Caring Headlines
January 21, 2010

IV nurses: integral members of the healthcare team

January 25th is IV Nurse Day

See story on page 4

Patient, Bob Soden, closes his eyes as veteran IV nurse, Mary McCormick-Gendzel, RN (left), inserts peripheral IV line. Staff nurse preceptee, Nicole Reisinger, RN, looks on.

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

Jeanette Ives Erickson

HCAHPS

Hospital Consumer Assessment of Healthcare Providers and Systems

Essentially, HCAHPS are a standardized survey and method of collecting data that gives hospitals and the general public a way to measure and compare patients' perceptions of care.

When was the last time you attended a meeting, read a professional journal, or chatted with colleagues, where HCAHPS didn't come up in the conversation? If you're like me, you can't remember a time when HCAHPS wasn't a pivotal part of every discussion. And that's a good thing for patients and families. While HCAHPS are bringing much-needed access and transparency to important healthcare information, it's just as important that clinicians and the general public understand what HCAHPS are and how they're being used.

HCAHPS stands for, 'Hospital Consumer Assessment of Healthcare Providers and Systems.' Essentially, HCAHPS are a standardized survey and method of collecting data that gives hospitals and the general public a way to measure and compare patients' perceptions of care. It is the first national standard of its kind, and it has generated the largest comparative healthcare database in the country, currently encompassing more than 3,500 hospitals.

MGH uses an independent contractor to administer our HCAHPS survey. (The survey can be administered in English, Spanish, Russian, Chinese, and Vietnamese.) Recently discharged patients are contacted and invited to participate in a telephone survey about their hospital stay. Questions are designed to capture information that patients consider important when choosing a hospital or healthcare facility. Questions are intended to obtain patients' impressions related to: the effectiveness of communication with their nurses and doctors; the responsiveness of hospital staff; the cleanliness and quietness of the hospital environment; pain-management; communication about medications; discharge information; their overall rating of the hospital, and whether patients would recommend the hospital to others.

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

With some exceptions, most questions are 'Yes/No,' or answerable on a scale of 'Never, Sometimes, Usually, or Always.' Some sample questions include:

- During this hospital stay, how often did nurses treat you with courtesy and respect?
- During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
- During this hospital stay, how often were your room and bathroom kept clean?
- Before giving you any new medicine, how often did hospital staff describe possible side-effects in a way you could understand?

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In addition to the statistical (quantitative) data generated by the HCAHPS questionnaire, the survey also captures more subjective data (qualitative) via numerous comments offered by responders. HCAHPS surveys are conducted on an on-going basis every month, and the results are publicly posted four times a year on the *Hospital Compare* website at: www.hospitalcompare.hhs.gov.

You can see how the information obtained by the HCAHPS would be of great interest to patients and the public. Having the ability to make side-by-side comparisons of prospective hospitals based on meaningful quality data is invaluable.

But HCAHPS are useful for hospitals, too. They provide incentive for hospitals to improve the quality of care by increasing transparency around important quality indicators. They're one of the richest sources of feedback from patients about how we're doing in terms of fulfilling our mission. And they are a veritable instruction manual for designing services that meet our patients' needs and foster a culture of Excellence Every Day.

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Data from the HCAHPS combined with other patient-satisfaction indicators (feedback from patient and family advisory councils, the Office of Patient Advocacy, hourly rounding, letters from patients, and many other sources) helped inform our strategic direction for the coming year. As you may recall from my last column, our strategic goal for 2010 is to improve the patient, family, and employee experience by:

- improving clinician and support staff communication with patients and families
- improving responsiveness
- improving the cleanliness of the hospital
- eliminating patient falls
- eliminating hospital-acquired pressure ulcers
- enhancing utilization of evidence-based practice to promote safety

Guided by data collected via the HCAHPS (and other sources) we can hone in on specific areas of focus and set goals accordingly. We've already implemented a number of tactics to help advance our strategic plan and others are being developed as we speak, including:

- regular rounding with an un-scripted, 7-P approach (to assess Person, Plan, Priorities, Personal hygiene, Pain-management, Position, and Presence)
- new training, better tools, and an enhanced service model for unit service associates
- tent cards and cleaning logs in patients' rooms to let patients know when their rooms have been cleaned
- sharing best practices and evidence-based learning to prevent falls and pressure ulcers
- vigilant attention to quality and safety issues to positively impact clinical outcomes and the patient experience

These are just some of the initiatives we're working on, and a small example of how the HCAHPS help direct our work. For more information, or if you have questions about the HCAHPS, please consult your nursing director or supervisor, or visit the HCAHPS website at: www.hcaphsonline.org.

