

Caring

HEADLINES

December 20, 2001

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Patient Care Services well represented at Partners in Excellence Awards



Pictured here with MGH president, James Mongan, MD (left), and Partners president and CEO, Samuel Thier, MD, staff of the Office of Patient Advocacy (l-r): Sheryl Katzanek, Diann Burnham, and Anita Galloway, accept their Partners in Excellence Award. Steve Reardon (not pictured) is also part of the team. (More coverage on page 12)

MGH Patient Care Services

Working together to shape the future

Quality: there's no such thing as the next-best thing

In the book, *Crossing The Quality Chasm: A New Health System for the 21st Century*, a report on the quality of health care in America, the Institute of Medicine purports that "The American health care delivery system is in need of fundamental change. Many patients, doctors, nurses, and health care leaders are concerned that the care delivered is not, essentially, the care we should receive." The Committee on the Quality of Health Care in America, created in 1998, was charged with developing a strategy to improve the quality of health care over the next 10 years.

Crossing The Quality Chasm goes on to say that, "Now is the time for change. Technological advances make it possible to accomplish things today that were impossible only a few years ago. Patients, healthcare professionals, and policy-makers are becoming all too painfully aware of the shortcomings of our current care-delivery systems and the importance of finding better approaches to meeting the healthcare needs of all Americans. It will not be an easy road, but it will be most worthwhile." I think most of us would

agree with that sentiment.

There is no substitute for quality. Providing a safe environment for our patients and staff, and ensuring that all patients receive the best, most appropriate care, are the cornerstones of our Quality and Safety Program. It's been just over a year since MGH leadership announced the establishment of our hospital-wide program to coordinate the many quality and safety efforts under way at MGH. The Quality and Safety Program, co-led by Cy Hopkins, MD, and Joan Fitzmaurice, RN, PhD, is a collaborative effort between MGH and the Massachusetts General Physicians Organization (MGPO). The program focuses on providing leadership and support to quality-related endeavors and improving the communication systems that enable those efforts.

The MGH Quality and Safety Program is committed to:

- integrating and coordinating all quality-improvement and patient-safety activities
- ensuring that processes and policies are in place to optimize safety measures
- monitoring and analyzing hospital performance and progress

- providing training for clinical and support staff to assist in these activities

New rules set by the Joint Committee on Accreditation of Healthcare Organizations (JCAHO) require hospitals to inform patients if they have been harmed as a result of a medical error. MGH has long been in line with this new JCAHO standard, but we have recently revised our policy to include even more specific guidelines to help support efforts to maintain a safe environment for all patients, staff and visitors. This revised policy is one of several initiatives introduced by the Quality and Safety Program to help establish a culture of safety at MGH.

The Quality and Safety Program is in the process of developing a medication-error prevention project to monitor the hospital's efforts around reducing medication errors. They are developing an improved tracking mechanism to follow up on incident reports.

On October 31, 2001, the Office of Quality and Safety held a retreat for MGH leadership to provide a forum for identifying quality- and safety-related priorities. Participants had the opportunity to dialogue about



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

specific quality-safety cases as a way of developing skills in addressing these types of issues.

Our goal is clear. Our Quality and Safety Program is focused. Our efforts are on target. As Johann Wolfgang von Goethe once said:

"Knowing is not enough;
we must apply.
Willing is not enough;
we must do."

Update

Rosemary O'Malley, RN, MS, MBA, currently a clinical nurse manager at New England Medical Center, has accepted the position of staff specialist for Patient Flow at MGH. She is scheduled to start in January of 2002. Please join me in welcoming Rosemary to our team.

The Employee Assistance Program Work-Life Lunchtime Seminar Series presents

"Estate Planning"

Presented by Jeffrey Bloom, Esq.

Seminar will provide an introduction to estate planning. Attorney, Jeffrey Bloom, will discuss the basic terms of estate planning, such as wills, power of attorney, guardianship, trust, probate, executors and administrators, and how elder care can coincide with estate planning, particularly around financing nursing home costs.

Information will be included on how to access services for estate planning.

**Thursday, January 10, 2002
12:00-1:00pm
Wellman Conference Room**

For more information, please contact the Employee Assistance Program (EAP) at 726-6976.

Patient-Family Advisory Councils

The Fielding the Issues section of Caring Headlines is an adjunct to Jeanette Ives Erickson's regular column. This section gives the senior vice president for Patient Care a forum in which to address current issues, questions, or concerns presented by staff at various meetings and venues throughout the hospital.

