

# Caring

Headlines

May 27, 2010

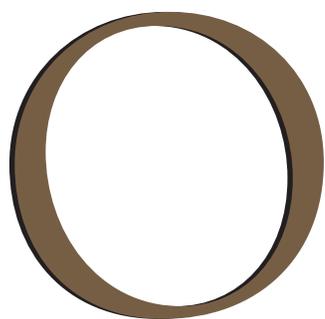
# Nurse Week 2010



*This special issue of Caring Headlines  
contains coverage of Nurse Recognition Week  
events and presentations*

New graduate nurse, Jennifer Ashley, RN (right), and preceptor, Alicia Sheehan, RN,  
with patient, Richard Giller in the Ellison 9 Cardiac ICU

# A nursing journey that would make Florence Nightingale proud



On Thursday, May 6, 2010, senior vice president for Patient Care and chief nurse, Jeanette Ives Erickson, RN, took the podium for her annual Nurse Week address with one goal in mind—to let the nurses of MGH know they are, ‘Simply the best.’ And with the help of pictures, videos, testimonials, and three actual MGH nurses, she did just that. Heeding her

own mantra, “No missed opportunities,” Ives Erickson used the occasion to extol the legacy of visionary nursing pioneer, Florence Nightingale. She compared the challenges Nightingale faced with the challenges we face today. She likened Nightingale’s fierce determination to the passion and commitment of MGH nurses. She made it clear to everyone in attendance (and those watching via teleconference) that nurses who practice at MGH, like Florence Nightingale, are nothing short of heroes.

Following is an encapsulated version of Ives Erickson’s remarks.

This is my favorite week of the year. We come together to celebrate you — MGH nurses, to recognize our profession, and to honor its founder, Florence Nightingale. Nightingale, the Lady with the Lamp, faced monumental adversity in her lifetime, but through perseverance, dedication, and compassion, forever changed nursing as she cared for soldiers and civilians during times of war and peace.

Nightingale died in 1910, one hundred years ago this year. Her life and accomplishments are remarkable. She helped us understand what’s required to be qualified to practice nursing and the knowledge essential to become a nurse. Through the lens of her teachings, I want to reflect on the past century of our profession.

Nightingale’s message from 100 years ago holds true today. Nurses, as care providers, teachers, researchers, and citizens, through acquired knowledge and skill, have a responsibility to the people of the world.

We reflect on the work of this visionary nurse to see if we’re living up to the expectations of the founder of modern nursing who serves as

an inspiration to all caregivers because of the way she cared for and about people. Let me share a passage from the book, *The Florence Prescription*, by Dick Schwab.

The hour was half past midnight. The Lady with the Lamp made her way slowly through the corridors filled with wounded, sick and dying soldiers, clear-headed and broken-hearted. The men were jammed together along the floors like too many plants packed into a row of beans, their only mattress the fetid and bloodied straw that was spread across the floors.

The lucky ones had a blanket to themselves. “We can do better than this,” Florence Nightingale whispered into the foul air of the old Turkish army barracks building that had, almost as an afterthought, been converted into a hospital for British casualties of the war against Russia in the far-off Crimean Peninsula. “We must do better than this.”

Nightingale knelt beside a young soldier who was crying for his mother. He would, she knew, die during the night watch. “They always cry for their mothers,” she thought as she pulled the last orange from her apron pocket. She peeled away a slice and, gently lifting the young man’s head, squeezed the juice into his mouth. His eyes flickered open. “Thank you.” Nightingale saw, rather than heard, his last words. Words she had so often seen on the lips of dying men so grateful for the most trivial of kindnesses.

We must do better than this. The young man drifted back into his final sleep. As she so often did for dying soldiers, Nightingale massaged his feet. “Soldiers live on their feet,” Nightingale often told the nurses under her charge. “So it is for us to care for their feet as well as for their wounds.”

She made note of the dead soldier’s name and the time of his dying. Later, she would update the records she so meticulously kept on her patients, and would send the dead man’s scant possessions home to his family, along with a personal

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## Jeanette Ives Erickson (continued)

note reassuring his parents that he had died peacefully. She covered his face with the blanket, knowing that before morning call it would be covering another miserable wretch perhaps also doomed to die in Turkey.

It was long past midnight by the time Nightingale finished making her nightly circuit through the 4-mile maze of the Scutari Barrack Hospital.

She could not, of course, personally tend to each of the thousands of patients whose miserable fate it was to be lying in those stinking corridors, but it was later said that as the Lady with the Lamp passed by, soldiers lying in those corridors would kiss her shadow.

“We must do better than this,” Nightingale wrote in her personal journal before crawling onto the soldier’s cot that was her bed. And do better she did. By the time the Crimean War had ended, Florence Nightingale established the first hospital pharmacy, using her own funds to purchase needed medications.

She recruited a French chef to start the first hospital nutrition service, and instructed her nurses to begin boiling sheets, cloths and rags, simultaneously creating the first hospital laundry and infection control process.

To give her patients something to do

other than spend their army pay on drink, she established the first patient library, and she personally took responsibility for assuring that the money they saved was sent home to their families. Her meticulous record-keeping was the forerunner to the medical records and epidemiology functions of the modern hospital.

Nightingale largely disappeared from public view upon her return to England, but her work did not end there. She personally helped each of the nurses who had gone with her to Turkey find employment upon their return home. She was the guiding light for the world’s first school of professional nursing, which to this day bears her name, and her book, *Notes on Nursing*, informed and inspired future generations of nurses.

She designed the first hospital building that was constructed specifically for that purpose. The pioneering epidemiological methods she developed were the basis for revolutionary improvements in the British military health service, and she was a leading proponent for public health improvements in what was then the British

*(continued on  
page 24)*



Senior vice president for Patient Care and chief nurse, Jeanette Ives Erickson, RN (right), speaks with MGH nurses recently back from deployment in Haiti (l-r): Denise Lauria, RN, Operating Rooms; Jennifer Garrity, RN, Pediatric ICU; and Joseph Roche, RN, Surgical ICU

# The effects of sensory interventions on an inpatient psychiatric unit

**K**icking off Nurse Week on May 3, 2010, nurse researchers, Joanne Parhiala, RN; Meaghan Rudolph, RN; and Martha Root, RN, presented, “The Effects of Sensory Interventions on an Inpatient Psychiatric Unit: a Pilot Study,” on behalf of their research team, which included Leslie Delisle, RN; Christina Stone, RN; Gabe Dumont, RN; Robin Lipkis-Orlando, RN; and mentor, Patricia Martin Arcari, RN.

The purpose of the study was to test the efficacy of sensory interventions as strategies to improve mood states, blood pressure, and heart rates of patients in a Sensory Room in an inpatient psychiatric setting, and to describe their experiences. The study sought to answer three questions:

- What is the patient’s experience of exposure to sensory interventions in the Sensory Room in the inpatient psychiatric setting?
- What are the specific sensory interventions selected by psychiatric inpatients in the Sensory Room?
- Are there significant differences between emotional states, blood pressure, and heart rates of patients before utilizing Sensory Room interventions compared with after?

The Sensory Room is a quiet area furnished with comfortable seating, serene paintings, a fish tank, lava light, weighted blanket, neck massagers, and an assortment of other gentle, multi-sensory stimulants.

A total of 25 patients participated in the study ranging in age from 20–63 years old; seven were male, 18 female. Diagnoses included: major depression; anxiety; bipolar disease; and substance abuse.

Data was collected at three intervals: prior to receiving any intervention; in the Sensory Room during the intervention; and immediately following the intervention.

In terms of the research questions, the study concluded that sensory interventions created significant changes in emotional states, providing a useful tool to assist patients with emotional modulation. Sensory interventions did not significantly impact heart rate and blood pressure. And sensory interventions are effective tools for psychiatric nurses to incorporate into patient care.

The team further concluded that sensory interventions could be useful in caring for general medical-surgical patient populations, and in fact, some sensory carts are already in use.

**(L-r): Patty Arcari, RN; Joanne Parhiala, RN; Meaghan Rudolph, RN; Martha Root, RN; and Robin Lipkis-Orlando, RN**



# Evaluation of basic arrhythmia knowledge-retention and clinical application by registered nurses

**N**ursing researchers, Laura Sumner, RN; Sheila Burke, RN; Lin-Ti Chang, RN; and Mary McAdams, RN, presented their research findings on, “The Evaluation of Basic Arrhythmia Knowledge-Retention and Clinical Application by Registered Nurses,” which they conducted under the mentorship of, Dottie Jones, RN. The purpose of the study was to evaluate knowledge-retention over time and clinical application of basic arrhythmia knowledge through the use of simulation following participation in an orientation program on basic arrhythmias. They sought to answer the questions:

- Is there a difference in pre- and post-test scores related to cardiac-arrhythmia knowledge on a basic arrhythmia test (multiple choice, anatomy, rhythm strips) following participation in a program on arrhythmias during central hospital orientation?
- Is there a difference in post-test scores on a basic arrhythmia test and retention of similar arrhythmias using scores from a simulated arrhythmia experience?
- Is there a relationship between achievement on pre- and post-test basic arrhythmia test scores and nurse-identified learning preferences?

