

# Caring

## HEADLINES

July 17, 2003

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## Student Nurse Oncology Fellowship Program

*preparing student nurses for a career in oncology nursing* (See page 14)



Student nurse, Lindsay Murray (right), flushes central-line catheter for 4-year-old, Moises 'Bam Bam' Rivera, under the watchful eye of preceptor, Kim Waugh, RN.

**MGH** Patient Care Services

Working together to shape the future

## JCAHO visit scheduled: patient safety goals expected to be major focus

As many of you already know, the JCAHO accreditation visit to MGH has been scheduled for the week of September 15–19, 2003. And with patient safety a growing national concern, we expect a major focus of the visit to be the new National Patient Safety Goals issued recently by the JCAHO.

For your review, the newly articulated patient safety goals are:

*Goal 1:* Improve the accuracy of patient identification

*Goal 2:* Improve the effectiveness of communication among caregivers

*Goal 3:* Improve the safety of using high-alert medications

*Goal 4:* Eliminate wrong-site, wrong-patient, wrong-procedure surgeries

*Goal 5:* Improve the safety of using infusion pumps

*Goal 6:* Improve the effectiveness of clinical alarm systems

These goals are already at the center of our quality and safety initiatives and embedded in our policies and practices. Our job will be to make those practices visible to our JCAHO surveyors.

As always, we are coordinating a number of activities to help prepare staff to articulate our commitment to patient safety and identify the mechanisms we have in place to ensure our success.

Maryanne Spicer, director of Corporate Compliance, is chairing the hospitalwide JCAHO Steering Committee. Joan Fitzmaurice, RN, director of the MGH Office of Quality and

Safety, is a member of that committee as well as the chairperson of the PCS JCAHO Task Force. These two groups are working closely to synchronize our preparation efforts.

During the month of August, mock surveys will be conducted on all inpatient care units to give staff a feel for what the actual JCAHO visit will be like. A series of one-page, 'Talking Papers' is currently being created with information on key topics likely to be covered by surveyors.

The PCS JCAHO Task Force is using a number of forums to disseminate information about the new National Patient Safety Goals. Joan Fitzmaurice and staff specialist, Carol Camooso Markus, RN, attended a recent meeting of the Staff Nurse Advisory Committee for an in-depth discussion of two of the goals (Goal 1: Improve the accuracy of patient identification; and Goal 6: Improve the effectiveness of clinical alarm systems).

When asked how we ensure the accuracy of patient identification, members of the Staff Nurse Advisory Committee were quick to respond with:

- check the patient's ID band
- check the patient's medical record number



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

- ask the patient his or her name (or ask a family member when the patient is unable to speak)
- ask the patient's date of birth, address, or Social Security number
- make sure the patient's medication book and ID band match

Joan stressed that the JCAHO requires *two or more* verifiable patient identifiers (such as name and medical record number). Just knowing that a patient's name is John Smith is not sufficient. We need to know it's the *right* John Smith.

Members of the Staff Nurse Advisory Committee also offered suggestions on how to ensure proper identification when two patients on the same unit have the same name. They advised assigning different nurses to each patient; physically separating patients with the same name; using a word-of-mouth alert system to notify all caregivers of the similarity; and using the built-in

alert system in POE for same-name protection.

Discussion about the effectiveness of clinical alarms centered on ensuring that alarms are turned on; that parameters are set correctly; that alarms are able to be heard given the location, distance, and ambient sound level on the unit; and that alarms are responded to in a timely manner. Staff Nurse Advisory Committee members praised the effectiveness of team coverage with respect to responding to alarms, and stressed the importance of knowing each patient's individual parameters based on age, diagnosis, and his or her baseline norms.

As healthcare providers, we all realize the importance of JCAHO accreditation. But more importantly, we appreciate the need to have standards of quality and excellence. MGH has always been a leader in the delivery of quality patient care. As long as we continue to meet our own standards, we will have no trouble meeting the JCAHO's.