Question: Do we have patient-family advisory councils at MGH?

Jeanette: MassGeneral Hospital for Children has had a pediatric patient-family advisory council since October of 1999, and this month we launched an adult patient-family advisory council within the MGH Cancer Center. The councils are made up of between 15 and 20 members, and include representatives from MGH, our patients, and their

families. Members may be in active treatment, may themselves be survivors, or may be family members of living or deceased patients.

Question: What is the purpose of a patient-family advisory council?

Jeanette: A patient-family advisory council allows us to create a partnership; it's an opportunity to collaborate with, and learn from, patients and families as we build new programs

and facilities and enhance the current experience of those seeking our care. Patient-family advisory councils reflect our value of the opinions of our patients and families, and provide a formal mechanism by which to incorporate their viewpoint into planning programs and activities on an ongoing basis.

Question: How do we measure their success?

Jeanette: We are successful if we can demonstrate a mutually bene-

ficial partnership that influences how we deliver care; orient our staff, patients and families; design our facilities; develop our programs; listen to our patients and families; and build a vision for future programs.

Question: What qualities do you look for in potential members?

Jeanette: Individuals need to have the courage to share their experiences, be able to listen, be respectful of others, and believe in our mission. (And it helps to have a good sense of humor!) Members should be able to look at the big picture and recognize that they are part of a

process. This is not a support group intended to meet the individual needs of a patient or family in crisis (There are other groups available for that purpose). This is an advisory council geared toward looking at ways to improve services at MGH.

Question: Why do most patients and families participate?

Jeanette: Most members report having a desire to help others navigate a sometimes complex healthcare system; they want to be part of solutions, or give something back when they feel they've received excellent care and consideration at MGH.

Confidentiality: we take privacy seriously

MGH has kicked off a campaign to promote patient confidentiality in an effort to heighten awareness about our confidentiality policies. The campaign, appropriately themed, "Caring for Patients while Respecting their Privacy," utilizes e-mail messaging, posters, fliers, presentations, meetings, educational sessions, and articles in hospital publications.

Many individuals in the healthcare setting see, hear, or otherwise come into possession of confidential information

in the course of doing their jobs. It is the responsibility of every employee to keep patient information confidential. Violating confidentiality policies could lead to disciplinary action, up to and including, termination of employment. That's how seriously MGH takes its commitment to patient confidentiality. Remember:

- Keep patient information (including but not limited to) patient's name, condition, emotional status, financial situation, or demographic information, confidential.

- Patient information should only be accessed, discussed or shared when it is required for employees to do their job or if a patient gives specific permission for information to be shared.
- Be mindful of surroundings when discussing patient information. Avoid discussing cases in public areas, such as elevators, hallways, shuttle buses, public transportation or at social events.
- Keep confidential papers, reports, and computer data in a secure place.

- Retrieve confidential papers from fax machines, copiers, mailboxes and conference tables as quickly as possible.
- Use technology such as fax machines, e-mail, cell phones and pagers only to support patient-care activities. Do not fax information to attorneys, employers or patients.

- Always tear or shred paper copies of any document containing patient information.

For more information about patient privacy and confidentiality policies, call Deborah Adair, director of MGH Health Information Management Services, at 726-2465.

Feeling stressed?

The Greater Boston Acupuncture Group, Inc., which is working with the MGH Stop Hypertension with Acupuncture Research Program, is offering discounted massage and acupuncture therapy to all MGH employees.

Acupuncture:
usually \$78—\$58 for MGH employees

Massage:
usually \$75 per hour—\$65 for MGH employees
(half-hour rates also available)

Services provided at 100 City Hall Plaza
For appointment, call 617-720-2221

Fresh perspective on continuum of care

On July 16, 2001, we started our professional careers as administrative fellows at MGH. We both completed our master's degrees in Health Administration last May, but neither of us had significant work experience. The administrative fellowship is a two-year program that allows us to rotate through different areas of the hospital much like a medical-residency rotation. The program is designed to expose us to the many complex systems that work in concert to successfully operate the hospital. Our goal is to determine, by the end of our two-year fellowship, the areas of health administration where we feel we can make the greatest contribution.