The study enrolled 138 nurses, mostly female (93%) between the ages of 21–66 years old. A four-hour basic arrhythmia program was offered to all the nurses in the group on the second day of nursing orientation.

Participants completed:

- a written pre-test one day before the program
- a written post-test four weeks after the program
- a written post-test three months after the original arrhythmia program

The study found significant difference in pre- and post-test achievement scores; knowledge-retention of arrhythmia content at three months after the basic arrhythmia program; and simulation testing reinforced clinical application at three months after the basic arrhythmia program.

Researchers posited that simulation is a safe, efficient, and practical way to enhance learning; that academic nursing programs could benefit from including more in-depth basic arrhythmia content tailored to different learning styles and age groups; and that simulation should be incorporated into basic arrhythmia programs in nursing orientation.

Looking to the future, the team plans to expand their study, including evaluating the long-term influence of arrhythmia knowledge on patient safety, reduction in adverse events, and advanced physiologic monitoring.



(L-r): Lin-Ti Chang, RN; Laura Sumner, RN; Sheila Burke, RN; and Mary McAdams, RN

# Healthcare reform and nursing care of older adults

**T**erry Fulmer, RN, Erlene Perkins McGriff professor and dean of the College of Nursing at New York University, is passionate about nursing and certain that nursing will be the key to healthcare reform. Describing our aging population as, “like an egg in a snake,” Fulmer noted that we’re on the verge of profound demographic change, both locally and globally, with the number of Americans 65 or older expected to reach 70 million (or 30%) by the year 2030.

According to Fulmer, in order to meet the healthcare needs of an aging America, hospitals across the country will need to:

- increase recruitment and retention of clinicians knowledgeable in geriatric care
- explore ways to widen the responsibilities of workers at all levels of training (what she calls the cascade effect)
- develop new models of healthcare delivery and payment
- increase knowledge and skill of family members and friends in the caregiver role

The care of older adults requires an inter-disciplinary approach, and caregivers at the bedside are pivotal to the prevention, early detection, and treatment of common geriatric syndromes. Make no mistake, said Fulmer, “I’m talking about nurse-led models to champion better, more meaningful care of our aging patient population.”

Fulmer extolled the impact of the NICHE program in advancing care toward more positive outcomes.

NICHE, which has evolved over the past three decades, was created to provide tools and education to help effect a change in culture toward a more patient-centered approach to caring for older adults. Fulmer called MGH’s *65plus* program (an inter-disciplinary offshoot of the NICHE program) an exemplar of geriatric care.

Said Fulmer, “MGH is at the forefront of this change. You are a Magnet hospital. You are a NICHE hospital. You had the first funded RN Residency Program (Transitioning to Geriatric and Palliative Care). And you have a long-standing commitment to best practices in geriatric care.”

She made reference to the Institute of Medicine’s findings that:

- the knowledge of front-line nurses is critical to reducing medical errors and improving patient outcomes
- acute-care settings require integrated systems that use technology effectively and increase the efficiency of nurses allowing them to spend more time with patients
- collaborative, multi-disciplinary care teams improve the quality, safety, and effectiveness of care
- many of the innovations necessary to improve healthcare systems already exist somewhere, but barriers to sharing best practices keep them from being utilized more widely

In closing, Fulmer listed the requirements of successful nursing practice systems:

- taking full advantage of the intellectual capacity of nurses
- encouraging nurse-led models of care
- supporting creative initiatives
- using the evidence

And most of all, don’t stop listening to your patients. That’s where the real solutions will be found.



**Terry Fulmer, RN, Erlene Perkins McGriff professor and dean of the College of Nursing at New York University**

# Research utilization in nursing practice at MGH

## *a comparative study of barriers and facilitators*

**P**rincipal investigator, Chelby Cierpial, RN, speaking on behalf of her research team: Mary E. Larkin, RN; Catherine A. Griffith, RN; Diane L. Carroll, RN; and consultants, Carolyn Paul, and Ellen Mahoney, RN, presented their study, “Research Utilization in Nursing Practice at MGH: a comparative study of barriers and facilitators,” which was conducted under the mentorship of Virginia Capasso, RN. The purpose of the study was to measure the perceptions of barriers and facilitators to using research findings in nursing practice among MGH nurses and compare the results to a 1995 study conducted by Diane Carroll, RN, and her research team in the same setting.

The sample group encompassed 187 participants with about 1/3 of the group between the ages of 50–59. Participants represented a variety of practice areas with the largest percentage (40%) in inpatient acute care units; the majority (72%) were staff nurses.

In comparing data with the previous study, researchers found the top two barriers remained the same in ranking:

- The nurse is unaware of the research
- There is insufficient time on the job to implement new ideas

Other barriers changed in ranking. For instance, ‘The nurse feels the results are not generalizable to their own setting’ went from 10th in 1995 to 6th in the current study.

**(L-r): Carolyn Paul; Virginia Capasso, RN; Chelby Cierpial, RN; Mary Larkin, RN; and Catherine Griffith, RN**

Facilitators to research utilization included (not a complete list):

- increasing the time available for reviewing and implementing research findings
- conducting more clinically focused, relevant research
- improving availability of or accessibility to research reports
- enhancing administrative support and encouragement
- providing colleague support and networking mechanisms

Respondents perceived each facilitator listed as important to research utilization ‘to a great extent,’ and notably, to an extent higher than perceived in 1995.

The team feels it’s worth repeating this study every five years to monitor changing perceptions related to incorporating research findings into practice. And they feel it’s important to support and celebrate staff involvement in new evidence-based practice initiatives and disseminating outcomes.



# The proclamation for change: promoting nursing practice

**A**nn Hendrich, RN, vice president, Clinical Excellence Operations, Ascension Health, is convinced that the change necessary to salvage our ailing national healthcare system resides in the interconnectedness of healthcare delivery models. She recognizes it isn't easy to coordinate all the services involved with providing seamless care, but ultimately, the relationships that exist at the micro-system level hold the answer. She pointed to our own Excellence Every Day champion model as a case in point.

In her landmark study, "Time and Motion: a Multi-Site Study of how Medical Surgical Nurses Spend their Time," Hendrich and her team followed 827 nurses through more than 2,200 work shifts in 36 clinically diverse hospitals in 15 states. According to their results, most nurses spent less than 1/3 of their time providing direct patient care and almost half their time on indirect patient-care tasks such as documentation, medication administration, gathering and retrieving supplies, and communicating with other members of the care team.

The study prompted nursing leaders to develop a set of national recommendations to maximize unit efficiency and improve the quality and safety of patient care. Those recommendations included:

- Hospitals and healthcare technology should be designed around patient needs (from the patient out, not from technology in)
- Architects and vendors should work closely with nurses and other caregivers when designing workspace and technologies to ensure patient needs are met

**Ann Hendrich, RN,**  
vice president, Clinical  
Excellence Operations,  
Ascension Health



- The physical design of patient care units should integrate work processes and technology so caregivers always have the right materials and the right information at the right time and the right place
- The design and operation of technology should be intuitive and easily accessible so caregivers can access information in in-patient and outpatient settings alike

Hendrich shared some ground-breaking news related to pressure ulcers and a study conducted to gain consensus on whether some pressure ulcers might be considered 'unavoidable.' A panel of 24 national experts unanimously agreed that there are situations where pressure ulcers are unavoidable despite interventions, re-positioning, and efforts to prevent them. This finding will likely lead the National Pressure Ulcer Advisory Panel to re-define its understanding of unavoidable pressure ulcers and require new documentation guidelines.

Understandably excited, Hendrich observed, "Never underestimate the power of nurses and doctors when they come together to influence the future."

Later that day, Hendrich moderated a session in which four staff nurses read riveting accounts of situations where patients had fallen while in their care. In a hushed O'Keeffe Auditorium, Jenna Delgado, RN; Klare O'Keefe, RN; Lily Shaw, RN; and Stephanie Lessard, RN, shared very different, but equally compelling stories. Discussion afterward focused on risk factors, gender issues, the need for patients to preserve their dignity and independence, and the most dangerous words a nurse can say: "I'll be right back."

All four narratives can be found on pages 18–23 in this issue of *Caring Headlines*.

