

Caring

HEADLINES

March 21, 2002

National Patient Safety Awareness Week

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*M*GH and hospitals across the country observed National Patient Safety Awareness Week, March 10–16, 2002. At MGH, the Office of Quality and Safety joined with the MGPO to host an information table in the Main Corridor, where patients,

visitors, and staff could stop to ask questions, pick up educational materials, and enter a raffle to win a gift certificate to the MGH General Store.

Information was available on fall-prevention, medication safety, and how to become a more informed healthcare consumer. Says

Joan Fitzmaurice, RN, director of the MGH Office of Quality & Safety, “Patient safety has always been a priority at MGH. We’re happy to have this opportunity to inform our patients about our efforts to keep them safe in the hospital, and help educate them about how they can make safety a priority at home.”



During Patient Safety Awareness Week, (l-r): Valery Petit-ton, RN; Maryann Columbia, RN, quality nurse coordinator for Anesthesia; and staff specialists for the Office of Quality & Safety, Honor Keegan, RN; and Tricia Lemon, RN, staff educational table in the Main Corridor

MGH Patient Care Services
Working together to shape the future

Getting to Yes: an alternative to positional negotiating

We all encounter conflict, to some degree, every day; conflict is part of life. How we choose to handle conflict, can be a big factor in how satisfied we are at work, at home, and even at play! As I've talked with staff and leadership in different forums about conflict management, I was reminded of a book I read several years ago. It's called, *Getting to Yes: Negotiating Agreement Without Giving In*, by Roger Fisher, William Ury, and Bruce Patton. The premise is so simple, it's amazing we didn't all think of it on our own. But the concepts are so logical and effective, I'd like to share some of them with you here.

The authors of *Getting to Yes* present an alternative to what they call 'positional' negotiating where two parties typically choose sides and then argue in an attempt to reach agreement. Positional bargaining, they say, is inefficient, can lead to hurt feelings, and frequently fails to generate a positive resolution.

Fisher, Ury, and Patton, all members of the Harvard Negotiation Project, suggest a different strategy, one they

call, 'principled negotiating.' Four basic points define the fundamentals of principled negotiating. They are:

1) *Separate the person from the problem.* Separating the person from the problem protects the relationships that exist between people. It lets us think of the negotiating parties as partners in a search for agreement rather than 'us' and 'them.' It is much easier to reach a common solution when you think of the negotiation process as a partnership rather than an adversarial confrontation.

2) *Focus on interests, not positions.* We all know how rigid people can become once they decide on a position and resolve to 'stand their ground.' Sometimes the position becomes more important than the actual interest or concern that sparked the position in the first place. The authors of *Getting to Yes* suggest that a wise solution reconciles interests, not positions.

3) *Generate a variety of possibilities before deciding what to do.* So often in the negotiation process, both parties see an 'either/or' situation, when in reality, there might be several solutions that would be agreeable to both sides. *Get-*

ting to Yes suggests that a conflict of interests is an opportunity for creative thinking and imaginative solutions. The more options you have, the more likely it is that a mutual solution can be reached. Clinging to the belief that there's only one right answer short-circuits the decision-making process before it even gets started.

4) *Insist that the result be based on an objective standard.* I think this is the most important component of the *Getting to Yes* strategy. As a nurse, I

would certainly never compromise my practice at the expense of patient safety, nor would anyone expect me to. That's because patient safety is an objective standard we all respect. When all parties work toward a solution based on mutually agreed

upon standards, no one's 'position' is weakened, and the outcome can only be a fair one.

Obviously, this is a simplified version of the *Getting to Yes* philosophy. But hopefully this brief overview, and the

continued on next page



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

Positional Negotiating

Soft

Participants are friends

The goal is agreement

Make concessions to cultivate relationship

Be soft on person and on problem

Trust others

Change your position easily

Make offers

Disclose your bottom line

Accept losses to reach agreement

Insist on agreement

Try to avoid contest of will

Yield to pressure

Hard

Participants are adversaries

The goal is victory

Demand concessions as condition of relationship

Be hard on person and on problem

Distrust others

Stand firm on your position

Make threats

Mislead as to your bottom line

Demand gains as the price of agreement

Insist on your position

Try to win contest of will

Apply pressure

Principled Negotiating

Principled

Participants are problem-solvers

The goal is a wise outcome reached efficiently and amicably

Separate the person from the problem

Be soft on person and hard on problem

Proceed independent of trust

Focus on interests, not positions

Explore interests

Avoid having a bottom line

Invent options for mutual gain

Insist on using objective criteria

Try to reach a result based on standards independent of will

Reason and be open to reason; yield to principle, not pressure

(From *Getting to Yes*, by Roger Fisher, William Ury, and Bruce Patton)

Patient Classification Indicators

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 questions presented by staff at meetings and venues throughout the hospital.

Question: I know our patient classification indicators have changed recently. Has this change affected our acuity measurements?