We spent our first five months at MGH in our Patient Care Services rotation under the direction of associate chief nurse, Trish Gibbons, RN, director of The Center for Clinical & Professional Development. We both strongly agree that starting with Patient Care Services was to our advantage since neither of us has a clinical background, and we will probably never have the opportunity to be exposed to a clinical setting again to this degree. Without exposure to the ins and outs of daily

patient care, an administrator can become distanced from the main focus of hospital administration: maintaining and improving systems that ensure all patients receive quality clinical care.

In our PCS rotation, we were precepted by nurse managers, Donna Jenkins, RN, and Sue Tully, RN. On their units we worked as operations associates shadowing a wide variety of people including nurses, operations coordinators, case managers, pharmacists, and social workers. We completed unit-specific and other PCS projects, and had opportunities to attend meetings and work with senior members of PCS management. All of these experiences were helpful and informative for us. But working on just one unit only gave us a snapshot of a patient's experience at MGH. We didn't really get a sense of the continuum of care. So Rosalie Tyrrell, RN, professional development coordinator, arranged for us to participate in a two-day continuum-of-care experience on the cardiac care units.

We began by talking in detail with nurse manager, Judy Silva, RN, and other staff on the unit to gain insight into

the goals of the Cardiac Access Program and the effect it has on the population of cardiac patients at MGH. Judy explained that the Cardiac Access Program gives community doctors the opportunity to refer patients to MGH for specialized cardiac care. We were amazed at the number of patients transferred and referred from outside facilities and the insurance and reimbursement issues involved with each patient.

We spent time learning about the role of the nurse practitioner on Ellison 11. It was very valuable to learn the differences between NPs and RNs in terms of their work responsibilities and education necessary for certification. We saw first-hand the benefits that NPs bring to the unit by observing NPs with patients and in their interactions with other clinical staff. It occurred to us that NPs could be of great use throughout the whole hospital.

The majority of our second day was spent in the Cardiac ICU with clinical nurse specialist, Cathy Griffith, RN, discussing how the ICU fits into the cardiac continuum of care. Cathy described the care pathways and resources involved in cardiac treatment. We



Administrative fellows, Shea Sherrod, MHSA (left) and Meg Vitter, MHA

learned about equipment set-up and replacement and some of the issues associated with new technology.

We visited with a case manager from Ellison 8 who described her role in patient care and told us how valuable she finds the clinical pathways on the Cardiac Unit in guiding discharge planning and evaluating length of stay. We were impressed that so many clinical staff find clinical pathways to be valuable tools in providing excellent and efficient patient care. In graduate school, we had both read a Harvard Business School case study that described the development of cardiac clinical pathways at MGH. It was exciting to revisit the information presented in that study and then witness first-hand the successful standardization of cardiac care and see how the pathways have evolved since their original implementation at MGH.

Although no diagnosis or patient population is exempt from variation, the nature of cardiac care lends itself to standardization of protocols, procedures, and care plans. Standardization contributes to efficient systems and improved patient care. Efficiency leads to increased patient flow. It is not unusual for a cardiac patient to move through two or three cardiac units in two days; in fact, it is expected.

It seemed to us that managing the cardiac service was a delicate balancing act, always coordinating patient-care needs, handling patient transfers from other hospitals, bed management, and prioritizing elective and previously scheduled patients who needed to be delayed or rescheduled due to emergent cases coming in through the ED and other areas. Strong communication is extremely important in maintaining the efficient

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Evaluating collaborative governance and its impact on empowerment

On October 10, 2001, at the annual collaborative governance celebration and presentation, Dottie Jones, RN, nurse scientist for The Center for Clinical & Professional Development, presented the results of her research evaluating the impact collaborative governance has had on staff's sense of empowerment. The study sought to measure staff's perceptions of empowerment among members versus non-members of collaborative governance committees; and to see if those perceptions had changed over time by comparing three separate sets of

data collected at various intervals following implementation of the collaborative governance model in 1997.

For the purposes of the evaluation, empowerment was defined as:

- amount of opportunity in present job
- access to information
- access to support
- access to resources
- work setting overall
- opportunities for specific activities within present job

Based on the results of the surveys, Jones concluded that collaborative governance has proven to be a successful structure by which to promote decision-making and

ensure that authority, responsibility and accountability for patient care is in the hands of practicing clinicians. Said Jones, "Collaborative governance members report feeling more empowered within the organization to control their own practice and participate in opportunities that promote growth and contribute to professional development. Members and leaders within the organization support the continued growth of collaborative governance."