In this Issue

A day in the life of an IV nurse

—by IV nurse, Mary McCormick-Gendzel, RN

When I sense tension or fear, I adapt my teaching to the needs of that patient. Sometimes that involves humor, sometimes it requires a more formal approach. I'm always amazed when, in just a few minutes, patients trust me to perform an intimate, invasive procedure.

My role as an IV nurse at MGH is both challenging and rewarding. I treat patients with complex vascular-access needs. Sometimes, I see between 30-50 patients in an eight-hour shift. On a typical day, I arrive at work at 6:30 in the morning. Patient care needs identified during the night have been documented in the message book. Assignments have been coordinated according to unit needs. Certain IV nurses carry certain pagers so unit-based staff can reach the appropriate IV nurse when needed.

My practice is largely autonomous. I spend the first half-hour planning my day. I stock my cart with the supplies I'll need as I wait for the PICC list to print. The PICC list identifies all the inpatients who have PICC or midline catheters. I use this list to assess each patient for: the condition of the PICC dressing; the date of the last dressing change; and the location and functionality of the catheter.

I begin my rounds by checking on patients who are scheduled to have procedures and patients with PICC lines (before they have breakfast). PICC dressings are changed 48 hours after insertion and then weekly after that. I greet each patient, assess the situation, perform the dressing and cap change, flush the lumens to determine patency, then document what I've done in the medical record. If I have any concerns, I find the nurse caring for the patient and communicate my recommendations. This is a key role of the IV nurse—assessing and maintaining PICC lines to prevent catheter-related blood-stream infections.

From the moment I start my day, I field calls from nurses on many different units and triage my time according to patient needs. Fielding these calls requires strong assessment skills, the ability to prioritize, and the ability to effectively communicate with nurses and physicians. Typically, I'll ask:

- Is this blood work needed because the patient is a 'difficult stick' (i.e., no one else has been able to get a sample)
- Is this related to a patient's pain management?
- Does the patient need venous access for a CT scan?
- Is a staff nurse having trouble with a PICC?

My role includes teaching staff about vascular access—when it's appropriate and when it's not.

I'm often asked why I like being an IV nurse, since people associate what I do with pain. I try to focus on the outcome of my interventions—helping patients meet their vascular-access needs. It's very rewarding to hear a patient say, "Wow, I didn't feel a thing"; or when a patient is terrified of needles and I cannulate a vein in one try. My skill helps alleviate stress. Staff nurses often express gratitude that they can now administer a patient's therapy.

I'm proud that patients put their trust in me. When I sense tension or fear, I adapt my teaching to the needs of that patient. Sometimes that involves humor, sometimes it requires a more formal approach. I'm always amazed when, in just a few minutes, patients trust me to perform an intimate, invasive procedure.

I believe nursing is a calling. I know my role as a certified registered infusion nurse requires both the art and science of nursing. Despite the intensity, I love my work. I know I make a difference in the lives of many patients.

Third annual *65Plus* Best Practice Conference

—by Deborah D'Avolio, RN, and Mary Ellen Heike, RN

Understanding the complexities of caring for older adults is a challenge for many clinicians. To some degree, all healthcare providers touch the lives of older adults. Yet, as noted in the recent IOM report, *Retooling for an Aging America*, few healthcare workers are trained to address the specialized needs of this growing population. Fewer than 1% of American nurses are certified in Geriatrics.