Jeanette: The acuity of our patients has been steadily increasing over the past ten years. The new patient classification tool reflects the same acuity measures as the previous tool, but we are still educating staff on its use to ensure we are getting reliable data.

Question: How can a newborn baby and an adult patient be considered the same "type" under the new classification system?

Jeanette: Patients are classified based on the amount of care they require in a 24-hour period. 'Type' is not a reflection of the specific activities performed for a patient, but rather the time required to care for a patient over a 24-hour period.

Question: A patient on our unit is very confused. She's sweet and harmless (she thinks I'm her niece). Should I be using the "Cognitive Support" indicator to describe her care?

Jeanette: In terms of patient classification, 'confusion' refers to the level of increased risk that may result from that confusion. If a patient is 'pleasantly confused,' but doesn't present a risk

to herself or others, you wouldn't use the "Cognitive Support" indicator because the workload is not affected as a result of her confusion.

If you needed to orient this patient to people, places, time, and do additional work to meet her safety needs, then you would use the "Cognitive Support" indicator.

Question: I have a patient who is receiving medication PRN (as necessary). Should I use the "Medication Management" indicator?

Jeanette: If you're administering medication

every four hours (or more frequently) for at least eight hours, *and* you're assessing her when you administer the medication, then you should be using the "Medication Management" indicator. What we are seeing is that staff correctly use this indicator when assessing patients being medicated for pain, nausea, and/or fever, but frequently forget this indicator when assessing patients in the above PRN situation. And it's important that we be able to measure this aspect of a nurse's workload.

Ives Erickson

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chart on page 2, will give you an idea of the different strategies that exist around problem-solving and conflict-management. It's a good springboard to get us thinking about how we handle and resolve conflict in our own lives. And like anything else, it takes practice.

Updates

I am very happy to inform you that Debra Burke, RN, nurse manager of the Vascular Unit, has accepted the position of associate chief nurse for Women & Children, Mental Health, and Community Health Nursing. In addition to working with our Pediatric, OB/

GYN and Psychiatric units on the main campus, Deb will be an important link to nursing at all our health centers and ambulatory-care practices. I'm very excited about this key addition

to Nursing and the Patient Care Services executive team.

Welcome Deb. We look forward to working with you and supporting you in your new role.

2002 Oncology Nursing Career Development Award

The Oncology Nursing Career Development Award recognizes professional staff nurses for meritorious practice. The award provides financial assistance for continuing education.

Nominees must be MGH registered nurses functioning at the staff level in the inpatient or outpatient setting. He or she must:

- be a registered nurse
- provide direct patient care
- demonstrate consistent excellence in delivering care to patients with cancer
- serve as a role model to others in the profession
- demonstrate a commitment to professional development.

Nomination packets may be obtained from Joan Gallagher by calling: 6-2551.

Only completed nominations will be considered. All nominations should be received no later than May 24, 2002.

The Employee Assistance Program

presents

"Nourishing your Newborn"

Presented by
Germaine Lambers, RN, IBCLC

A program geared for expectant parents, new parents, and families contemplating having children. Information will be shared on the latest facts about breastfeeding, and time will be set aside for a tour of the Mother's Corner Lactation Room.

**April 2, 2002
12:00-1:00pm
VBK 401**

"Single Parenting"

Presented by
Ann Fishel, PhD, director,
Adult Couples and Family Therapy

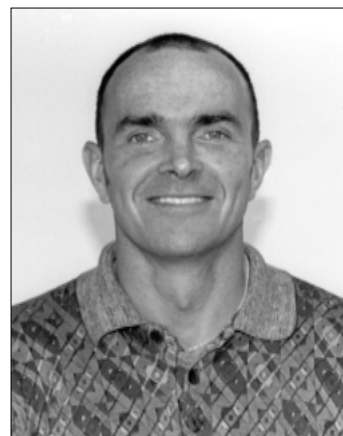
A growing number of women and men are raising children alone. This seminar will explore the challenges of daily life as a single parent and provide practical suggestions on how to succeed. Age-specific advice for parenting children at various stages of development will be provided.

**April 11, 2002
12:00-1:00pm
Wellman Conference Room**

For more information, call 726-6976.

More letters from South Africa

Chris Shaw, RN, a participant in the Nursing Partners AIDS Project (NPAP), a joint undertaking with the Partners AIDS Research Center, was recently dispatched to South Africa as part of a two-year humanitarian assistance program. NPAP sends clinicians to areas hardest-hit by the AIDS epidemic to implement and coordinate services to help alleviate the suffering caused by this devastating disease. Shaw has agreed to share his experiences with readers of Caring Headlines. Below is a recent correspondence.



Chris Shaw, RN

February 17, 2002

It's been a while since I've written. I wanted to send updates regularly, but the time seems to slip away.