Following are some of the open-ended questions and the responses given by committee members:

What has it been like serving on a CG committee?

- I feel listened to. I feel like my opinions count.
- It has been wonderful. I feel extremely informed; I know more about what's going on.

How has it influenced your decision-making within the institution?

- I feel that my opinion is respected.
- I realize that my department is appreciated and contributes to the whole.
- I see that staff positions can influence decision-making.

How has being on a CG committee influenced your professional development?

- It has increased my awareness of practice changes.
- It increased my ability to express concerns.

- It inspired me to become more active in overall hospital activities.
- It allowed me to see the hospital as a whole.

What do you see for the future of CG?

- Keep it going!
- CG has a positive future—more staff need to be involved.
- I hope it continues to influence major decisions.

Collaborative governance committees will continue to align their goals with organizational and unit-based initiatives, promote professional growth across disciplines, and support organizational efforts to improve patient care.

For more information about collaborative governance, contact The Center for Clinical & Professional Development at 6-3111.

Fresh Perspective on Continuum of Care

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cy of these systems. Nurse managers on the cardiac service keep the lines of communication open to facilitate care between the units. Nurse practitioners, case managers, and staff nurses all work together to ensure that patient care is on target and that patients are navigated through the system as efficiently as possible.

The cardiac units at MGH have done an excellent job of implementing programs that work not only to improve quality and efficiency, but are also business savvy. For instance, the Cardiac Access Program ensures that transfers are appropriate, that the admissions process is smooth, and that care is received

in a timely manner. This creates stronger relationships with community physicians and increases referral rates. The MGH Cath Lab is expanding its services to include the use of peripheral catheterization. This will increase treatment options for patients and balance the potential decrease in patient census that will

occur as a result of community hospitals offering interventional central catheterization.

As non-clinical healthcare employees just beginning our careers, it's difficult to grasp all the complex roles and interactions that take place among clinical staff on units that provide complementary cardiac care. The opportunity to spend time directly observing the delivery of patient

care on these interconnected cardiac units and communicate with clinicians from all disciplines was extremely educational. Above all, the experience significantly increased our knowledge of clinical relationships, and our understanding of the systems, teamwork, and communication necessary to provide a successful and efficient continuum of care.

During their rotation with Patient Care Services, administrative fellows are available to do projects to enhance their knowledge of clinical operations as well as provide support to managers.

If you have such a project, please contact Trish Gibbons, RN, in The Center for Clinical & Professional Development at 6-3111.

A willingness to listen helps unfold mystery of young boy's behavior

My name is Pamela Quinn, and I am a nurse in the Emergency Department's Acute Psychiatric Service. In preparing to write this narrative, I spent time reflecting on the past year. I found myself wondering what it is about psychiatry that I find so interesting, fulfilling and such an integral part of treating the whole patient... despite the fact that it is sometimes overlooked or deemed less important than 'medical' concerns.

I thought about why some 'non-psychiatric' caregivers are uncomfortable dealing with psychiatric issues. While I'm certain there are many reasons, I'm choosing to deal with just one: the discomfort of dealing with angry or uncomfortable feelings. Addressing these feelings can be so overwhelming that some people are unable to recognize them at all and end up avoiding them completely; thus, they are never dealt with.

There are many qualities one must possess to be a good psychiatric nurse: compassion; empathy; a willingness to listen to the most uncomfortable information without passing judgment; the ability to sift through information to

figure out what people are really saying, how their experiences affect their lives, and what to address to ensure proper treatment.

Quite often, I imagine myself in the shoes of the patient and try to understand what he or she is feeling. In doing so, I render what I believe to be the most helpful and appropriate care for that patient. All this reflection led me to remember a particular patient. A young boy with serious juvenile-onset diabetes... a medical condition.

He came in with his mother and father. His internist had called earlier alerting us to the fact that the boy was considered actively suicidal. It seemed he had recently become irritable and argumentative at home, was having trouble getting to and staying in school, and most important, he wasn't adhering to his dietary restrictions. He was either eating 'taboo' foods or flat out refusing to eat at all. Given his degree of 'brittleness,' this could be life-threatening. Also, the boy's doctor from the Joslin Clinic had called with concerns. No one could understand this sudden change in this previously responsible, happy boy.

As my interview with this patient and his family began, I began my assessment. His mother was clearly distraught over her son's recent behavior. She was tearful most of the time and genuinely concerned for her son. His father was holding the fishing tackle box that contained all his son's diabetic tools and medications. He, too, had an overwhelming concern for his son. There was another sibling who wasn't present, but who was reportedly very close to the patient.