# The effect of a preparatory information session prior to a cardiovascular procedure

**C**o-investigators, Carolyn Cain, RN, and Anne Gavigan, RN, presented their research on, “The Effects of a Preparatory Informational Session Prior to a Cardiovascular Procedure,” which was conducted under the mentorship of nurse researcher, Diane Carroll, RN. Their study sought to examine the effects of a preparatory informational session versus standard preparation prior to a cardiovascular procedure. It also sought to compare standard care to standard care plus an informational session on anxiety and patients’ satisfaction with preparation for the procedure.

Cain and Gavigan hypothesized that an informational session plus standard care would reduce anxiety compared to standard care alone, and that an informational session plus standard care would improve patient satisfaction with preparatory information compared to standard care alone in the Knight Center for Interventional Cardiovascular Therapy (Cath Lab).

The ‘informational session’ used by Cain and Gavigan was a video (DVD) they created based on extensive interviews with patients and staff to ascertain what information patients want as they prepare for a cardiac procedure. Combining the feedback they received with their years of clinical experience, they created a video containing a step-by-step account of the entire Cath-Lab experience, proactively answering all the questions typically asked by patients.

The study encompassed 185 participants, 94 in the treatment group, and 91 in the control group. Anxiety levels were measured before and after watching the video and again before and after the procedure using the

Spielberger State-Trait Anxiety Inventory (STAI) Scale. Patient satisfaction was measured using a similar survey tool.

No significant difference in anxiety was detected in the treatment group. But satisfaction with preparatory information was statistically higher in the treatment group than the control group.

Cain and Gavigan concluded that specially tailored education is helpful to patients who may receive unreliable information from external sources; preparatory information corrects misinterpretations and helps define expectations about their unique sensory experience; and providing sensory preparation increases patient satisfaction.

Further, nurses need to be aware of cues that indicate a need for more information; nursing interventions need to focus on decreasing anxiety; and nursing can use preparatory information to improve the patient experience.



**(L-r): Diane Carroll, RN; Carolyn Cain, RN; and Anne Gavigan, RN**

# From the NICU to OB clinics: the research practice trajectory

**D**elivering this year's Yvonne L. Munn Nursing Research Lecture, was dean and professor at the William F. Connell School of Nursing at Boston College, Susan Gennaro, RN. And if one thing is clear from her presentation, it's that clinicians don't drive research—research drives clinicians. Gennaro started with a single research question back in the 1970s. She wanted to understand more about anxiety and depression in mothers of full- and pre-term babies, so she designed a research study she thought would help her do that. Her research questions was: "What are the maternal risk factors regarding adapting to being the mother of a pre-term baby?" Though the study produced some valuable data, it didn't quite capture the information she was looking for.

So she learned to ask better questions.

Gennaro's research took her from Alabama to Pennsylvania, to Africa, to Boston. She continued to receive funding to dig deeper into the issues affecting this patient population.

Gennaro's presentation took listeners on a virtual journey of the evolution of her research from the 70s through today as she learned to refine her research methods. The questions she asked led to more and more questions. Her decades of study have added to the body of nursing knowledge about pre- and post-natal care of babies and mothers and helped identify barriers to good care in diverse populations.

Among the many lessons learned along the way was the importance of mentor-

**Susan Gennaro, RN, dean  
and professor at the William  
F. Connell School of Nursing  
at Boston College**



ship. She learned that when you design research studies that have synergy with other disciplines, you increase learning, increase participation, ask better questions, and ultimately bring greater benefit to the patient. The real challenge, she said, is translating research findings into practice. We need to focus more on research utilization or how to incorporate new knowledge into our care.

Gennaro suggests the best way to connect research to practice is through publication of research findings in vehicles that reach the lay public; serving on committees; and advocating for change through involvement with national organizations.

In closing, Gennaro noted that nursing research should be "gender-neutral, diverse, and question technology over other forms of care. Researchers should come from all races and ethnicities and work with the communities of which they are a part. They should strive to support care that is evidence-based and values autonomy and social justice.

Nursing science will bring efficiency to the healthcare system—we can't keep doing things the 'same old way.' The future of health care is bright, and you all will make a very real and important contribution to it."

Following Gennaro's presentation, director of The Yvonne L. Munn Center for Nursing Research, Dottie Jones, RN, gave a brief overview of the Center, including strategic goals and the growing number of funding sources (including the NIH, the Robert Wood Johnson Foundation, the federal Department of Human Resources and Services Administration, AARP, and others). She shared emerging areas of research, including care of the elderly,

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# 2010 Yvonne L. Munn Nursing Research Awards

complementary healing, work-force evaluation, and symptom-management.

Said Jones, "Our goal is to work collaboratively to advance patient care; establish partners; generate resources; promote knowledge-development within nursing; and create a safe, cost-effective, healing environment for patients, families, and staff."

Jones and senior vice president for Patient Care, Jeanette Ives Erickson, RN, presented this year's Yvonne L. Munn Nursing Research Awards (see photos on this page).



Director of the Munn Center for Nursing Research, Dottie Jones, RN (left), and senior vice president for Patient Care, Jeanette Ives Erickson, RN (right) with recipients of the 2010 Yvonne L. Munn Post-Doctoral Nursing Fellowship (l-r): Tara Tehan, RN; Mary Guanci, RN; and mentor, Donna Perry, RN. The study will look at, "The Impact of Death and Dying in the Intensive Care Unit on New Graduate Nurses."



Recipient of the 2010 Yvonne L. Munn Nursing Research Award, Julie Cronin, RN (left), and mentor; Paul Arnstein, RN, with senior vice president for Patient Care, Jeanette Ives Erickson, RN (second from right), and director of the Munn Center for Nursing Research, Dottie Jones, RN. Cronin's study will look at, "Family Members' Perceptions of Most Helpful Interventions during End-of-Life Care of a Loved One."



2010 Yvonne L. Munn Nursing Research Award recipient, Paula Restrepo, RN (second from left), and mentor; Diane Carroll, RN (left), with senior vice president for Patient Care, Jeanette Ives Erickson, RN, and director of The Munn Center for Nursing Research, Dottie Jones, RN. (recipient, Deborah Jameson, RN, not pictured)

The study will look at "Improving Compliance with Non-Invasive Mechanical Modalities for Venous Thromboembolism (VTE) Prophylaxis in the Surgical Intensive Care Unit,"

# Interactive nursing research poster display and doctoral consultations

*sharing nursing knowledge and best practices*

As part of the MGH Nursing Research Expo, which included scientific sessions, poster displays, oral presentations, and doctoral consultation sessions, members of the MGH nursing research community came together to share, educate, inspire and foster interest in future nursing research.



## Nursing Research Expo (continued)



### 2010 Nursing Research Expo Poster Awards

#### 1st place

"A Feasibility Study of Low-Cost Self-Administered Skin Care Intervention in Head-and-Neck Cancer Patient Receiving Chemoradiation"  
Investigators: Catherine M. Mannix, RN; Mimi Bartholomay, RN; Carol Doherty, RN; Maryellen Lewis RN; and Mary-Liz Bilodeau, RN

#### 2nd place

"Process Considerations for Improving Committee Efficiency"  
Investigators: Chelby Cierpial, RN; Kate Fillo, RN; Patricia Flaherty, RN; Mary Larkin, RN; and Virginia Capasso, RN

#### 3rd place

"Development of a Unit-Based Quality and Nursing Practice Committee"  
Investigators: Melissa Donovan, RN; Julie Dillon, RN; Patricia Fitzgerald, RN; and Kate Barba, RN

# The patient experience of endocrine-based oral chemotherapy and drug ‘holidays’ in women with breast cancer

**P**resenting on behalf of herself, fellow principal investigator, Loren Winters, RN, and co-investigators, Karleen Habin, RN, and Barbara Cashavelly, RN, Jane Flanagan, RN, shared the results of their study, “Women’s Lived Experiences of Endocrine-Based Oral Chemotherapy for Breast Cancer,” which was conducted under the mentorship of Dottie Jones, RN. This qualitative study grew out of concerns about adherence to treatment and the fact that many women take ‘holidays’ from treatment regimens due to the many and severe side-effects that accompany medication.

To be eligible for the study, female patients had to have been diagnosed with estrogen-sensitive, early-stage breast cancer, be taking endocrine-based oral chemotherapy (EBOC), and have taken a break from treatment for any reason. Participants were recruited by nurse practitioners who knew them personally.

Each participant was asked:

- What has it been like for you to be on oral chemotherapy?
- What was it like to take a break from treatment?
- Have you resumed treatment?
- What role did nursing play to help you make this decision?
- What other supports did you have as you made decisions about your care?

Twenty-one women, ranging in age from 44–79 years old, either attended focus groups or participated in a telephone conference call with other participants. As a result of these interviews, five themes emerged. Women reported:

- feeling like more than their disease
- feeling a need to save face and brave the storm for others

- feeling a need to be in the driver’s seat
- a feeling of being old before their time
- discovering new priorities and being vulnerable

Discussion revealed that participants balanced many issues and concerns related to side-effects they found difficult to manage. They reported feeling a sense of being on their own as they sought solutions. And they shared a desire to be known beyond their disease.