I did want to let you know that I have been here in South Africa since October 1, 2001, and it has been a fascinating and much different experience than I ever imagined. It really has taken this long just to scratch the surface of the multi-layered cultures and politics of this very beautiful, often sad country, that never seems to lose its resolve to work toward a better, brighter future.

For the past four and a half months I have been involved with training nurses and caregivers for the long-overdue and still awaited treatments for HIV/AIDS. It's so frustrating to see young people suffer this much without the resources, education, or access they need to medicines that could make them better. But that's just one piece of the puzzle. The issues of poverty, class distinctions, provincial differences and hesitancy on

the part of the national government to facilitate treatment is a very big challenge.

Interestingly, I just returned from Botswana where the government has committed to treating all patients in need of care. HIV is a tremendous problem there too, but they have only a fraction of the population of South Africa and far more resources. I met two other nurses from Boston in Botswana at the KITSO AIDS training program, a program to train nurses on the use of anti-retroviral medications for people in the later stages of HIV/AIDS. Bruce Walker, MD, the director of the Partners AIDS Research Center at MGH, recognizes the important role nurses play in the battle against HIV/AIDS and supports programs in Africa to train and educate nurses and other healthcare workers. This is especially important in countries in sub-Saharan Africa where nurses are the primary providers of care.

My week in Botswana was incredible. Not only did I have the

opportunity to meet with and teach nurses about HIV/AIDS treatment, but I went with them and identified patients and did teaching and case-management work with them as well. The number of young people sick in Botswana is enormous, but again it's only a fraction of the number here in South Africa.

One patient we saw, a young 19-year-old man, named Kabelo, lived in a shack village and was suffering with TB and AIDS. He was carried to the clinic for a TB treat-

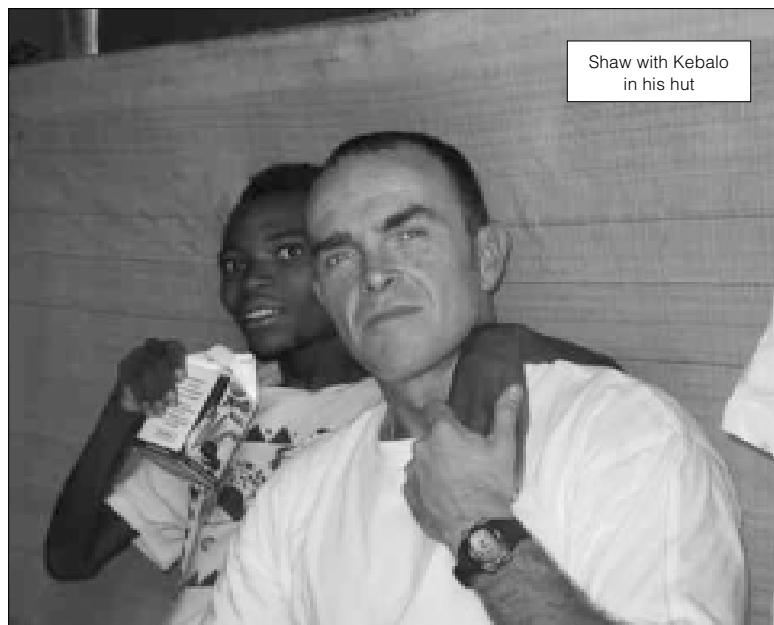
ment and an HIV test, which he wouldn't have received had there not been hope that his life could be saved.

In our conversation with Kabelo, he spoke of his fear that if he was diagnosed HIV-positive the shock of it might kill him, and his family might reject him (this was a man who was too weak to walk or bathe himself). His mother and two brothers sat in the hut with

him, and their eyes spoke volumes. We asked him if he thought his family would turn him away, and his eyes filled with tears as he nodded. In Setswana, his mother said, "You are my son, and I love you no matter what."

His older brother said, "You are my brother, and I will carry you, wash you, and take care of you until you get well."

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Shaw with Kabelo
in his hut

(photographs provided by Shaw)

Letters from Africa

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There is such a stigma surrounding HIV/AIDS that whole villages bury their young far too often. People in Kwa-Zulu Natal, the province hardest hit by HIV/AIDS, are in dire need of education, resources and treatment.

Sheila Davis, RN, NP, of the MGH Infectious Disease Clinic and Partners AIDS Research Center, led a nursing symposium here earlier this month. Nurse leaders from the nine provinces were invited to attend. It was an amazing collective effort that brought together a very diverse group of clinical, educational and research nurse leaders from the United States and Africa. They collectively identified research, support, and education as the primary needs of nurses working in South Africa.

I have witnessed so many things in these past months. I've seen nurses who won't get tested because they're sure they're already infected, and knowing would just speed the illness along. I've had the opportunity to travel throughout the province with the Department of Public Health and speak to nurses. I've worked closely with members of the "Treatment Action Campaign," which is partially comprised of people living with AIDS. One young man we engaged to help,

Thabo, is a very quiet, humble man but he is one of the most effective and wonderful motivators we have met.