Mother reported that the boy had always been an excellent student, pleasant and cooperative at home, outgoing with a lot of friends, and very responsible and accepting of his illness. He was a joy to both his parents. This had changed about two weeks earlier and his family and team of doctors couldn't figure out what had gone so wrong that the boy was now engaging in life-threatening behavior.

So, I asked my patient question: "Has anything happened in the recent past that was particularly upsetting or difficult for him or the family?"

And then the story was told, which explained everything for me. A few weeks earlier the family was out late at a

birthday party. The next day, the boy was still reeling from the night's activities and felt ill. After eating a light breakfast and taking his normal morning dose of regular and NPH insulin, the boy decided to return to bed. Not feeling well, he slept right through lunch. His parents realized late in the afternoon that their son was still in bed. When they were unable to rouse him, they immediately called 911. They checked his blood sugar only to find it was life-threateningly low. The boy had a seizure. Paramedics worked on him, and he finally woke up in his bedroom surrounded by frantic EMTs and a distraught family.

His mother was crying as she re-told the story. The boy was very quiet, looking down. Then she said it. "We forgot that he hadn't eaten lunch but had taken his normal dose of insulin!"

Instantly, I put myself in the boy's shoes. Oh

my God. He had almost died because they forgot. He must be so angry with them.

Mother went on to say that after the incident, the other sibling had wanted to talk about it. Both parents agreed that it would be good to talk about it, but the boy hadn't wanted to talk. "I guess we didn't listen to you," she said.

Again, I put myself in the boy's place—they weren't listening to him! With that, I said to the patient, "You must have been terrified."

He gently nodded. "And you must be so angry that they forgot."

Again, he nodded. "And then they didn't even listen to you when you said you didn't want to talk about it."

Again, a nod.

I thought about the parents and how guilt-ridden they must have been. As a parent myself, I would have felt the same way even though I knew it was an accident.

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Pamela Quinn, RN,
staff nurse, ED Acute Psychiatric Service

Health and disease: universal human concerns

—by Jean Nardini, RN, nurse manager
and president of the ANNA

Recently, I completed my term as president of the American Nephrology Nurses Association (ANNA). In my opinion, professional associations exist to meet the needs of their members. The ANNA exists to advance nephrology nursing and to improve health and illness outcomes of individuals with kidney and other disease processes requiring replacement therapies. The most successful associations of the 21st century will be those that are knowledge-based.

As president of the ANNA, my goal was to create an environment that built upon this nursing specialty's rich his-

tory of high quality care. It was important to me that diversity and culturally competent care be a priority of the ANNA. I saw this as an extension of my own growing awareness as a result of issues that have been addressed here at MGH.

As most health care providers know, diabetes is a principle cause of kidney failure. It is noteworthy that Native Americans, African Americans and Hispanic Americans are twice as likely to be affected by this disease than the general population. Even more disturbing is that in some Native American communities, as much as half of the population is affected by diabetes.

Hypertension is also a leading cause of kidney disease. According to the National Kidney Foundation, 43% of African Americans on dialysis didn't know they were in kidney failure until one week before they began dialysis. This says a lot about the need for access to health care and health education for everyone.

As consumers, patients are becoming more and more involved in the decision-making surrounding their care. Patients need, demand and use information about medical treatments and drug therapy, and understand the standards that should be applied to ensure the quality of their own health care.



Jean Nardini, RN
nurse manager, Bigelow 10, and
past president of the ANNA

I believe this activism will increase as educational levels continue to rise and greater access to information is achieved via the Internet. The Internet is a wellspring of information about the health-status disparities that exist between minority communities and the general population. Growing numbers of consumers are becoming wary of hospitals and health professionals and distrustful of government health policies. This change in public attitude creates major opportunities and challenges for the national nursing agenda.

Health and disease are universal human concerns. The health of all people is profoundly affected by scientific, technical, economic, social, educational and behavioral factors that are changing at an unprecedented rate as the world's economy becomes increasingly interconnected.

Globalization has benefited many people in many countries, but it has also created risks that cannot be addressed within traditional national borders. More than two million people every day move across national borders, and the growth of international commerce inevitably leads to increased health risks. Distinctions drawn between domestic and international health problems are losing their usefulness and can be misleading.