65Plus, the Patient Care Services program created to support the needs of older adults, recently hosted its 3rd annual Best Practice in Acute Care for Older Adults Conference. Sponsored in collaboration with The Norman Knight Nursing Center for Clinical & Professional Development, the two-day, inter-disciplinary conference focused on increasing knowledge, sensitivity, and competence in providing geriatric care while preparing nurses for ANCC geriatric certification.

More than 80 attendees from MGH and the greater Boston area immersed themselves in the world of geriatric nursing. Drawing on the clinical expertise of MGH nurses, chaplains, physical therapists, speech pathologists, pharmacists, and doctors, the conference focused on geriatric assessment skills, evidence-based interventions, and case studies to illustrate how to enhance care for older adult patients. Sessions addressed topics such as sensory changes, delirium, dementia, depression, and the spiritual needs of older adults. Presenters shared evidence-based solutions for some common complaints including, irregular sleep patterns, urinary incontinence, Foley catheter issues, falls, pain-management, and pharmaceutical issues. The conference closed with a panel of geriatric-certified nurses discussing their certification experiences in, "Preparing for the Gerontology Certification Test."

Feedback from participants validated the need for ongoing geriatric education programs with comments such as: "The conference enhanced my knowledge of caring for older adults," and, "It was very informative. The case studies and shared experiences were helpful for my practice."

The Best Practice Conference is currently the only geriatric continuing education program in the area specifically designed for healthcare providers caring for acutely ill older adults. Said Deborah D'Avolio, RN, geriatric specialist, "This year's conference was especially meaningful because nurses who had been mentored through the *65Plus* program served as expert faculty sharing their knowledge with their peers."

For more information about *65Plus*, or to learn more about unit-based geriatric education, contact Deborah D'Avolio, at 3-4873.

Below: at recent Best Practice Conference, geriatric-certified nurses (l-r): Monica Staples, RN; Jean Stewart, RN; Amy McCarthy, RN; Susan Gage, RN; and Debra Conkey, RN. Center: Amy McCarthy, RN (left), and Mary McDonough, RN. Right: geriatric specialist, Deborah D'Avolio, RN.

Primary nursing

a kaleidoscope of intimate moments with patients and families

My clinical judgment is built on 25 years of experience working as a primary nurse with critically ill patients, and advanced education, most recently in the specialty of anticoagulation management.

My name is Palmie Riposa, and I have been a staff nurse at MGH for more than half my life. My clinical judgment is built on 25 years of experience working as a primary nurse with critically ill patients, and advanced education, most recently in the specialty of anticoagulation management.

I first met Mrs. D when she was referred to MGH for anticoagulation management services. She had been diagnosed with new-onset atrial fibrillation (rapid, irregular contractions of the heart). She would need to be managed with Coumadin to keep her blood from clotting. I met Mrs. D and explained what she could expect over the next few days after being discharged from the hospital. I explained that a visiting nurse would come by every day to give her a blood test (PT/INR), and the results would be sent to me. I would review the results and contact her with dosing instructions and let her know when the next blood test would be needed.

I managed Mrs. D's Coumadin dosing over the next two weeks. I scheduled an appointment with her for a comprehensive educational session and invited her daughter to join us. I had spoken with her daughter on several occasions, and it seemed to me that she was part of Mrs. D's support system.

Palmie Riposa, RN, staff nurse
Anticoagulation Management Services

I began the session by asking Mrs. D if she understood her condition and why she was taking Coumadin. She said she thought she was taking Coumadin to treat her fast heart-rate. I explained that she was taking Coumadin as a preventive measure to help keep a blood clot from forming that could potentially cause her to have a stroke.

During the session, I asked which lab would be most convenient for her to use on a long-term basis, and Mrs. D became weepy. I noted that she didn't look at her daughter as she said she'd prefer to use the lab at their local hospital, but her children didn't allowed her to drive since her diagnosis and hospitalization. She

continued on next page

told me she enjoyed driving very much, but her children thought it best if she didn't drive. She made it clear that she knew her children loved her, but they had taken something very important away from her. She hadn't told them how she felt because she didn't want to hurt their feelings and didn't want to appear ungrateful for everything they had done for her.