Just two weeks ago Thabo lost his beloved Lindaway to HIV/AIDS. They had planned to marry. She was 26 when she died. He was devoted to her and brought me to see her at King Edward Hospital here in Zulu-land. He asked me to watch over her while he was away at a training workshop in Cape Town. I visited her in hospital and spent time with her that weekend. Unfortunately, she died while Thabo was away. But I saw this young woman, who shared a hospital room with five other women, look after each of them. She would ask me to bring juice and food, not just for her, but for her roommates. I marveled that this young woman so close to death herself, recognized the needs of those around her. And I think this is what we as nurses do, too. In addition to the skills and knowledge we have, it's the caring that provides the best healing.

As I left Botswana yesterday morning, Kabelo, the young man we had visited, was sitting up eating bread and peanut butter and drinking a bottle of (something similar to) Gatorade. His coloring had come back some. His body, still



Kabelo with his mother and aunt

emaciated and weak, was at least sitting up, and he had a smile on his face. He was relieved to know his HIV status, happy that his family was still there with him, and a bit angry that we were leaving. In that anger, there was energy I was happy to see. I explained to him that a hospice nurse named Karbie would now follow him, and that it was important that he continue to eat, drink,

and think positively. He smiled and thanked us as we left, and it was obvious that our nursing interventions had made a difference.

Kabelo's mother told us that his two brothers had gone to be tested. Our education with them had made it possible for them to see that HIV/AIDS didn't mean the end of the world. Hope is on the horizon in sub-Saharan Africa.

The Mother to Child Treatment program at St. Mary's Hospital is now under way. Almost 60% of the women who have been tested at the antenatal clinic are infected. They are receiving medication to reduce the chances of infecting their babies. The treatment project we're working on will offer treatment to babies who are born infected. Antiviral treatment will be offered to moms as well. Nurses at St. Mary's are being educated in all aspects of HIV and antiviral medications.

As I learn and see more, I'll keep you posted on the progress of our program and the situation of the nurses here. It's nice to know that MGH is there. I find myself writing to nurses and physicians 'back home' whenever I need information or just a friendly ear.

Until next time...

Call for Nominations!

Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

Nominations are now being accepted for the June, 2002, Stephanie Macaluso, RN, Excellence in Clinical Practice Award.

Deadline for nominations is April 5th

Registered nurses, occupational therapists, physical therapists, respiratory therapists, speech-language pathologists, chaplains and social workers are eligible.

The \$1,500 award may be used toward an educational offering of the recipients' choosing.

For more information or assistance with the nomination process, call Mary Ellen Smith, RN, professional development coordinator, at 4-5801.

Call for Nominations!

Family-Centered Care Award

Nominations are now being accepted for the MassGeneral Hospital for Children's Family-Centered Care Award

Deadline for nominations is April 2nd

Any employee of the MassGeneral Hospital for Children may be nominated by any individual (patient, family member, visitor, or fellow employee)

To make a nomination, simply write a brief letter describing why you think your nominee deserves to be recognized.

Submit nominations to Judy Newell, RN, Ellison 17, no later than April 2nd.

For more information, call 4-5720

Knowledge, collaboration contribute to individualized care in the SDSU

My name is Pam Wrigley, and I have been a nurse for 26 years. For the past five years, I have been the pediatric team leader in the Same Day Surgical Unit (SDSU).

I'd like to describe a meaningful experience I had one busy morning while I was preparing children for surgery in the SDSU. It was on this morning that I first met 7-year-old, Tanya. Tanya arrived with her parents and two grandparents. They were greeted by Karen, one of the pediatric team nurses, who introduced herself and began the perioperative routine. Tanya was being admitted for an excision of an adrenal mass, which had been detected on MRI earlier in the week. As Tanya changed into hospital attire, her mother spoke with Karen privately. She revealed that Tanya thought she was here for 'more tests,' and she didn't want Tanya to know she was having surgery. Karen's knowledge of pediatric growth and development and the needs of school-aged children told her immediately that she was going to need additional resources to help prepare Tanya for surgery.

Karen contacted a child life specialist on

the inpatient Pediatric Unit. She agreed to assist us, and told Karen she was on her way. Karen was needed in the recovery room, so that's when I became Tanya's nurse.

When Tanya was finished changing, I asked her to sit with her grandparents in the waiting room. I needed to talk with Tanya's parents alone so I could understand their perception of their daughter's needs and why they felt Tanya shouldn't be told about her impending surgery. From this knowledge I would develop a plan of care for Tanya and her family that would involve perioperative education about Tanya's surgery. Tanya's mother worked in health care and was the decision-maker for the family. I discussed the importance of pre-operative teaching. I focused on the importance of the trusting relationship they all have with Tanya and emphasized the need to prepare her appropriately for surgery. I assured them that the information we would provide would be presented in an age-appropriate manner and would be adjusted according to any cues given by Tanya. I stressed that by preparing Tanya for surgery her post-operative course would be much smooth-

er. After lengthy discussion, Tanya's parents agreed to let the child life specialist talk with her.