The interests of the American people are best served when our nation acts decisively to promote good health around the world. Our research needs to reflect an international perspective and should involve our colleagues from other nations.

As one of my colleagues years ago told me, "Minds are like parachutes. They need to be open to work."



(Photo provided by Nardini)

Caring for patients with delirium requires special skill

—by Kate Barba, RN, MS, CS, GNP
clinical nurse specialist

As a clinical nurse specialist on a busy medical unit, I'm often asked by staff nurses to help assess and develop a plan of care for older adults who are confused. Often, these patients are delirious. Delirium is defined as an acute state of confusion characterized by alterations in level of consciousness, attention span, and sleep patterns. The symptoms of delirium develop over a short period of time and may resolve in a few hours or persist for several weeks. It is estimated that 30% of hospitalized patients over the age of 65 develop delirium.

Mrs. H is an 83-year-old woman who was transferred from another hospital to Bigelow 11 to receive intravenous antibiotics for an infected pacemaker. During her first night on our unit, she became restless and irritable and was unable to fall asleep. She refused to take her medications, saying she had already taken them "a few minutes ago." She began to pull at her IV, remove her clothes, and climb out of bed.

There are three forms of delirium: hyperactive, hypoactive, and mixed. Mrs. H exhibited signs of hyperactive delirium.

Hyperactive delirium is characterized by agitation, wandering, fidgeting with clothes, bed sheets, or IVs, verbal or physical aggression, and hallucinations. With hypoactive delirium patients may appear quiet, apathetic, withdrawn, and have decreased responsiveness. Mixed delirium is a combination of hyperactive and hypoactive delirium. A patient with mixed delirium may have alternating periods of lethargy and agitation.

The following morning, Mrs. H's nurse and I reviewed her chart before entering her room. We learned that prior to arriving on Bigelow 11, Mrs. H had undergone a procedure to remove her infected pacemaker and place a new one. For this procedure she had received two intravenous medications: Versed and Demerol. We also learned that Mrs. H was hard of hearing and needed glasses to read.

There are many risk factors for developing delirium. One easy way to remember common risk factors for delirium is this mnemonic adapted from the Journal of Gerontological Nursing:

D drugs, dehydration
E elderly, electrolytes, environment, endocrine
L lack of sleep, lack of sensorium
I infection
R reduced sensation (eye/ear)
I impaction
U urinary tract infection, urinary retention
M metabolic, myocardial, misc. (pain, etc.)

Often patients have multiple factors that contribute to their delirium. Mrs. H's risk factors included: advanced age, recent surgical procedure, infection, recent administration of medications that may cause confusion (Versed and Demerol), impaired vision and hearing, and a change in her environment. It is important for healthcare professionals to be able to identify and treat all underlying causes of delirium.

When we entered Mrs. H's room, she greeted us by saying she was "ready to go home." We noticed she had removed her hospital gown and intravenous line and was fully dressed in her street clothes. A mental status exam revealed that Mrs. H was only orienting to herself; she didn't know what hos-



Kate Barba, RN, MS, CS, GNP,
clinical nurse specialist

pital she was in nor the date or year. Mrs. H didn't want to stay in her room; she began walking in the hallway.

Nursing interventions for a patient with delirium should focus on creating a safe environment for the patient. In Mrs. H's case, we individualized our interventions to best meet her needs. First, we obtained information from Mrs. H's primary care provider as to what her baseline mental status was prior to this hospitalization. This allowed us to more easily recognize any changes in her behavior. Then we helped re-orient Mrs. H by reintroducing ourselves, stating the name of the hospital, the date, and why she was here every time we entered her room. We arranged her environment to help keep her safe. For example, we removed extra clutter such as unused equipment from her room. We opened the blinds to allow natural

sunlight into her room. This not only helped Mrs. H to see better, it also helped reinforce the difference between night and day. We made sure that her room was quiet and non-stimulating. Often being too close to the nurse's station can be overstimulating for patients with delirium. We addressed Mrs. H's impaired vision and hearing by encouraging her to wear her hearing aide and glasses. We replaced her intravenous line and covered it with gauze to help prevent her from pulling it out again. And finally, since she was steady on her feet, we allowed Mrs. H to independently ambulate in the hallway while wearing her street clothes. To prevent her from leaving the unit, the nursing staff monitored her closely and the exit doors were kept shut.