Sharing experiences through focus groups gave participants an opportunity to validate their feelings and support one another.

Co-investigator, Barbara Cashavelly, who was in the audience, stressed the power of focus groups. Said Cashavelly, “Patients connected in a way we didn’t expect and couldn’t have predicted. The support they derived just from being in the same room and sharing their experiences was a positive outcome in itself.”

Said Flanagan, “The study showed us the extent to which patients are trying to figure it all out. As nurses we need to ask ourselves how we can help them. We need to be sensitive to the fact that adherence to treatment creates significant quality-of-life issues for women on endocrine-based oral chemotherapy, and we need to be prepared to advocate for them as they seek solutions.”

Flanagan suggested that to better serve patients with breast cancer, nurses need to become more knowledgeable in complementary therapies; supportive care; symptom-management interventions; and co-morbidities. We need to come from a place of knowledge as we help patients cope with the side-effects of treatment.

**Jane Flanagan, RN, nurse practitioner and principal investigator**



# Florence Nightingale: a pioneer of modern nursing

**R**eprising her 2007 performance, *Florence Nightingale: Medical Revolutionary*, Kathleen Duckett, RN, director of Clinical Programs for Partners Home Care, returned to MGH, Friday, May 7, 2010, in the form of Florence Nightingale, circa 1890-1910, complete with period dress, props, and an obvious affinity for her subject matter: the feisty founder of modern nursing.

In her lively monologue, Duckett recounted highlights of Nightingale's life, from her privileged childhood, to her inauspicious entry into nursing school (her parents told people she was pregnant out of wedlock because it was more respectable than becoming a nurse!), to her oft-cited travails during the Crimean War. Reading from a series of letters between Nightingale and long-time friend, Secretary of War, Sydney Herbert, Duckett pieced together a story of courage, perseverance, and triumph.

Nightingale's letters told of a primitive time for nursing with abysmal conditions for patients and oppressive restrictions for nurses

(indeed, many prostitutes were treated with more respect than nurses). Nightingale bristled under those restrictions and the bureaucratic red tape but never stopped advocating for her patients, even as they suffered from mortal injuries, frostbite, cholera, and scurvy.

When an article appeared in *The London Times* referring to her as the Lady with the Lamp, she resisted the nickname saying it was a distraction from her work.

Describing her interactions with dying soldiers, she said, "A nurse must feel and *not* feel at the same time. She must be able to face death, then turn to the next patient with joy."

By all accounts, Nightingale was ahead of her time. She led by example, tackling issues not yet recognized as within the scope of nursing—issues such as diversity, education, advocacy, nutrition, documentation, research, re-

source-management, systems efficiency, and putting patients first. Nightingale was the first to regard nursing as a calling not an occupation. Her teachings shaped the development of modern nursing, and her ideas continue to influence the direction of the nursing profession.



Kathleen Duckett, RN,  
as Florence Nightingale

# Author compares MGH nurses to pebbles in the water

**N**urse Week ended on a high note with a tribute to a local nurse, a member of the Army Nurse Corps, who was killed in World War II, but not before leaving an indelible mark on the heart of a nation. Author, Bob Welch, spent much of the last two years researching and writing, *American Nightingale*, the story of Frances Slanger, a young nurse who wrote a now-famous letter to *Stars and Stripes*, the US military newspaper, praising the boys in uniform for their commitment and sacrifice. Hours after sending the letter, Slanger was killed by sniper fire.

Captivated by Slanger's story, Welch interviewed surviving family members, nurses, doctors, and soldiers. He visited her childhood home, went to the beach at Normandy where she and three other nurses had waded ashore on D-Day, and read countless letters written by soldiers thanking her for her kind words in *Stars and Stripes*. Finally, he visited the field in Belgium where Slanger had died in his quest to honor this 'forgotten heroine.' The result was *American Nightingale* and a number of life lessons, many of which he weaved into his multi-media presentation.

Said Welch, "Honor comes from giving of ourselves to something greater than ourselves. People have a tendency to underestimate the impact they have on the people around them. Nurses, for example, make a difference in the lives of their patients every day. You have no idea how many lives you've touched. I

urge you to take a moment to reflect on what you do, appreciate your accomplishments, and gain that perspective."

Welch posited that most change is brought about by four factors:

- Desperation
- Imagination
- Education
- Dedication

Said Welch, "You come into contact with patients every day who may feel hopeless, desperate. What do you do? Ask yourself how often desperation, imagination, education, and dedication play a part in your practice."

He shared a poem by James Foley:

*Drop a pebble in the water: just a splash, and it is gone;*

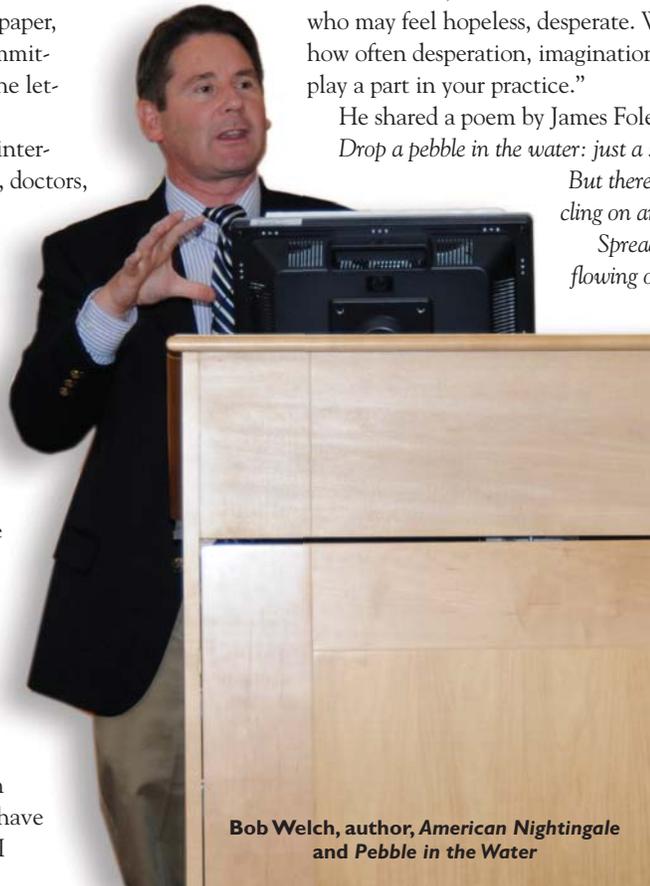
*But there's half-a-hundred ripples circling on and on and on,*

*Spreading, spreading from the center, flowing on out to the sea.*

*And there is no way of telling where the end is going to be.*

"You are each pebbles in the water. Your actions, your care, the difference you make in the lives of your patients creates a ripple, the effect of which is felt by thousands."

Welch closed with a quote from Jewish philosopher, Martin Buber: "Every journey has a secret destination of which the traveler is unaware."



**Bob Welch, author, *American Nightingale* and *Pebble in the Water***

October 21, 1944

*To the editor of Stars and Stripes:*

*It is 0200, and I have been lying awake for an hour listening to the steady even breathing of the other three nurses in the tent, thinking about some of the things we had discussed during the day.*

*The fire was burning low, and just a few live coals are on the bottom. With the slow feeding of wood and finally coal, a roaring fire is started. I couldn't help thinking how similar to a human being a fire is. If it is not allowed to run down too low, and if there is a spark of life left in it, it can be nursed back. So can a human being. It is slow. It is gradual. It is done all the time in these field hospitals and other hospitals in the ETO.*

*We had read several articles in different magazines and papers sent in by grateful GIs praising the work of the nurses around the combat zones. Praising us—for what?*

*We wade ankle-deep in mud - you have to lie in it. We are restricted to our immediate area, a cow pasture or a hay field, but then who is not restricted?*

*We have a stove and coal. We even have a laundry line in the tent.*

*The wind is howling, the tent waving precariously, the rain beating down, the guns firing, and me with a flashlight writing. It all adds up to a feeling of unrealness. Sure we rough it, but in comparison to the way you men are taking it, we can't complain nor do we feel that bouquets are due us. But you—the men behind the guns, the men driving our tanks, flying our planes, sailing our ships, building bridges — it is to you we doff our helmets. To every GI wearing the American uniform, for you we have the greatest admiration and respect.*

*Yes, this time we are handing out the bouquets — but after taking care of some of your buddies, comforting them when they are brought in, bloody, dirty with the earth, mud and grime, and most of them so tired. Somebody's brothers, somebody's fathers, somebody's sons, seeing them gradually brought back to life, to consciousness, and their lips separate into a grin when they first welcome you. Usually they say, "Hiya babe, Holy Mackerel, an American woman" — or more indiscreetly "How about a kiss?"*

*These soldiers stay with us but a short time, from ten days to possibly two weeks. We have learned a great deal about our American boy and the stuff he is made of. The wounded do not cry. Their buddies come first. The patience and determination they show, the courage and fortitude they have is sometimes awesome to behold. It is we who are proud of you, a great distinction to see you open your eyes and with that swell American grin, say "Hiya, Babe."*

*Lt. Frances Slanger  
45th Field Hospital*

# Patient experiences unwitnessed fall in Neuro ICU



Staff nurses, Klare O'Keefe, RN (left), and Kathy Berger, RN

**M**y name is Klare O'Keefe, and I am a nurse in the Neuroscience ICU. I've been a nurse for 11 years and have worked in critical care for the past eight. This narrative was written by my colleague, Kathy Berger, who was unable to be heard today. In the Neuroscience ICU, we don't experience many patient falls, but our patients are considered at risk for falling, especially those regaining strength and moving forward in their recovery.