My next step was to contact the surgeon to apprise him of the situation. The secretary who took the message remembered Tanya immediately. She informed me that during an office visit, Tanya had said, "No one is going to cut me open!" This information shed light on why Tanya's mother didn't want to tell her about the surgery. How do you prepare your child for surgery after she's made a statement like that?

When Marilyn, the child life specialist, arrived, I brought her up to date on the situation. Luckily, Tanya had arrived early, so there was time to educate Tanya and her family about her surgery. Tanya sat on her mother's lap. Marilyn talked about the surgery while carefully observing Tanya for cues, and modified her teaching accordingly. At times, Tanya's eyes would grow wide, or she'd bury her head in her mom's shoulder, but other times she would sit relaxed, appearing to accept the explanations. After this patient-education session, both Tanya and her parents seemed more

relaxed. Marilyn and I sat with them to listen to their concerns and answer any questions. All family members contributed to the conversation.

It was now time for Tanya to go to the operating room. She decided she would 'take a ride' on the stretcher. Her parents, dressed in OR jumpsuits, walked along beside her. From the "Thank-you" and gratifying look Tanya's mother gave me, I knew I had helped all of them in some small way.

I phoned Marilyn the next day to see how Tanya and her family were doing. She told me that the mass was benign, Tanya's recovery was going well, and her family was doing fine. I was very relieved and satisfied with the care we gave Tanya. I can't imagine how she would have felt waking up in the busy environment of the PACU with a painful incision, without any prior knowledge that she was going to have surgery.



Pamela Wrigley, RN, MS,
pediatric team leader, SDSU

What made this a successful encounter was the knowledge and collaboration of the pediatric team. As team leader of Pediatrics in the SDSU, my responsibilities are both diverse and rewarding. They include direct patient-family care, managing daily operations, leading the pediatric nursing team, overseeing practice and operations for pediatric patients having surgery, and integrating pediatric care into the broader operations of the SDSU and the MGH Hospital for Children. Since pediatrics in the SDSU is a small part of a big unit, it's rewarding to know we can provide the kind of individualized care that was necessary for Tanya and her family.

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

This narrative is a wonderful example of how patients achieve the best
continued on next page

Palliative Care Service celebrates 5th anniversary

—by Connie Dahlin, RN, MSN, CS
advanced practice nurse, Palliative Care Service

On Wednesday, March 6, 2002, the MGH Palliative Care Service celebrated its 5th anniversary with a special presentation by Rabbi Earl Grollman, entitled, "Explaining Dying and Death to Children and Ourselves." Grollman is an internationally acclaimed author and expert on grief

and grief counselling, and a founding member of the Good Grief Program that provides interventions when a family member, friend, or teacher becomes ill or dies.

In a warm and animated presentation, Grollman shared many personal experiences that shaped his life and career, including a time in

London in 1969 when he heard the word, 'hospice' for the first time. He filled the hour with countless observations and lessons he's learned counselling families throughout his career. Some of Grollman's observations:

- Include children in conversations about death and dying

- Don't underestimate the importance of treating dying patients like living people
- Don't assume that dying patients don't want to talk about death
- Trust children to be able to handle the grieving process
- Grief is like a snowflake or a fingerprint; it is completely unique to each individual
- It can be comforting to acknowledge the anniversary of the death of a loved one
- Don't be afraid to touch people when you talk to, or comfort, them
- *It's okay to cry!*
- Anger is a normal, healthy, human response to death and sadness
- We celebrate important milestones in our lives like birth, marriage, graduation; we need to acknowledge death with the same openness and honesty

Grollman concluded saying, "People often ask how we can work with dying patients. Isn't it hard? The truth is, we get more out of it than we give. The way I look at it, palliative care is like a valentine for dying patients."

In 1996, The MGH Palliative Care Service began seeing patients diagnosed with life-threatening illnesses. At that time, the team was comprised of director, Andy Billings, MD;

nurse practitioner, Connie Dahlin, ANP; administrative assistant, Nan Lawless; a part-time social worker and an even less part-time chaplain. Today, the team also includes associate director, Eric Krakauer, MD; Coleen Reid, MD; full-time social worker, Sheryn Dungan; full-time director of Community Relations, Paul Montgomery; and fellows Erik Fromme, MD; and Earl Quijada, MD.

The Team works to improve the care of patients with life-threatening illnesses by working directly with patients and by providing consultations, ongoing continuing education and volunteer/bereavement support. Some units have ongoing palliative care rounds, and staff of the Palliative Care Service assist with debriefing sessions when a difficult death takes place.