I looked at Mrs. D's daughter and was surprised to see that she was crying, too. I wasn't quite sure what to say. I didn't know why she was crying, but I felt there might be more to the story. It seemed important for this mother and daughter to have a chance to talk about their feelings. I handed them each a tissue and gave them a moment.

Through years of experience, I've come to appreciate what a privilege primary nursing is. It's a kaleidoscope of intimacy and distance in some of the most dramatic, poignant, and mundane moments in a patient's life. Understanding how each patient is affected by her illness and treatment (or how she thinks she's affected) not only guides our interventions, but helps us empower patients and families.

Mrs. D's daughter told her mom she had stopped her from driving because she was trying to help. It was the only thing she could think of to try to make her life easier—it had nothing to do with the her mom's ability to drive. She had just assumed her mom would appreciate not having to worry about getting around. She felt terrible that her mom was upset and had been keeping her feelings inside for so long. When Mrs. D talked about how much she enjoyed driving, I could see the sparkle in her eyes.

After they had a chance to air their feelings, they both seemed more relaxed and comfortable. I knew I could continue our teaching session with their full attention. I told Mrs. D I was happy she felt comfortable enough to share her feelings with me. I let her know that as her primary nurse, being aware of these kinds of details could be relevant in evaluating her condition. I encouraged her to share any personal details about her physical or emotional health in the future as it could affect the way I manage her Coumadin dosing and testing intervals.

Interjecting a little humor, I told her, "Not everyone wants to hear about things like vomiting and diarrhea, but I do."

I explained how changes in her health, diet, alcohol intake, or medications all play a role in anticoagulation management.

By the end of our teaching session, I felt as though we had known each other for years. We shook hands, and I told her I'd call by the end of the day with her test results and the date of her next blood test. When I received the results later that day and phoned Mrs. D, her daughter answered the telephone. She happily reported that she had let her mom drive home.

Through years of experience, I've come to appreciate what a privilege primary nursing is.

It's a kaleidoscope of intimacy and distance in some of the most dramatic, poignant, and mundane moments in a patient's life. Understanding how each patient is affected by her illness and treatment (or how she thinks she's affected) not only guides our interventions, but helps us empower patients and families. As healthcare providers, we provide patients with knowledge they can use to take back some control over their health and quality of life.

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

What a beautiful, simple story about the power of nursing presence. Palmie created a safe space for Mrs. D and her daughter to explore their feelings. Years of experience and insight gave Palmie the wisdom to know just how much (or how little) to intercede in this family matter. It empowered Mrs. D and her daughter to move forward in a positive way and helped lay the foundation for a trusting relationship between Mrs. D and her primary anticoagulation nurse.

Thank-you, Palmie.

Responsiveness: then and now

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

You can hardly have a conversation these days without hearing the word, responsiveness. More and more nursing and professional journals are publishing articles on the subject. But is it really a new concept? Responsiveness simply means the ability to answer or reply. In health care, we traditionally associate it with patients' call lights. But responsiveness is taking on new meaning as we focus more on patient- and family-centered care.

I remember when I was a nursing student—learning how to enter a patient's room, how far away to stand, to address patients by their surnames. I remember my first clinical rotation as a nursing student, reviewing my 'speech' in my head before entering the room. Communicating with patients about who, what, where, and why are important considerations in creating and maintaining good nurse-patient relationships.

Today, the nurse-patient relationship is being thought about in new ways, linking responsiveness to patient outcomes. This is exciting and creates an opportunity for nurses to demonstrate the positive influence we have on the patient experience. Of course, it comes with responsibility and that means educating ourselves about the 'new' responsiveness.

Due to some recent changes in healthcare legislation, hospitals are no longer eligible for reimbursement when certain complications occur. Falls and pressure ulcers, the two most common hospital-associated complications, result in longer patient stays and increased costs. The literature suggests that more frequent nursing presence at the bedside can have a dramatic effect on reducing these and other complications. One strategy to help prevent falls and pressure ulcers is hourly, or patient-safety, rounding.

