthStream is going live for nurses within Patient Care Services on January 21, 2009.

Question: Is HealthStream just for nurses?

Jeanette: HealthStream is being rolled out in phases, beginning with nurses in Patient Care Services. Over time it will be rolled out to all members of Patient Care Services.

Question: What are some of the topics that nurses will be able to access?

Jeanette: HealthStream offers more than 100 free courses on a variety of subjects. Nurses will be able complete their annual required training (such as Infection Control, HIPAA, Environment of Care, etc.) through HealthStream. In the future, content will include annual competencies, unit-specific competencies, and components of orientation. Further down the road, staff will be able to use HealthStream to register on-line for programs offered through The Norman Knight Nursing Center for Clinical & Professional Development.

Question: Does HealthStream keep a record of the courses we take?

Jeanette: HealthStream automatically tracks all courses taken by staff, those taken for required training and those taken for contact hours, and provides each person with a complete transcript.

Question: Will other role groups have access to this learning opportunity?

Jeanette: Eventually, other role groups (patient care associates, operations associates, unit service associates, operating room associates, physical therapists, occupational therapists, respiratory therapists, and speech-language pathologists) will have access to HealthStream for educational purposes.

Question: Is it possible to see HealthStream before it's implemented?

Jeanette: You can access a HealthStream test site that's been set up to give staff a sneak preview. The site features an instructional guide and one sample course to give staff a sense of the various features available through HealthStream. This is only a test site; none of the results from this site will be saved. You can visit the test site at: www.healthstream.com/hlc/mghtrain.

Question: How can I learn more about HealthStream?

Jeanette: For more information or to register for a HealthStream class, contact the The Norman Knight Nursing Center for Clinical & Professional Development at 6-3111. Questions about specific learning opportunities can be e-mailed to project chairs: Tom Drake or Mary McAdams.

Linens 'n things Tiger Team findings

—by Jennifer Daniel, RN, staff specialist

Linens are a hidden but substantial hospital resource. Every year, MGH generates ten million pounds of laundry at an annual cost of \$2 million dollars, and we spend approximately \$1.4 million dollars each year on new linens. Recently, Patient Care Services formed a Linens Tiger Team to review our current practices and identify ways to minimize waste, conserve resources, and reduce our impact on the environment.

The Linens Tiger Team started by talking to unit staff. Many unit service associates expressed concern about the large amount of un-used linen being laundered after patients were discharged. Though the items had never been used, they were considered 'dirty' and sent off to be washed. Observation on three units revealed that anywhere between eight and 18 pounds of un-used linens were being laundered per day. Over the course of a year, the amount of linens being un-necessarily laundered on just those units is equal to the weight of three Toyota Corollas.

Not only does this add to the workload, but we're wasting water, gas, and electricity. It takes 1.2 gallons of water to wash every pound of laundry. Reducing our linen usage by 10% would conserve 1,200,000 gallons of water every year and reduce the amount of chemicals and detergents being pumped into the environment.

As part of a 'Go Green' program on White 9 and Bigelow 11, staff piloted an environmentally-friendly bed-making policy. For patients who met the criteria, staff began changing bed linens on certain days of the week instead of every day. They reduced the

quantity of linens being brought into patients' rooms and stocked linens on carts to decrease the number of steps needed to retrieve them. Feedback from staff, patients, and families was overwhelmingly positive, and unit service associates on both units reported a reduction in the amount of un-used linen removed from patients' rooms.

Contributing to waste of any kind is not good practice. When it comes to linens, we need to use the right amount of the right product, for the right reason, at the right time.

Here are some ways you can help:

- Bring only those linens you expect to use during your shift into a patient's room
- Don't use linens for your own personal needs
- Use mops instead of towels/linens to clean up spills
- Remove tape and adhesives from linens before sending them to be laundered. This reduces wear and tear
- Don't put damaged or un-usable linen in a laundry bag. (And don't throw it away.) Put unusable linens in the assigned bag on your unit so they can be pulled out of circulation and recycled

Remember, we all have a role in reducing waste. By following these simple steps, we're not just reducing waste, we're helping the environment.