The MGH Palliative Care Service cares for approximately 350 patients and families each year, most in the inpatient setting. The service provides care for patients in their homes, in outpatient clinics, in various nursing homes, and at Spaulding Rehabilitation Hospital and Youville Hospital.

The goal of palliative care is always to maintain continuity across all settings. For more information about the MGH Palliative Care Service, call 724-9197.

During his presentation in O'Keeffe Auditorium, Rabbi Grollman shakes an audience member's hand while Dr. Andy Billings, director of the MGH Palliative Care Service, looks on.



Exemplar

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outcomes when their providers work as a team. Pam's ability to be non-judgmental and understanding of Tanya's parents' fears allowed her to diffuse a potentially harmful situation. Part of being a skilled and ex-

perienced nurse is understanding the 'inexperience' of others.

The team wisely called in a child life specialist, who was able to explain the surgical procedure to Tanya and her family in a way that was simple, clear, and non-threatening. Part of being a good nurse is also

knowing about and accessing other resources in the hospital when specialized services are required.

Pam's presence and support allowed everyone involved to face their fears and make informed decisions about Tanya's care.

Thank-you, Pam.

Risk-factor assessment and management improving care on Ellison 11

My name is Colleen Gonzalez and I am the clinical nurse specialist (CNS) for the Ellison 11, Cardiac Access Unit. The majority of beds on this unit are dedicated to the care of cardiac interventional patients. Patients with and without coronary artery disease (CAD) are admitted to this unit to undergo diagnostic cardiac catheterization, and many require balloon and stent coronary interventions. Other patients require coronary artery bypass grafting, and they are cared for on Ellison 11 as they await surgery. The unit is staffed by nurse practitioners who work collaboratively with cardiologists and the clinical nursing staff to manage the care of our patients.

Although heart-disease mortality has declined since the 1960s, it remains the leading cause of death in the United States. In 1995, the American Heart Association (AHA) published a statement on secondary prevention for patients with atherosclerotic cardiovascular disease, which was endorsed by the American College of Cardiology (ACC). It was noted in this statement that aggressive risk-factor management clearly improves patients' chances

for survival by reducing recurrent events and the need for interventional procedures, and improves quality of life. Since the original publication of this statement, important evidence from clinical trials has emerged that further supports the benefits of aggressive risk-reduction therapies for this patient population.

As a CNS working with the Ellison 11 patient population and clinical nursing staff, an important part of my role is to stay current on this information. I look for opportunities to improve patient outcomes and enhance the knowledge of the clinical nursing staff by using the most up-to-date information I find in the literature. In an effort to improve secondary prevention, the AHA has developed a discharge program called, *Get with the Guidelines*, to improve utilization of evidence-based guidelines.

Get with the Guidelines is a hospital-based discharge program aimed at the prevention of cardiovascular events and strokes. The program focuses on care protocols to ensure that patients are discharged on appropriate medication and with risk-factor modification counseling. The program is based on AHA guidelines that

measure:

- smoking cessation counseling
- lipid lowering therapy
- ace inhibitor use
- aspirin or other anti-thrombotic medication
- blood pressure treatment
- beta blocker use
- weight and exercise management
- diabetes management
- atrial fibrillation management
- prevention of alcohol and drug abuse

The guidelines address all of the risk factors associated with cardiovascular events. A key component of this initiative is the continuous monitoring of quality-improvement through data measurement.

The AHA patient-management tool is web-based and easy to use. Features of the program are designed to meet clinical, quality, accreditation and research needs.

Get with the Guidelines works by identifying individuals to develop, mobilize, and lead teams to impact discharge protocols for patients in the acute-care setting. Lynne Chevoyna, RN, MS, ANP, Ellison 11 nurse practitioner, and Donald Lloyd-Jones, MD, the Ellison 11 medical director, are leading the MGH team. Judy Silva, RN, MS, Ellison 11 nurse manager, Diane



Colleen Gonzalez, RN,
clinical nurse specialist

Carroll, RN, PhD, clinical nurse specialist, Paul Nordberg, project manager from the Decisional Support Unit, and I are working together as the initial group to mobilize the program. We look forward to collaborating with the clinical nursing staff, Physical Therapy, Nutrition & Food Services, Pharmacy and Social Services. It is hoped that the program will achieve significant reductions in death and recurrent cardiac and stroke-related events. This is a great opportunity to work collaboratively as a healthcare team to improve patient outcomes.

Nurses play a major role in assisting patients to assume responsibility for health behaviors to prevent the development and progression of CAD. Nurses also have a significant role in primary and secondary prevention. Nurses need to be knowledgeable about the assessment of cardiac risk factors and interventions at each level of

prevention. Patients have become more informed about their disease and treatment. Nurses must remain current on new treatment modalities and risk-factor prevention strategies in order to direct change in patient behavior.