Rounding is one way to help us understand patients' expectations, anticipate their needs, and enhance communication. Each rounding visit should be unscripted and touch on the seven Ps

Rounding is an excellent way to connect with patients and increases nursing presence at the bedside. Rounding is one way to help us understand patients' expectations, anticipate their needs, and enhance communication. Each rounding visit should be unscripted and touch on the following points (the seven Ps):

- Person—treat everyone with dignity and respect
- Plan—explain what you're going to do, and do what you say you'll do
- Priorities—set priorities in collaboration with the patient and family
- Personal hygiene—offer assistance with simple activities such as going to the bathroom
- Pain management—no one should experience on-going pain
- Position—help re-position patients frequently to prevent pressure ulcers
- Presence—we all know the power of the nurse-patient relationship

The seven Ps should echo in your mind like the voice of a trusted instructor. They're at the center of the nurse-patient relationship and the reason many of us went into nursing in the first place.

In the coming months you'll be seeing a lot more about responsiveness and have opportunities to engage in educational programs to help you transform old practices into a renewed commitment to our patients and families. 2010 will be a pivotal time in health care, and each of us will play an important part in the journey.

For information about programs offered by The Knight Nursing Center for Clinical & Professional Development, call Gino Chisari, RN, director, at 3-6530.

Professional Achievements

Curley presents

Suzanne Curley, OTR/L, occupational therapist, presented, "Professionalism," at Tufts University, October 5, 2009.

O'Toole publishes

Jean O'Toole, PT, physical therapist, authored the article, "Breast Cancer and Lymphedema," in the September/October, 2009, *Coping Magazine*.

Blakeney elected

Barbara Blakeney, RN, innovation specialist, was elected, secretary of the Board of Directors of Health Care Without Harm in Arlington, Virginia, in October, 2009.

Nurses publish

Mary Larkin, RN; Chelby Cierpial, RN; Teresa Vanderboom, RN; Kelli Anspach, RN; Kelley Grealish, RN; Stephanie Ball, RN; and Catherine Griffith, RN, authored the article, "Evidence-Based Nursing: Research Ambassadors Bringing Findings to the Bedside," in the October, 2009, *Nursing Management*.

Fillo becomes fellow

Katherine Fillo, RN, staff nurse, became a fellow of the Massachusetts Institute for Community Health Leadership, in September, 2009.

Inter-disciplinary team publishes

Barbara Lakatos, RN; Virginia Capasso, RN; Monique Mitchell, RN; Susan M. Kilroy, RN; Mary Lussier-Cushing, RN; Laura Sumner, RN; Jennifer Repper-Delisi, RN; Erin Kelleher, RN; Leslie Delisle, RN; Constance Cruz, RN; and Theodore Stern, MD, authored the article, "Falls in the General Hospital: Association With Delirium, Advanced Age, and Specific Surgical Procedures," in the May/June, 2009, *Psychosomatics*.
They received the Dorfman honorable mention award for best original research from the Academy of Psychosomatic Medicine, in October, 2009.

Nurse practitioners publish

Nurse practitioners, Krista Rubin, RN, and Caroline Kuhlman, RN, authored the article, "Lower Extremity Edema in a Patient with Melanoma," in a recent issue of *Oncology Nurse*.

Arnstein publishes

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, recently authored the chapter, "The Future of Pain Management Nursing," in *Core Curriculum for Pain Management Nurses*, second Edition.

Barba and Good present

Kate Barba, RN, clinical nurse specialist, and Grace Good, RN, nurse practitioner, presented, "Delirium in the Acute Care Patient: Recognition, Diagnosis and Treatment," at the 2009 National Clinical Conference of the American College of Nurse Practitioners, in Albuquerque, New Mexico, October 9, 2009.

Inter-disciplinary team presents

Ellen M. Robinson, RN; Angelika Zollfrank, MDiv; Katherine Brown Saltzman, RN; and James Hynds, presented, "Moving Beyond Traditional Ethics Consultation: Case Studies at the End of Life," at the Annual Meeting of the American Society of Bioethics and Humanities, in Washington, DC, October 18, 2009.