Mrs. A was a 75-year-old woman who'd had a bi-frontal craniotomy to remove a tumor the day before. She had been brought to the Neuroscience ICU and was waiting to be transferred to a unit. While awaiting transfer, she was alert and oriented to person, place, and time, but that changed at 10:55am when she experienced an unwitnessed fall in her ICU room.

My first experience with Mrs. A was on the morning she was to transfer. She had set up her own breakfast tray, fed herself with no difficulty swallowing food or liquid, and eaten a fair amount of her breakfast. Her room was across from the nursing station, which allowed easy visualization into her room. My other patient assignment was two rooms away. My priority for Mrs. A was to ready her for transfer. When I left her room at 10:40, I had done all I would have normally done to keep her safe—I had placed her bed in the low position; I made sure her bedside table was within reach; I made sure she had her call bell, and told her to call if she needed anything.

Mrs. A was alert. Because of the complexity of her procedure, I carefully assessed her cognitive status and completed a thorough physical exam (good affect, no arm drift). She hadn't attempted to get out of bed since arriving from the operating room the night before. Several nurses had come in and offered to help that morning, so I felt confident Mrs. A was being observed, at least passively, as staff moved about outside her room.

Earlier that morning, I had been concerned about my other patient. This young, non-English-speaking woman had difficulty using her call bell and was scheduled for some bedside tests. I knew the speech pathologist and interpreter were due to arrive any minute. I spent five minutes at the nurses station and another few minutes on the phone with the Interpreter's Office until I saw them arrive. After being away from Mrs. A for about 15 minutes, I was summoned to her room by an overhead page. I went immediately and found three nurse colleagues surrounding Mrs. A, who was lying on the floor.

The nurses shared the following account of what happened:

At 10:55am, the nurse who had been in the next room heard a loud crash. "It sounded like the bedside table hit the bathroom door, then there was a loud thud." She ran into the hallway and saw another nurse, who'd also heard the crash from four rooms away, running toward the room.

The second nurse found Mrs. A sitting on the floor at the foot of the bed, leaning against the bed frame. "She must have moved down in the bed and slid out the bottom," she surmised. Mrs. A's heart rate was normal, but her blood-pressure transducer had pulled across the bed (arterial line and IV line were intact). She was pale, diaphoretic, and short of breath. She said she needed to use the bathroom despite having a Foley catheter in place.

A third nurse explained that Mrs. A had struck her hip in the fall. We laid her on the floor and used a three-person lift to get her back to bed. I took her vital signs as we settled her back in place.

I asked Mrs. A if she had hit her head, and she said, "No." I asked if she had hit her hip, and she said, "Yes." I asked if anything hurt, and she said her hip. I assessed the alignment of her hips as she lay in bed, and the right hip was slightly asymmetrical. I felt my stomach knot.

She had a Foley bladder catheter, a left radial arterial line connected to a bedside monitor, two left-arm peripheral IVs, EKG leads, and pneumoboosts on both legs. All these lines and tubes

*(continued on page 22)*

# High-risk patient falls while transferring with family member



Lily Shaw, RN, staff nurse

**M**y name is Lily Shaw. I graduated last May from Simmons College and started working at MGH in November. The story I'm sharing occurred at 6:30am on a 7:00pm-7:00am shift. It was my first time caring for Mrs. M. She had been on our unit for a few days, so I had seen her in passing and witnessed some nurses' frustration when caring for her. Mrs. M had been admitted with a diagnosis of altered mental status secondary to opioid overdose, which caused her to be non-compliant and reluctant to participate in her plan of care.

On receiving report from the day-shift nurse, what stood out most was the fact that Mrs. M's mental status had cleared somewhat, and according to her family who was very involved with her care, she was pretty much back to her baseline. Even before completing the Morse Fall Scale on Mrs. M, I noted that she would be considered a high fall-risk due to the fact that she had fallen at home prior to being admitted. She had a cast on her left ankle that impaired her mobility, and she was supposed to be non-weight-bearing. For a woman like Mrs. M who was used to being able to walk around by herself, this new handicap would be a substantial and frustrating change. She also had the potential to overestimate her abilities and be forgetful due to her recent alteration in mental status. She wasn't connected to telemetry, but she did have an intravenous hep lock, and she was taking medication for her blood pressure and the pain in her ankle. This had the ability to make her light-headed, another factor that increased her risk for falling. On top of all of this, there was a language barrier. Mrs. M spoke only Spanish.

Through report, I learned that Mrs. M was able to use her walker to pivot and transfer to the commode at her bedside with assistance while maintaining non-weight-bearing status on her ankle. Physical Therapy had determined she would need the cast for another two weeks. She didn't always use the call bell for assis-

tance, though she had been instructed and encouraged to do so. But her family was always with her, and they knew to call the nurse or patient care associate for assistance if Mrs. M needed anything. Most importantly, they were to let us know if they left her alone because then we would initiate more precautions such as turning on the bed alarm, conducting more frequent visual checks, and hourly rounds.

I felt confident in my knowledge of Mrs. M's history and plan of care, so I signed off with her day nurse and proceeded into her room to introduce myself to her and her five family members. Mrs. M was sitting up comfortably in a chair, and I could tell she was at ease with me as I told her my name, informed her that I'd be her nurse throughout the night, took her vitals, and assessed her. Her vital signs were all stable, and she was alert and oriented. As far as fall risk, I knew Mrs. M would have to be monitored more closely than my other patients. I could see how the cast on her ankle was a huge factor in terms of her safety and mobility. Before I left, I made sure all the proper fall precautions were in place, including non-skid socks, good lighting, no clutter. She wasn't receiving continuous oxygen or telemetry-monitoring, she wasn't hooked up to any intravenous medications, her walker and commode were easily accessible, and her call bell was within reach. I made sure she and her family knew how to use it and encouraged them to call if they needed anything. They demonstrated proper use of the call light and agreed to call when they needed me.

Our interactions throughout the evening and night were easy-going. Mrs. M and her children had a very close relationship, and it put Mrs. M at ease to have them there. The fact that they were there all the time reinforced how involved they were with her care. I could tell they were comfortable helping her, and I felt more at ease having them at her bedside, knowing I had an extra pair of eyes to watch her. For patients at risk for falling, I assess their risk factors every time I see them. I try to make sure they

*(continued on page 22)*

# Patient falls while afforded brief moment of privacy



Jenna Delgado, RN, staff nurse

**M**y name is Jenna Delgado, and I have been working as a nurse on Ellison 16 since I graduated with a BSN more than five years ago. Ellison 16 is known as one of the busiest general medical units with the most challenging, medically complex patient population outside of an ICU. Perhaps that's why our unit has one of the highest fall rates in the hospital. I've had two patients fall while assigned to my care, and I have assisted my colleagues with patients who have fallen numerous times.

We have successfully reduced the number of falls per patient on our unit and have taken many steps to accomplish this. Last year, we received customized, interactive fall-prevention training. This training made us more aware of the problem of hospital falls and led us to implement numerous fall-prevention tactics. Among them: new fall scales; greater utilization of chair and bed alarms; recognition of early signs of fall risk; and improved communication among healthcare providers related to fall risk and prevention.

Unfortunately, a patient I recently cared for suffered a fall. It was a frustrating and disheartening event for me and a frightening and painful experience for the patient, to say the least. I hope this experience will help me prevent falls in the future.

I first met Mr. V and his wife about two and a half weeks prior to a fall on a previous admission. Mr. V was a 58-year-old Spanish-speaking Puerto Rican man, a life-long fisherman who had been diagnosed only seven months earlier with Stage IV cancer of the larynx. He had undergone a total laryngectomy and chemotherapy, but was no longer receiving treatment when I first cared for him. His disease was resistant to treatment.