Being able to leave her room and ambulate freely seemed to greatly

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Exemplar

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At that point, mother and father burst into tears and ran to the boy. Hugging and kissing him, they told him how much he meant to them and how profoundly sorry they were for their awful, awful mistake.

I said to the boy, "It's really hard when parents make mistakes, huh?"

He looked at me with tear-filled eyes, and nodded.

See, he wasn't suicidal at all. He was angry that the two people he trusted most in the world had let him down; and he just couldn't articulate that. They were the parents—they were supposed to take care of him. Parents aren't supposed to make mistakes. Isn't that what every child thinks?

Once it was all out in the open and they had a chance to talk about it (the anger, the fear, the apology) the healing was able to begin, and it did. This family went home that night much closer than they'd been when they came in. They were finally able to sit with the uncomfortable, angry feelings they

had, which came from an accident they never, in a million years, had intended to happen. They were able to take responsibility and apologize to their son, an apology he so desperately wanted to hear. Everyone was able to come to grips with the truth they had all avoided for two weeks: that the boy could have died. Their son was finally able to tell them how angry he was that he almost died because, in their words, "they forgot" to wake him up.

This boy had a team of doctors who possessed a wealth of knowledge about diabetes, a medical condition. But all that was really needed here was a discussion about uncomfortable feelings. And that discussion saved that boy's life.

It is my hope that the enlightenment experienced by this family, simply by sitting down and talking about their feelings, will never be forgotten; that they will always remember to talk about their feelings to help them through the dark times they are bound to encounter. I guess being able to do that for a child is why I am a psychiatric nurse.

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

When you read a narrative like this 'after the fact,' it's easy to think, "How could this family, so strongly connected by love and devotion, not have understood the impact of this young boy's near-death experience? But as Pamela explains, the thought of giving voice to deeply painful feelings is a powerful deterrent; so powerful, in fact, it finally erupted in this boy's attempted suicide.

Pamela went into her meeting with this family with an open mind and no pre-conceived judgments about blame or responsibility. She was able to see *all* of the emotions at work. Using her knowledge, skill and her own professional experience, she got to the root of the boy's feelings and became his voice. She made it okay for him to reveal his fear and anger. And as quickly as the words and feelings were exchanged, that's how quickly healing began for this young boy. How fortunate they were to have Pamela guiding their care.

Thank-you, Pamela.

CNS

continued from previous page

decrease Mrs. H's agitation. Eventually, a sitter was able to come and provide one-on-one monitoring of Mrs. H.

At one point, Mrs. H told us that she and her mother had just finished a "nice cup of tea together." The nurse caring for Mrs. H responded by asking her to tell us more about her mother resulting in a nice, relaxing conversation between the nurse and Mrs. H.

It's important to not argue or try to reason with a patient who is delirious. This will only make her more agitated. Instead, many experts recommend using a validation technique by showing the patient that you respect and value their feelings and beliefs. In Mrs. H's situation, she became calmer when she was allowed to reminisce about her mother.

Eventually, Mrs. H's delirium cleared, and she returned to her baseline mental status. The nursing staff on Bigelow 11 did a great job ensuring Mrs.

H's safety during the time she was confused. Just as importantly, they helped Mrs. H maintain her independence and individuality.

Overall, this clinical experience was positive for staff as well as the patient. My role as clinical nurse specialist allowed me to guide, educate, and support nursing practice in the successful care of this delirious patient. Working closely with the nursing staff each day, we have fostered a team approach that is committed to providing quality patient-focused care.

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Written contributions should be submitted directly to Susan Sabia **as far in advance as possible.** *Caring Headlines* cannot guarantee the inclusion of any article.

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Emergency Food Pack Program launched by Social Services and Nutrition & Food Services

—by Ellen Forman, MSW,
coordinator, Community Resource Center

Frequently, patients going home after extended hospital stays are not immediately ready to resume activities like shopping and cooking. They may have limited food in their home, and perishable foods may have spoiled during their absence. In the days and weeks before hospitalization they may have been unable to shop resulting in poor nutritional status upon admission.

Many patients are fortunate to have family members, friends, or neighbors to help them in these situations; but many others are not so fortunate. Some individuals may be eligible for Meals-on-Wheels, but typically it's not possible to resume or arrange new meal-delivery service on weekends. These are the kinds of situations, relatively rare but nonetheless serious, that caught the attention of a working group called, Seeking Solutions. Seeking

Solutions is comprised of representatives from many of Boston's health-care, elder-service, and home-healthcare organizations.