Rubin publishes

Krista Rubin, RN, nurse practitioner, Center for Melanoma, authored the article, "Dysplastic Nevi and the Risk of Melanoma: Current Evaluation and Management," in the July/August, 2009, *Journal of the Dermatology Nurses' Association*.

Rubin also authored, "Management of Metastatic Melanoma: Nursing Challenges Today and Tomorrow," in the *Clinical Journal of Oncology Nursing*.

Rubin co-authored with Donald Lawrence, MD, the article, "Melanoma Staging, Prognosis, and Treatment," in a recent issue of *Oncology Nurse*.

Harmon Mahony presents

Carol Harmon Mahony, OTR/L, occupational therapist, presented, 'Fracture Management," and "Wrist Injuries," at Tufts University, October 13, 2009.

Jampel and Moore present

Physical therapists, Ann Jampel, PT, and Aaron Moore, PT, presented, "Clinical Instructor Case Presentation," at the New England Consortium of Academic Clinical Coordinators, in Tewksbury, October 30, 2009.

King presents

Janet King, RN, staff nurse, Endoscopy Unit, presented, "Approach to a GI Motility Patient from a Testing Perspective," at the Management of Motility and Functional Bowel Disease Clinical Cases and Practical Lab, in Burlington, October 10, 2009.

Rubin presents

Krista Rubin, RN, nurse practitioner, Center for Melanoma, presented, "Melanoma: a Unique Cancer Among Cancers," at the Scripps Oncology Nursing Symposium in San Diego, October 7, 2009.

Brandolini presents

Richard Brandolini, RN, staff nurse, Endoscopy Unit, presented, "The Smart Pill," at the Management of Motility and Functional Bowel Disease: Clinical Cases and Practical Lab, in Burlington, October 10, 2009.

O'Toole presents

Jean O'Toole, PT, physical therapist, presented, "A Multi-disciplinary Approach to the Management of Breast Cancer-Related Lymphedema: the MGH Experience," and, "Defining a Threshold for Lymphedema Intervention: Utilizing Prospective Assessment and Natural History in Patients Treated for Breast Cancer," at the International Meeting of the Society of Lymphedema, in Sydney, Australia, in September, 2009.

Mulgrew and Squadrito present

Physical therapists, Jackie Mulgrew, PT, and Alison Squadrito, PT, presented, "Management of the Acute Care Patient," at the Duke Raleigh Medical Center in Raleigh, North Carolina, October 2-3, 2009.

Nippins presents

Physical therapist, Matthew Nippins, PT, presented, "Incorporating Exercise Assessment into Outpatient Cystic Fibrosis Clinic Visits," at the 2009 North American Cystic Fibrosis Conference, in Minneapolis, October 13–24, 2009.

Corry and Ranford present

Jennifer Corry, OTR/L, and Jessica Ranford, OTR/L, occupational therapists, presented, "The A-ONE: Neurobehavioral Assessment of Function," at Boston University, October 17, 2009.

Robinson presents

Ellen M. Robinson, RN, ethics clinical nurse specialist, presented, "Ethical Issues in Case Management Practice: Ethical Analysis and Strategy," at the Annual Conference of the Case Management Society of New England, in Worcester, October 2, 2009.

Scholl presents

David Scholl, RN, staff nurse, Endoscopy Unit, presented, "Wireless pH Capsule-BRAVO," at the Management of Motility and Functional Bowel Disease: Clinical Cases and Practical Lab, in Burlington, October 10, 2009.

Lang presents

Betsy Lang, LICSW, clinical social worker, presented, "When the Face Across the Room Reflects My Own: Counter-Transference and Workplace Burn-Out," at the 10th Clinical Team Conference of the National Hospice and Palliative Care Organization, in Denver, September 24, 2009.

Announcements

Looking for new members

The MGH Employee Blood Donor Committee is looking for new members. The primary function of the Employee Blood Donor Committee is brainstorming ideas to increase visibility of the donor center; developing new events and promotions; and encouraging blood donations from MGH employees.