Patients undergoing interventional cardiac procedures have limited contact with healthcare providers due to short inpatient hospital stays. Patients and families can benefit from knowing their own personal risk-factor information and developing a plan to modify their risk profile. In my role as CNS, I am working with staff to develop and facilitate the Cardiac Resource Model. This program has three goals:

- Develop clinical nurses as experts in various dimensions of risk-factor assessment and modification
- Provide patients and families on Ellison 11 with information that will contribute to

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An interfaith prayer service for the healing of AIDS



(Left): At a special interfaith prayer service for the healing of AIDS, co-sponsored by the PCS Diversity Committee and the MGH Chaplaincy, former MGH staff nurse, Pat Beckles, RN (center), and operations coordinator, Judy Sacco, lay flowers on symbolic 'altar' in an offering of healing and remembrance. (Below): Deborah Washington, RN, director of PCS Diversity, and Father Felix Ojimba, of the MGH Chaplaincy, welcome guests to the service.



Perhaps nurse manager, Angelleen Peters-Lewis, RN, said it best when she read a declaration from The Council of Religious AIDS Network, saying, "As long as one member of the human family is afflicted [with AIDS], we all suffer." That was the spirit that prompted a special interfaith prayer service on Friday, March 8, 2002, in the MGH Chapel. Peters-Lewis and others, including: Deborah Washington, Father Felix Ojimba, Lulu Sanchez, Oswald Mondejar, Father Celestino Pascual, Mike McElhinny, and Glen McKenney, all spoke about the need to re-commit ourselves to the care, support and advocacy of patients and families, everywhere, living with AIDS. Singer, Aaron Stone, and accompanist, Brother Dennis, provided inspirational musical interludes.

Clinical Nurse Specialist

continued from previous page

reducing future cardiac events through recognition and management of risk factors that have contributed to their disease progression

- Facilitate the meaningful intent and implementation of the *Get with the Guidelines* program

The Cardiac Risk Factor Clinical Nurse Expert Program is

based on a framework described by Terry Fulmer, RN, PhD, that recognizes the professional nurse at the bedside and the expertise that nurses provide to patients and families. Clinical nurses have direct contact with cardiac patients and families. They are in a unique position to be able to

integrate research findings on risk-factor assessment and modification when patients and families are ready to learn.

Also, cardiac risk-factor experts serve as resources to their nursing colleagues and actively engage in facilitating their development. This program is providing many benefits to patients and families and many opportunities to improve the quality of care for patients on Ellison 11.

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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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by fax: 617.726.8594

or by e-mail: ssabia@partners.org

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Medical interpreter services and how to access them

MGH has always been committed to providing the highest quality care to our patients, but a new state law has heightened awareness about the availability of interpreters to non-English speaking patients. MGH Interpreter Services is committed to providing around-the-clock access to trained medical interpreters for all patients.

In outpatient settings, medical interpreters are available to be present for office visits, tests and procedures, obtaining consents, taking medical histories, telephone consultations, and confirming appointments.

Medical interpreters are available to inpatients for consultations with any provider, for any service, rounds, or to translate discharge instructions. Interpreters can make conference calls to patients' rooms to see if they need anything, clarify instructions, advise patients about upcoming tests, or help caregivers understand patients' requests.

Interpreter Services has a core staff of 23 interpreters who speak the ten most commonly requested languages at MGH, and a pool of free-lance interpreters who speak 40 other less-frequently-requested

languages. A telephone service is available for less common languages and to serve as a back-up interpreter resource.

Last year, MGH interpreters facilitated more than 25,000 encounters. This year, because of a new state law mandating the availability of interpreter services, that number is expected to increase dramatically. To meet this demand, Interpreter Services asks that clinicians call to request an interpreter at the same time they schedule an appointment, test, or procedure. For cases that require an interpreter who is not currently on site, Interpreter Services will make the necessary arrangements and keep you informed of their status. Interpreters are frequently called in from outside MGH or from other institutions, so advance notice provides more time to coordinate resources. Inpatient staff should try to schedule interpreter visits

around important aspects of care, such as obtaining consents, taking histories, pre- and post-operative teaching, and family meetings.

Medical interpreters for deaf or hard-of-hearing patients (sign language interpreters, lip readers, etc.) are requested through Interpreter Services but provided by the Commission for the Deaf and Hard of Hearing. This agency requires a two-week notice to make the necessary arrangements. TTY machines may be helpful for communication with deaf patients and are available by calling Materials Management at 6-2255.

Interpreter Services recognizes that there may be some instances when it is not possible to schedule an interpreter in advance, either because the visit was unexpected or because the provider was unaware of the need. In these cases, Interpreter Services will assist by trying to contact a medical interpreter outside the hospital (this can take up to an hour) or by offering the back-up telephone service.

Booklets are available containing common English medical phrases that have been translated into 19 languages. These booklets and other helpful information are available on all patient care units. Frequently-distributed patient handouts can be translated into one or two of our most requested languages by contacting Interpreter Services. There is no charge for translating

brief notes to and from patients.