If you're interested in starting your unit on a 'green' path, initiate a discussion with your colleagues and unit leadership today. For more information, call Jennifer Daniel, staff specialist, at 6-6152.

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For more information, call: 617-724-1746

Next Publication

January 22, 2009

Educational Offerings – 2009

January
20

Ovid/Medline: Searching for
Journal Articles
Founders 334
10:00am–2:00pm
Contact hours: 2

January
21

BLS/CPR Certification for
Healthcare Providers
Founders 325
8:00am–12:30pm
No contact hours

January
21

BLS/CPR Certification for
Healthcare Providers
Founders 325
8:00am–12:30pm
No contact hours

January
22

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

January
22

Phase I Wound-Care Education
Program
Simches Conference Room 3120
8:00am–4:30pm
Contact hours: 6.6

January
22

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

January
26

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

January
26

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

January
27

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

January
27

PCA Educational Series
Founders 325
1:30–2:30pm
No contact hours

January
29

Preceptor Development: Learning
to Teach, Teaching to Learn
Charles River Plaza
8:00am–4:30pm
Contact hours: 6.5

January
29

Management of Patients with
Complex Renal Dysfunction
Founders 311
8:00am–4:30pm
Contact hours: TBA

January
30

PALS Re-Certification
Simches Conference Room 3110
8:00am–4:00pm
No contact hours

February
2

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

February
2 & 9

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

February
6

On-Line Electronic Resources for
Patient Education
Founders 334
9:00am–12:00pm
Contact hours: 2.7

February
9

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

February
10

New Graduate RN
Development Program
Founders 311
8:00am–4:30pm
Contact hours: TBA

February
10

BLS/CPR Certification for
Healthcare Providers
Founders 325
8:00am–12:30pm
No contact hours

February
11

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

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

Hematology Oncology Nurse Practitioner Excellence Award

— by Barbara Cashavelly, RN, nursing director, MGH Cancer Center

The hematology oncology nurse practitioner is a valued and integral member of the multi-disciplinary team... Erika Barrett exemplifies one of the best in oncology nursing practice.

The Hematology Oncology Nurse Practitioner Excellence Award recognizes a nurse practitioner from Hematology Oncology whose practice exemplifies excellence in clinical knowledge and decision-making, compassionate care-giving, teaching and mentoring, and collaborative teamwork. On November 24, 2008, Erika Barrett, RN, became the first recipient of the Hematology Oncology Nurse Practitioner Excellence Award.

Barrett was nominated by physician colleagues, Donald Kaufman, MD, Anthony Zietman, MD, and Scott McDougal, MD. Said Kaufman in his letter of support, "Erika is an extraordinary nurse who possesses all the qualities one would hope to find at the highest level of MGH care-giving. She provides total care to patients always exceeding their expectations. She is known throughout the Cancer Center as a reliable and invaluable resource. She has given herself unselfishly as a mentor. She has visited many of her patients at home, usually at the end of a long day, always ready to do whatever is necessary to enhance a patient's comfort or contribute to a positive attitude. I know she will continue to bring great credit to the nursing profession which she reveres and serves with great devotion."

Said Zietman, "I cannot think of a nurse practitioner who better exemplifies the talents and qualities of the profession."



Erika Barrett, RN, hematology oncology nurse practitioner

The hematology oncology nurse practitioner is a valued and integral member of the multi-disciplinary team. Many strive for excellence and make a difference in the lives of our patients and families, bringing the best of themselves and their professions to work every day. Erika Barrett exemplifies one of the best in oncology nursing practice.

Patient Care Services congratulates Barrett for being the first recipient of the Hematology Oncology Nurse Practitioner Excellence Award.



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