No experience necessary. The committee meets quarterly. Enthusiastic, interested individuals welcome.

For more information, contact Meredith Wentworth at 4-9699.

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.

New Encryption Policy

New state regulations mandate that portable computing devices that store personal information of Massachusetts citizens be encrypted to protect their privacy.

In compliance with this law, MGH and Partners Information Systems have begun a program to encrypt laptops that connect to the MGH/Partners network.

Encryption is a process of converting information into a coded format that is only readable with the correct decoding key and provides greater security to computing devices than a password alone.

If you have a Partners portable computing device that requires encrypting and you have not been contacted, go to the helpdesk website at: http://helpdesk.partners.org/encryption/faq.htm, or contact Kirk Jones, MGH information security officer at kejones@partners.org.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

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

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

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

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

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Next Publication
February 4, 2010

Educational Offerings – 2010

February
1

BLS Heartsaver Certification AED

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

February
1 & 8

ACLS Provider Course

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

February
1

Pediatric Simulation Program

Founders 325
12:30 – 2:30pm
Contact hours: 2

February
3

BLS/CPR Re-Certification for Healthcare Providers

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

February
3

Simulated Critical-Care Emergencies

POB 448
7:00 – 11:00am
Contact hours: 3.75

February
4

BLS/CPR Certification for Healthcare Providers

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

February
5

PALS Instructor Class

Newton Wellesley Hospital
8:00am – 3:00pm
No contact hours

February
4 & 5

Oncology Nursing Society Chemotherapy Biotherapy Course

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

February
8

BLS/CPR Re-Certification for Healthcare Providers

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

February
9

New Graduate RN Development Program

Founders 311
8:00am – 4:30pm
No contact hours

February
9

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

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

February
10

ACLS Re-Certification Class

Founders 130
5:30 – 10:00pm
No contact hours

February
10

A Nursing Director's Guide to Evidence-Based Practice

Founders 311
11:00am – 12:00pm
Contact hours: TBA

February
17

Starting a Journal Club to Promote Evidence-Based Nursing Practice

Founders 311
11:00am – 12:00pm
Contact hours: TBA

February
23

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
11:00am – 3:00pm
Contact hours: TBA

February
24

Workforce Dynamics: Skills for Success

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

Beginning April 1, 2010, educational offerings will be found on the Knight Nursing Center website (http://www2.massgeneral.org/PCS/ccpd/cpd_sum.asp) and in the e-newsletter distributed weekly by the Center. For more information, call 6-3111.

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

Introducing the Code Blue Newborn Response Team

Question: What is a 'Code Blue'?

Jeanette: A Code Blue activates a team of specially trained clinicians in the event that a patient, employee, or visitor goes into cardiopulmonary arrest or experiences a medical emergency. And recently, we implemented a significant change in the emergency-response system.

Question: What is the change?

Jeanette: Because of the specialized needs of newborns, we have added a newborn component to the emergency-response team. This team is specially trained to handle emergent medical needs of infants younger than 2 weeks old. The Code Blue Newborn Team is in addition to the Code Blue Adult and Code Blue Pediatric Teams already in place.

Question: What if the baby's age is in question? Which team should I call?

Jeanette: Always call both the Code Blue Newborn *and* the Code Blue Pediatric teams unless you're in one of the newborn nurseries, the delivery room, or a post-partum unit. Calling for both teams will ensure you have the right clinicians for a medical emergency.

Question: How do I active the team?

Jeanette: To call the Code Blue Newborn Team, dial 6-3333 and specify that you need the Newborn Code Team. Be sure to provide the operator with the baby's location. When calling 6-3333, it is imperative to let the dispatcher know which team you need: Adult, Pediatric, or Newborn.

Question: When do these changes go into effect?

Jeanette: The Code Blue Newborn Team became active on January 19, 2010. Clinicians should complete the HealthStream training module to learn more about the Newborn Emergency Response Team. For more information, contact Mary Ellen Heike, RN, at 4-8044.

Caring Headlines
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