MGH Social Services and Case Management are part of the Seeking Solutions work group. Working with Nutrition & Food Services, the three departments came together to design the Inpatient Emergency Food Pack Program that began in October of this year. Under the new pro-

gram, social workers can authorize Nutrition & Food Services to provide generous food packs to financially needy or frail inpatients who are being discharged with no way of obtaining food over the weekend. The food packs, purchased with funds from The United Way, contain enough food for six to eight meals. This allows discharged patients to eat well balanced meals until community support can be mobilized or pa-

tients are able to manage on their own. Food packs contain frozen meals and shelf-stable foods that are nutritious and appetizing, and quick and easy to prepare by a person returning home after an extended hospital stay.

The Emergency Food Pack Program is being piloted as a weekend program only. Requests for food packs are accepted for Fridays, weekends, and holidays. For eligibility information or referrals, contact the social worker assigned to your inpatient unit (or the on-site social worker on weekends and holidays).

Says clinical social worker, Susie Black,

MSW, "We're fortunate to be able to offer this program, but we all need to work together to ensure that appropriate patients are identified and referred."

Members of the Emergency Food Pack planning committee include: Ellen Forman, MSW; Susie Black, MSW; Evelyn Bonander, ACSW, director of Social Service; Helen Doherty, RD, FMP, director of Nutrition & Food Services; and Eileen Hughes, RN, of Case Management.

For more information about the Emergency Food Pack Program, contact Ellen Forman at 6-5807.



In the Main Store Room of Nutrition & Food Services (l-r), Patrick Baldassaro, manager of Patient Food Services; Deborah Boudrow, manager of Food Procurement and Distribution; and clinical social workers, Ellen Forman and Susie Black, compile food pack for distribution.

Educational Offerings

December 20, 2001

When/Where	Description	Contact Hours
January 14—8:00am–5:00pm January 24—8:00am–4:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
January 14 8:00–10:00am, and 1:00–3:00pm	Management of Aggressive Behavior Wellman Conference Room	— — —
January 15 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	— — —
January 17 8:00am–4:00pm	CVVH Core Program VBK6	6.3
January 17 10:00–11:30am	Social Services Grand Rounds “Caring for the Chronically Suicidal Patient.” O’Keeffe Auditorium	CEUs for social workers only
January 17 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
January 23 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
January 24 8:00am–4:30pm	Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza	8.1
January 28: 7:30am–4:00pm January 29: 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1 at St. Elizabeth’s Medical Center; Day 2 at MGH (VBK6)	14.4 for completing both days
January 30 8:00am–12:00pm	Pediatric Advanced Life Support (PALS) Re-Certification Program Wellman Conference Room	TBA
January 31 and February 1 8:00am–4:30pm	BLS Instructor Program VBK601	13.2 for completing both days
February 1 12:30–4:30pm	Pediatric Trauma—Part II Wellman Conference Room	TBA
February 4, 5, 6, 11, 12, 13 7:30am–4:00pm	Critical Care in the New Millennium: Core Program Locations vary. Call 6-3111 for information.	45.1 for completing all six days
February 4 8:00am–5:00pm February 15 8:00am–4:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room.	16.8 for completing both days
February 7 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	— — —
February 7 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
February 8 8:00–11:30am	Intermediate Arrhythmias O’Keeffe Auditorium	3.9
February 8 12:15–4:30pm	Pacing: Advanced Concepts O’Keeffe Auditorium	5.1

For more information about any of the above-listed educational offerings, please call 726-3111.
For information about Risk Management Foundation educational programs, please check the Internet at <http://www.hrm.harvard.edu>



Jean Nardini, RN



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Above: Sue Briggs, MD, accepts special Partners in Excellence Award on behalf of the MGH DMAT Team for their efforts at Ground Zero following the September 11th tragedies.

The Partners in Excellence award ceremony, held in the WACC Lobby, on Friday, December 7, 2001, recognized 177 individual MGH employees and 58 teams for outstanding achievement in the areas of: Quality, Leadership and Innovation, Teamwork, Operational Efficiency, and Outstanding Community Contribution.



Watching the now-traditional, annual Partners in Excellence 'music video,' are (l-r): Martha Lynch, RD; Jeff Davis; Kathleen Myers, RN; Sue Briggs, MD; Meg Clapp; Samuel Thier, MD; and James Mongan, MD.

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