The Office of Interpreter Services is open weekdays from 7:00am–midnight, and weekends from 10:00am–10:00pm. Not all interpreters are present when the office is open, so requesting an interpreter in advance is strongly recommended.

During office hours, call 726-6966 to request an interpreter. After hours, call 724-5700 and enter:

- 3-0001 for a Spanish interpreter
- 3-0003 for a Portuguese interpreter
- 3-0005 for an Arabic interpreter
- 3-0009 for all other languages and authorization to use the telephone services.

Look for, "How medical interpreters are trained, hired and evaluated," in the April 4th issue of *Caring Headlines*.



Educational Offerings

March 21, 2002

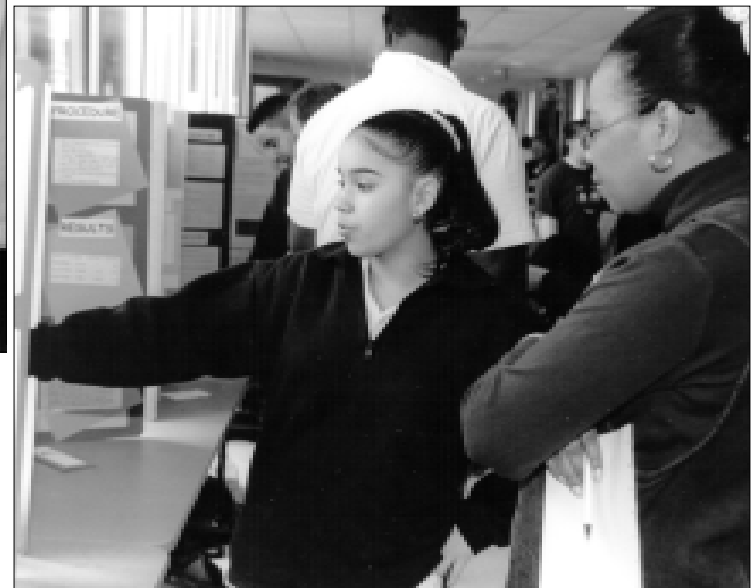
When/Where	Description	Contact Hours
April 1 and April 8 8:00am–5:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
April 4 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	— — —
April 4 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
April 5 8:00am–4:30pm	Nursing: a Clinical Update (MGH School of Nursing Alumnae Homecoming Program) O’Keeffe Auditorium	TBA
April 9 9:00am–4:30pm	Management of the Burn Patient Bigelow 13 Conference Room	6.9
April 10 1:30–2:30pm	OA/PCA/USA Connections “Handling Difficult Patient Situations.” Bigelow 4 Amphitheater	— — —
April 10 5:30–7:00pm	Advanced Practice Nurse Millennium Series O’Keeffe Auditorium	1.2
April 10 8:00am–2:30pm	Mentor/New Graduate RN Development Seminar I Training Department, Charles River Plaza	6.0 (mentors only)
April 11 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
April 12 7:30am–4:00pm	Selected Topics in Emergency Nursing O’Keeffe Auditorium	7.2
April 16 and 17 8:00am–4:30pm	Pain Resource Champion Day Holiday Inn, 5 Blossom Street	TBA
April 18 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
April 18 10:00–11:30am	Social Services Grand Rounds “The essentials of Psychotropic Medicine.” For more information, call 724-9115.	CEUs for social workers only
April 18 8:00am–4:30pm	Preceptor Development Program: Level I Training Department, Charles River Plaza	7
April 22 8:00am–4:30pm	Kaleidoscope of Pediatric Care: Thought-Provoking Dilemmas Wellman Conference Room	TBA
April 22: 7:30am–4:30pm April 23: 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: New England Medical Center. Day 2: (VBK601)	14.4 for completing both days
April 23 7:30–11:30am, 12:00–4:00pm	CPR—American Heart Association BLS Re-Certification for Healthcare Providers VBK 401	— — —
April 24 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
April 25 8:00–11:15am	Intermediate Arrhythmias Haber Conference Room	3.9
April 25 12:15–4:30pm	Pacing : Advanced Concepts Haber Conference Room	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>



Annual Timilty Science Fair Poster Presentation

You need only attend one MGH-Timilty science fair to see that the future is bright. Year after year, seventh- and eighth-grade Timilty students, mentored by MGH employees, display posters reflecting a semester's work on a specific scientific topic. But what's really on display is the unbridled hope and enthusiasm of students and mentors alike. If you missed it this time, be sure to catch it next year. You just might learn something!



At this year's Timilty Science Fair Poster Presentation, (above): 12-year-old, seventh-grader, Kevin Lopez, explains his project, "Does the Shape of a Bell Affect the Loudness of its Sound?" (At right): 13-year-old, seventh-grader, Vivian Santiago, shows the results of her study, "Does Advertising Make a Difference in the Littering Habits of Timilty Middle School Students?" (Answer: Yes!)

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