### Joint Commission Satellite Network Presentations

August 14th: "Emergency Management: Creating and Implementing an Effective Plan"

September 18th: "Putting the Pieces Together: Self Assessment, Priority Focus Process, and Tracer Methodology"

October 16th: "Realizing the Vision: Effective Leadership"

November 13th: "Hospital-Wide Competency Assessment"

December 18th: "Performance Improvement: Achieving Results"

For information about these sessions, call 6-3111

## Assessing and managing patients' pain

**Question:** What is the procedure for assessing patients' pain?

**Jeanette:** For inpatients, an initial pain assessment is conducted when a patient is admitted to the hospital, and these findings are documented on the nursing admission assessment form. Pain should be assessed whenever the patient undergoes a procedure or treatment that could potentially exacerbate pain, when the patient reports new or increased pain, and at the discretion of clinicians.

In the ambulatory setting, patients should be assessed for pain on

their first visit to the hospital, at their annual preventative/maintenance visit, during a well-child visit, and at the discretion of the clinician.

**Question:** If a patient identifies pain as an issue, what should the assessment include?

**Jeanette:** Use the acronym, PAINED, as a way to guide your assessment.

P: place and pattern: time and location(s)

A: amount (severity) of pain using a standard instrument

I: intensifiers—what makes it worse?

N: nullifiers—what makes it better?

E: effect on ADLs, sleep, and concentration  
D: descriptors—dull, sharp, burning, throbbing, etc.

**Question:** The standard tool for assessing pain severity is the 0–10 scale. Are there special considerations for patients who aren't able to use the verbal 0–10 scale?

**Jeanette:** The 0–10 scale (0=no pain; 10=worst pain imaginable) is appropriate for most older children and adults. For patients who don't speak English, you can request the help of Interpreter Services.

There are also age-appropriate tools for younger children, non-verbal adults, and adults suffering from advanced dementia.

**Question:** In addition to medications, are there other nursing interventions that can be employed?

**Jeanette:** Some non-pharmacological interventions include distraction, repositioning, Therapeutic Touch, massage, and pet therapy.

**Question:** Where do I document patients' responses to pharmacological and non-pharmacological interventions?

**Jeanette:** The severity of pain is documented on the flow sheet so that patterns can be observed

over time and colleagues can easily follow the patient's progress. More detailed information about pain assessment and treatment is documented in the progress note.

**Question:** What resources are available to clinicians who have questions related to assessing and managing patients' pain?

**Jeanette:** On units, staff should seek out the clinical nurse specialist, nurse manager, or pain champion for guidance. Consultation services are also available from Palliative Care and the Pain Center. Unit pharmacists are important resources for medication-related questions. Information is also available on the Pain Relief website at: [www.massgeneral.org/painrelief](http://www.massgeneral.org/painrelief).

*Pain Relief Connection* is a monthly e-mail newsletter published by MGH Cares About Pain Relief. Past issues are available on the Pain Relief website.

**Question:** What resources are available to patients and families concerning MGH's commitment to pain relief?

**Jeanette:** The Blum Patient-Family Learning Center and the Cancer Resource Room are great sources of information related to pain. Brochures are available at both locations (and from Standard Register) for adults and parents of children with pain. Information is available to patients and families on the Pain Relief website.

**Question:** How are patients informed about their right to pain assessment and management?

**Jeanette:** The brochure entitled, *Patient Rights and Responsibilities* has been revised to include information about patients and families' right to pain assessment and management. Brochures are available in Spanish, and the "Pledge to Patients" posters are being re-distributed for posting in patient-care areas.

## Call for Nominations

### The Marie C. Petrilli Oncology Nursing Award

Nominations are now being accepted for The Marie C. Petrilli Oncology Nursing Award.

The award was created to recognize the high level of caring, compassion, and commitment reflected in the care of oncology patients at MGH. Any nurse who cares for patients with cancer is eligible to be nominated. Two nurses will be selected. Recipients will each receive \$1,000.

Any employee, manager, physician, patient, or family member can nominate a nurse by completing a brief nomination form, which will be available on all inpatient units, the Gray lobby information desk, in the MGH Cancer Center, and in the Cancer Resource Room on Cox 1.

A letter of support must accompany the nomination form. Nominations should be received no later than July 30, 2003.

For more information, call Julie Goldman, RN, at 617-724-2295.