Mr. V's first admission was essentially for failure to thrive. He had been constantly in pain, frustrated, anxious, and depressed from his diagnosis. His wife revealed that prior to admission, Mr. V had spent most of his time secluded in his room, which was a vast change from his usual way of life. He had been seen and examined

by many teams, therapists, and services, only to learn that he would be discharged home with hospice care.

Because I speak Spanish, I was very involved with his care during this stay. I bonded with him and his wife as is often the case when you care for someone during their most difficult days. One Sunday morning, when his pain seemed well controlled and his mood light, I spent some time with him and his wife as he watched a fishing show on television. It was then I learned that he, like the majority of men in his family, was a fisherman. He made every effort to share his fishing tales and adventures with me.

That week, he was discharged home for only two days before going into acute respiratory distress. He completely failed at home and required a ventilator and an ICU when he was re-admitted. When he returned to Ellison 16, he was weak, somnolent, but able to be aroused. Mr. V's mother and sister were at his bedside because Mrs. V had to return to Puerto Rico to be with her ailing mother. These two women were kind, caring, and loving, and I quickly formed a trusting relationship with them as I had with Mrs. V. They knew I would support Mr. V however I could—I stayed with him during procedures and sat with him after his family had gone home for the night. I would comfort him by speaking in Spanish, usually about anything except his condition. He would drift off to sleep while holding my hand.

When discussions took place between his physicians or social workers, I wanted to be present. Mr. V spoke very few words, but he made it clear that more than anything, he wanted to return to "mi casa." Puerto Rico. His family echoed this sentiment. On several occasions they said their goal was to take him back to his homeland, as they put it, "dead or alive, but God willing, alive."

Unfortunately, he made slow progress, and the plan was for him to be discharged locally. When I arrived one night, he seemed depressed but mustered a smile for me. He had not been out of bed and hadn't bathed or changed his hospital gown. His family told me he had refused help, especially help washing. I seized the mo-

*(continued on page 23)*

# Sudden change in status triggers unwitnessed fall



Stephanie Lessard, RN, staff nurse

**M**y name is Stephanie Lessard. As I reflect on this past year, my first year as a nurse, I recall countless challenging experiences. I've felt excited, thrilled, stressed, and above all, a real sense of connection to the nursing profession. This feeling has only deepened as I've come to feel more confident in my practice, something I thought was out of my reach when I first began my career as a nurse.

One experience that stands out happened on a Saturday morning when one of my patients fell. I remember specifically the chain of events and how the impact of that one fall grew into something terrifying and challenging for me.

Mr. B was an 82-year-old man with a history of coronary artery disease and coronary artery by-pass surgery in 1993, who had transferred to MGH from an outside hospital complaining of chest pains. His primary symptoms were shortness of breath and associated chest pain. In our Cardiac Cath Lab, Mr. B was found to have further progression of his coronary disease and a further depressed ejection fraction indicating increased heart failure.

On this Saturday, as I was standing at the telemetry monitors performing my 10:00am 'tele-checks,' I heard the call bell for Mr. B's room and Mr. B's voice saying he'd just fallen. I hurried to his room and found him on his feet, flustered, and heading for the bathroom. I called for help and took hold of his arm as we moved together toward the bathroom, all the while trying to assess if he'd been injured. I stayed with him in the bathroom. I asked what had happened, how he had fallen, what he's been doing when he fell, why he had wanted to get up, and if he felt any pain.

Mr. B seemed scared and shaken. He said he had urgently felt the need to go to the bathroom. He described how he

had gotten up from his chair and fallen, striking his left shoulder and elbow; he knew he hadn't hit his head. Fortunately, there were no bruises, scrapes, or open wounds visible as I checked him over. He said he remembered falling, but didn't know why he fell.

As another nurse and I walked Mr. B from the bathroom to his bed, he shuffled his feet—something that wasn't normal for him—and therefore I was concerned. As soon as I settled him in bed, I checked his neurological and vital signs, which were all normal. I thought perhaps it had been a mechanical fall, maybe he had tripped over himself while getting up from the chair and rushing to the bathroom. I paged the fellow, explained what had happened, and asked him to come assess the patient.

The fellow arrived, completed his exam, and had no new orders. He suggested I continue to watch Mr. B.

Within 30 minutes, Mr. B began to complain that his left side felt weak, and he slouched toward the left side of the bed. He said, "I'm in a euphoric state." He couldn't form his left index finger and thumb into a circle, but he could with his right. I paged the fellow again and he came up immediately, this time he looked worried and asked me to page the Neuro Stroke Team, stat.

I started to second-guess myself. Was there something I could have done differently to prevent this? I became overwhelmed as I thought about what had happened. But I realized it wasn't the time to doubt myself, so I put those thoughts out of my head. Mr. B needed me to get him to CT Scan and MRI right now, so that's what I focused on.

After reviewing Mr. B's scans with the radiologist, the stroke fellow determined that Mr. B. was not a candidate for thrombolytic therapy. Because the radiology study showed multiple embolic strokes, possibly due to the current changes in his cardiac status, Mr. B would need to receive more con-

*(continued on page 23)*

## Fall Narrative (Berger) continued...

(continued from page 18)

were intact, but her hip was asymmetrical. Only her nasal cannula had been disconnected during the event.

I called the responding physician, and the nurse practitioner responded. Neurosurgery had seen the patient at 6:30 that morning and was confident, despite Mrs. A's long surgical procedure the previous day (more than 11 hours), that she was ready to transfer to a unit. Now the Neurosurgery Team was adding orders for Radiology and Laboratory tests. The pace of my day was picking up. One of my colleagues offered to cover my other patient for the remainder of my shift. I was becoming increasingly busy.

Mrs. A's son and daughter-in-law arrived to visit her. I hadn't had time to call them or let anyone know that I needed to see them before they saw Mrs. A. Before I got to her room, Mrs. A told her son that she had fallen and hurt her hip while trying to get tea. The son was upset, repeating to me what his mother had said. I tried to explain that, yes, she had fallen, but the physicians had seen her, and I was trying to get her to Radiology for an X-ray of her hip. The day continued to get worse.

I was shocked and upset that this had happened to my patient. She had fractured her hip, which by itself would make for a complicated situation. But because she had just had brain surgery, the decision-making would be all the more complex. For the next week, Mrs. A remained in the ICU while decisions concerning anti-coagulation, orthopaedic surgery, and management of her ICU psychosis became the new priorities. The expectation that her recuperation would take weeks was turning into planning for months of rehabilitation.

I still wonder what I could have done differently to prevent Mrs. A from falling.

## Fall Narrative (Shaw) continued...

(continued from page 19)

have everything they need, they've been toileted, and they have the means to call if they need something else.

Because of Mrs. M's limited mobility, there was a commode at her bedside for her convenience. Whenever she needed to use the commode, we made sure the room was well lit, the commode was locked in place, and the floor was clutter free.

Mrs. M's son was present at her bedside the entire night. He was very involved in his mother's care and was used to assisting her at home. He was, however, aware that he was supposed to call the nurse for assistance when transferring his mother.

At about 6:30 in the morning, as I was going into Mrs. M's room to check on her, I found the lights on and saw Mrs. M sitting on the floor next to her son who was standing over her with her walker nearby. The patient care associate, who had come in to draw labs, informed me that Mrs. M's son had told her she'd just fallen while transferring back to bed from the commode. Neither I nor the patient care associate had been alerted that she needed to use the commode.

Neither of us had witnessed the fall.

We helped Mrs. M safely back into bed, and I asked her son what had happened. He said she had needed to go to the bathroom, and he was used to helping her so he'd helped her to the edge of the bed and transferred her to the commode. When she finished, he helped her back to bed, but, "all of a sudden,"

she felt weak and fell back on her butt. She reported no pain, and said she hadn't hit her head. After Mrs. M's fall, she was able to get up and transfer back to bed safely with assistance. The night resource nurse and night medical intern were both made aware of her fall and came in to assess and examine her.

I documented the fall in my daily shift report as well as in a formal safety report, where I described the specific details of the fall and the precautions that were in place to prevent it from occurring.

Mrs. M was discharged later that day despite the fall; however I had been unaware of this plan while caring for her. If I know a patient is going to be discharged, I want to feel confident they've achieved their prior level of independence and will be able to return to their everyday lives and be safe. I might change my goals for the day, for example, to ensure they're as independent as possible with their activities of daily living, or as close to their baseline abilities as possible.

I know that keeping the patient safe is the most important thing I can do. It's essential to partner with the family in providing the patient the care that they require—especially when the patient is so close to discharge. Despite Mrs. M's well-meaning family, I worry that families don't have the understanding or skills needed to manage patients in this time of transition. I realize that within the hospital setting families can be a huge help, but instructing them also means following-up and continually educating them rather than hoping they'll make the right choices when partnering with clinicians to keep their loved ones safe.

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Despite Mrs. M's well-meaning family, I worry that families don't have the understanding or skills needed to manage patients in this time of transition.

## Fall Narrative (Delgado) continued...

(continued from page 20)

ment and thought it would be a good idea to get him out of bed and into the bathroom to restore some semblance of normalcy, independence, and dignity to the situation. He was supposed to go home the following day where he'd have to manage stairs and navigate his apartment. He agreed to wash up in the bathroom.

When I assisted him out of bed, I noticed he was slightly unsteady in that way patients look when they get up for the first time in a while. I held one arm, he held the urinary catheter with his other hand, and we walked the short distance to the bathroom. He sort of veered back and forth from one side to the other as if he were failing a sobriety test. Perhaps that's exactly how he felt because he was receiving high doses of methadone to curb his pain.

Once in the bathroom, he sat in a chair in front of the sink with all his toiletries within reach. I made certain of this. I helped him take off his clothes, showed him where the pull cord was and how to use it, and told him I'd give him a few moments of

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They had trusted me, I had gone the 'extra mile' for him, and then he fell on my watch while I was just a few feet away.

privacy. I assured him I'd be nearby and return shortly. I told him I didn't want him to get up from the chair without my assistance. He agreed. I left the bathroom and proceeded to change the linens on his bed.

I hadn't even finished the bed when I heard a thud in the bathroom. I didn't think it was the

sound of him falling, but my gut told me to check. I opened the door and found him on the hard floor of the shower looking forlorn and in pain. I couldn't believe my eyes. I didn't *want* to believe it. How could this patient whom I cared so much about, I was so protective of, fall with *me*! And *why* had he gotten up when everything was right there at his fingertips. My heart raced. I felt my face turn red.

Mr. V was alert and responsive. There was no evident trauma. He said he was okay and wanted to get up. After further assessment, I helped him back to the chair. He told me he had wanted to use the toilet and that's why he stood up without me. He said he hit his shoulder and injured a finger. I examined him. There were signs of adequate circulation, motion, and sensitivity.

I explained that I'd need to inform his family and the covering physician about the fall and that it could inhibit the plan to be discharged the following day. He begged me to conceal the information. I hesitated for a split second not wanting to jeopardize our trust, but I knew what had to be done. I walked him back to his bed, measured his vital signs, which were all within normal range for him, and left to inform the physician.

No physical injury was discovered as a result of the fall, but the event led his family and the team to realize that the plan to discharge him the next day was not in his best interest. So he remained with us and became a patient of the Hospice Service.

It's always an unpleasant and worrisome experience when a patient falls, but this particular fall was troublesome to me because of the bond I had developed with Mr. V and his family. They had trusted me, I had gone the 'extra mile' for him, and then he fell on my watch while I was just a few feet away. I was extremely frustrated because my intention was to facilitate something positive, and in the end, more harm than good had come of it.

## Fall Narrative (Lessard) continued...

(continued from page 21)

servative treatment. Physicians were also reluctant to start Mr. B on anticoagulation medication because they worried he was at increased risk of hemorrhaging. They ordered baby aspirin daily. I returned to the unit with Mr. B and settled him into bed so he was comfortable.

That night, he became agitated, confused, and combative. The next day, I spent almost my entire shift in his room. I cared for him, spoke to him, and tried to keep him safe in his environment. My heart broke as I thought about this lovely man's life changing one Saturday morning. Being with him reminded me how precious life is and how as nurses we play such an important role in keeping patients safe.

I cared for Mr. B throughout the remainder of his hospital stay and recall fondly how he was so joyous and thankful to all of us as he left for rehab. He was excited to be moving on and tackling a new adventure. He was happy for the future.

I kept thinking about how sick and vulnerable he had been. I was also grateful that I was there for him that day and throughout his stay—to care for him, to encourage him. Caring for a patient who has a difficult course is never an easy thing. While caring for Mr. B, I gained confidence in my nursing practice, appreciation for my peers, and the knowledge that I had the support and resources to do my job in the safest manner possible.

colony of India. She was an advocate for preventative health and the healthcare rights of soldiers and veterans.

More than sixty years after the Crimean War, the children of an old soldier who was a veteran of that war were making final arrangements for his funeral. Among his possessions they found a shriveled old orange, no bigger than a walnut. With the orange was a note scribbled on a scrap of paper that read: "Given to me by Miss Florence Nightingale." When Nightingale herself was buried, her coffin was attended by octogenarian veterans of the Crimean War, one of those countless conflicts that have blighted the history of human progress, and which would have been forgotten by history but for the work of the Lady with the Lamp, Florence Nightingale.

What would Florence Nightingale say if she were here today? Would she say, "We must do better than this"?

Next year when we come together, we will be well into our celebration of the first 200 years of MGH and crafting a new vision for the next century of our hospital.

When patients and families come to MGH, their first impression will be of our new building. But the impression they will take away will be the exceptional care, teamwork, and loyalty of our workforce. Attitude is what determines whether a hospital is good or great.

Florence Nightingale was the first architect of hospital structures. She believed it was the people, not the bricks and mortar, that made a hospital great. We'll soon have a

beautiful new building, but what about the 'invisible' architecture—our core values, vision, and guiding principles?

When Nightingale was in Scutari, she worried about basic sanitation, morbidity, and mortality. Patient outcomes were her measure of success. Like us, she knew it was important to take ownership of patient and organizational goals.

I suggest that as nurses, we *are* owners of MGH. And with ownership comes a sacred responsibility. We're leaders—we are the largest role group in the hospital with responsibility for care, productivity, service, morale, education, and efficiency.

Pride in ownership motivates people. One hundred years after the death of Florence Nightingale, I want to propose new ways to maximize care delivery that come from personal and collective renewal. But in order to do that, we must assess our current performance... and raise the bar.

What does it mean to be owners?

Nursing care has always been and must continue to be rooted in patients and families; it must be delivered by passionate and compassionate practitioners. Using Florence Nightingale's legacy, let us explore the characteristics she thought crucial for the pursuit of perfection. Nightingale understood the importance of:

- Commitment
- Engagement
- Passion
- Initiative
- Stewardship
- Belonging
  - Fellowship
  - Pride

Ownership of MGH requires all these qualities.

Commitment, engagement, and passion are why we became nurses. If you've lost these qualities, turn to Nightingale; she has the answers.

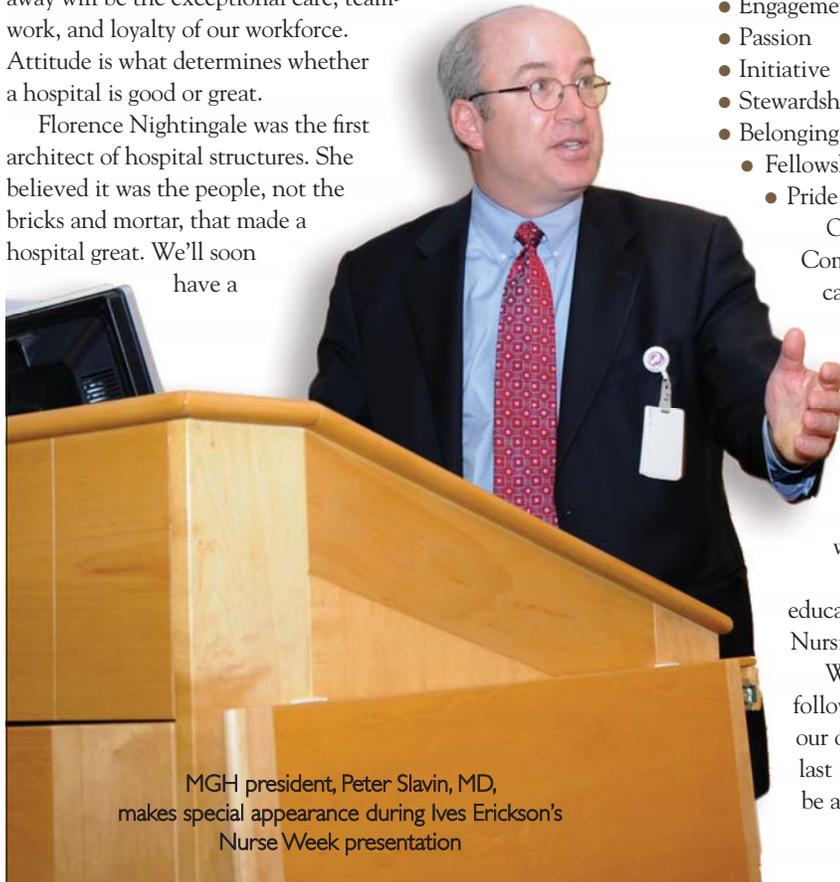
People who are committed, engaged, and passionate take initiative (the fourth characteristic).

If you see a problem, do you fix it? As the owner of MGH, if something isn't working well, do you seek a solution? If it's outside your scope of responsibility, do you say, "That's not my job?" or do you look for a way to make it better?

Do you identify best practices through networking, educational sessions you attend through the Knight Nursing Center, the literature you read?

When building a culture of ownership, leaders are often followers, and followers often leaders. Are we stewards of our organization? Will the next 100 years be as good as the last 100 or 200 years of MGH nursing? Together, will we be able to navigate the turmoil of healthcare reform that

*(continued on next page)*



MGH president, Peter Slavin, MD, makes special appearance during Ives Erickson's Nurse Week presentation

## Nurse Week Presentation (Ives Erickson) continued

will bring increased pressure to contain costs, report outcomes of care, innovate, and shed traditions that don't add value?

When you come to work each day, do you feel you truly belong, or are you just a participant? If you're an owner, mere participation isn't enough. Having a team to rely on, to work through problems and generate ideas with, is important. We need your ideas.

If we have an organization where staff and leadership feel they belong, we have fellowship. As I've shared with you in the past, Gallup's research about employee engagement shows employees feel more engaged when they have friends on the job—fellowship, kindred spirits, people with unity of purpose—nurses working with colleagues to advance common goals.

The eighth characteristic is pride. When the first seven characteristics are in place, we're able to take pride in our work and accomplishments—pride in the business we own, called MGH Nursing.

We can have state-of-the-art buildings, but that doesn't mean anything when we ask patients and families if they're pleased with their care.

Responsiveness is an important aspect of care. Patient-satisfaction data tells us, as Nightingale would say, "We can do better." Nightingale also said, "The most important quality in a nurse is the ability to observe—to really pay attention to the patient. To read the little cues that tell you how your patient is doing—physically, emotionally, and spiritually.

A number of initiatives, including safety rounds, have been implemented to facilitate proactive identification of, and attention to, patients' needs.

We monitor quality and safety data related to patient outcomes influenced by nursing care. This includes patient falls, with and without injury, and pressure ulcers. Reducing falls and pressure ulcers is a major national priority. We have made the elimination of falls and pressure ulcers a Patient Care Services priority.

Nightingale talks about empowerment, noting it isn't something that's given—it's a choice that is made. No one can empower you but you. And once you've acquired that power, no one can take it away. At MGH, nurses choose to participate in decision-making about clinical practice through collaborative governance and as Excellence Every Day champions. This is ownership and empowerment. This is taking accountability.

During these times of economic trials and healthcare reform, we must remain true to our core business—caring for patients and families. We must embrace the challenges ahead. We must see opportunity where others see barriers. We must see hope where others see defeat.

In *The Florence Prescription*, author Dick Schwab says we need "contrarian toughness." In essence, we should be thankful for problems because how we solve problems is what differentiates us from everyone else.

The Institute of Medicine's, *To Err is Human* and *Crossing the Quality Chasm*, are often credited with forging today's quality and safety agenda. But look at these quotes from Florence Nightingale:

"I attribute my success to this—I never gave or took any excuse."

"How very little can be done under the spirit of fear."

"It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm."

Florence Nightingale was the first to speak of, and practice, transparency. Transparency means free and easy access to information—making decisions openly. The IOM taught us that we need to make information available to patients and families so they can make informed decisions when selecting hospitals, insurance, or treatment options. This transparency should include information about our performance related to quality, safety, and patient satisfaction.

We are working hard to be transparent. Earlier this year, an MGH patient died, and we identified a system error as the root cause. I think Florence Nightingale would have been pleased with our response to this sentinel event and our immediate action to define new criteria for patient monitoring. Once again, our work will shape practice, not only at our hospital, but beyond the walls of MGH.

We've looked at the eight characteristics of ownership, but I think Nightingale would say there's one more—service to the community. Ownership of practice goes *wherever* MGH nurses go.

At this point, Ives Erickson invited MGH president, Peter Slavin, MD, to the podium.

Said Slavin, "After working at MGH for twenty years, I'm happy to finally know who *owns* it! In the past, Jeanette has asked various members of the Red Sox and Patriots to make appearances here, but it's pretty clear to me that you don't have to look any further than our own walls to find the real heroes." With that, he introduced MGH nurses, Joseph Roche, RN; Denise Lauria, RN; and Jennifer Garrity, RN, all of who had deployed to Haiti in the days after the devastating earthquake.

In question-and-answer format, Roche, Lauria, and Garrity spoke about their experiences in Haiti, about the overwhelming poverty and destruction, about creating an infrastructure where there was none, and about carrying their MGH values with them into unimaginable circumstances. The common thread was the pride they felt for their colleagues, both here and in Haiti.

In closing, Ives Erickson thanked MGH nurses for their, "exquisite work, compassion, skill, inspiration, and commitment to a culture of ownership. If Florence Nightingale were with us today, I know she would admire our journey and wish you a very happy Nurse Week."



Staff nurse, Emily Curran, RN, of the Blake 6 Transplant Unit, reviews discharge information with patient, Robert White.

# Announcements

## Be Fit Lunchtime Seminars

Join advanced personal trainer, Mike Bento of The Clubs at Charles River Park, for a one-hour, lunchtime Be Fit seminar. Topics vary

Next session:  
June 14, 2010  
12:00–1:00pm

Bigelow 4 Amphitheater

For more information,  
call 6-2900.

## Support Service Employee Grant

Deadline for application is  
Friday, June 11, 2010

Sponsored by MGH Training and Workforce Development, the Support Service Employee Grant Program is part of the MGH effort to recruit and retain a skilled workforce. The program is open to eligible non-exempt employees working in clinical, technical, service, and clerical positions who want to improve their skills and advance within the MGH community.

To qualify for the grant, applicants must be employed at MGH for a minimum of two years and meet additional eligibility requirements.

For more information, or to download an application, visit the HR website at: [http://is.partners.org/hr/New\\_Web/mgh/mgh\\_training.htm](http://is.partners.org/hr/New_Web/mgh/mgh_training.htm) or call John Coco at 4-3368.

## 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.

## Patient Memorial Service

An opportunity for staff to honor patients who've passed away

Thursday, May 27, 2010  
O'Keefe Auditorium  
5:30pm

A "Remembrance Tree" will be available before the service and all day, May 26th, in the MGH Chapel. For privacy reasons, please write only the patient's first name or initials. If you're unable to attend and would like to have someone remembered, contact Katrina Scott at 6-4225.

For more information, call  
Todd Rinehart at 4-4525.

## Free Summer Help

The City of Boston's Summer Jobs Program may be the solution to your vacation-scheduling problem. For almost 20 years, MGH has provided meaningful part-time employment to local students while providing staffing support to departments throughout the hospital. Students spend 25 hours per week at the work site, July 8–August 20th. The program is funded through Human Resources and is available at no cost to participating departments. The only requirement is a commitment to provide a meaningful work experience in a supportive environment.

Note: we are recruiting department participation only. Students are selected from partner schools: East Boston High School, The Engineering School, Kennedy Academy for Health Careers and the James P. Timilty Middle school.

This resource is available through the MGH Center for Community Health Improvement and supported by an on-site program manager. For more information, call Galia K. Wise at 4-8326.

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For more information, call:  
617-724-1746

### Next Publication

June 10, 2010

# Banister, Donahue recognized by *Nursing Spectrum*

Every year, *Nursing Spectrum* recognizes the extraordinary contributions nurses make to their patients, one another, and the profession with its Nursing Excellence Awards. This year, MGH nurses, Gaurdia Banister, RN, executive director of The Institute for Patient Care, and Vivian Donahue, RN, cardiac clinical nurse specialist, were named recipients of the New England *Nursing Spectrum* Nursing Excellence Awards for their contributions in management and mentoring, respectively.



Gaurdia Banister, RN  
executive director, The Institute  
for Patient Care



(Photo by Paul Batista)

Vivian Donahue, RN  
clinical nurse specialist  
Cardiac ICU

tice and is being promoted by the Center to Champion Nursing in America, an initiative of AARP and the Robert Wood Johnson Foundation.

Donahue was recognized for her inspirational methods of teaching and sharing best practices. Always setting an example, she helps nurses, physicians, and others on her unit to understand policy, implement best practices, respond to emergencies, and provide exceptional care. She never just walks through the unit; she always looks for ways to help, teach, and make a differ-

ence. She's involved. Through her teaching and encouragement, nurses become more knowledgeable and more confident.

Donahue is more than a mentor, she's a counselor. When nurses experience set-backs or lose confidence in their abilities, Donahue intervenes to help them re-gain their footing. In her characteristic non-judgmental manner, Donahue is a constant source of learning, assistance, and encouragement, always with an eye toward improving practice and improving care.

Congratulations to Banister and Donahue on being named 2010 New England Nursing Excellence Award recipients.

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