## When was the last time you gave blood?

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building

The MGH Blood Donor Center is open  
Monday through Friday  
8:30am–4:30pm  
Platelet Donations:  
Monday, Tuesday, Friday  
8:30am–3:00pm  
Wednesday and Thursday  
8:30am–5:00pm

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

## Learning the language of pastoral care

—by Clare Swan, RN, staff nurse

Working with the Clinical Pastoral Education (CPE) Program was a new experience for me. No longer was I just concerned with the work of nursing; I was learning the language of pastoral caregiving—talking about forgiveness and repentance and reciting scriptures from the Torah and the Bible. My Jewish, Protestant, and Catholic colleagues helped me figure out that patients sometimes need forgiveness more than they need Tylenol, and that *they*, my fellow classmates, might be the ones who could offer it.

Every Monday we would gather in a confer-

ence room on Ellison 18. Thirteen clinicians sat around two large tables in a room with a window that looked out over the Charles River.

The group was comprised almost entirely of women with the exception of a priest, a rabbi, and a minister. Because of this, the dynamics were very people-oriented as opposed to some traditionally male-dominated organizations.

These meetings were a time of reconnecting after our individual 'field work' of the previous week. They were also a time to let off steam and offer support to one another. We would make jokes about our work;

share stories that helped us laugh, believe in life, ourselves, and prepare to do it all again for another week. This was our medicine, and we knew it as we looked across the table at each other with love and concern in our eyes.

As we sat around the table juggling coffee and bagels and pocketbooks and notebooks, there was no room to feel disengaged or self-important. Simply by coming together we were reminded that we needed each other. This was no one-man or one-woman show. Our professions needed each other, and the enormity of the life-and-death care we provided challenged

us out of our professional self-sufficiency. This didn't come easily. As professional caregivers, we didn't immediately merge in splendid synchronicity. Our directors, Reverend Charles Kessler and Reverend Mary Martha Thiel nurtured this.

We have had an extraordinary experience learning to work together. Never have I felt such loving solidarity among people I've worked with! Perhaps we were brought to it by facing death—our patients' deaths and, in them as in a mirror, our own.

Mother Theresa spoke of gently peeling into her arms the body of a man baked to the pavements of Calcutta, a man who had been dying for days as people stepped around or over him with indifference. It is said that she

did not become lost in the fears or even the fragile sentimentalities that might arise in such circumstances. Instead, she recognized this man as 'Jesus in His distressing disguise.' She saw him as the Beloved on His way to the heart of completion.

From my perspective, our patients are Jesus in His distressing disguise. People with AIDS, Hispanic, Jewish, Irish, black, poor, or rich—they are of different faiths and different traditions, but their common mortality unites them.

Participating in the CPE program has taught me something important: everyone's faith—not just Catholicism or Christianity—is a way to God. Yahweh, Buddha, and Allah are the image of God for others the way Jesus Christ is for me. If we can manage to meet each other with mutual respect for our different expressions of faith, surely God must do the same! Being so close to so many different people at their most critical times has made me see more of what God's way might be. Not to make the world Christian, or Muslim, or Buddhist, or Hindu, or Jewish, but for believers everywhere to go deeper into their own faith no matter what it is. This is what ecumenism must mean. Deep down in our roots is where we will all meet the one, true God.

Early in the program, I found I presented my-

*continued on page 9*



Mary Martha Thiel, director of the MGH Chaplaincy, speaks at the Clinical Pastoral Education Program graduation ceremony. Members of the graduating class are seen in the background; Clare Swan is second from right.

## Back-injury prevention the focus of MGH Safe Products and Worker Safety Committee

—by Susan Loomis, RN,  
director, Occupational Health Services

How many patient lifts do most nursing professionals perform before their first work-related back injury? It is well known from individual experience and injury reports that nurses are overwhelmingly susceptible to back injury. Because of the high rate of back injuries among health-care workers, back-injury prevention has become a major focus of the National Institute of Occupational Health and Safety.

Moving or lifting larger than reasonable loads, often under awkward conditions, is the primary cause of back injury among nurses. Generally speaking, to prevent injury, loads of

50 pounds or more should be lifted only with the assistance of co-workers or lift devices. Staff should be aware that other variables can increase the risk of in-

jury, such as when patients weigh more, have limited strength and mobility, or are unable to participate in transferring from one place to another. There is a growing number of morbidly obese patients in hospital settings, which further compounds the problem

of moving and lifting patients. The MGH Safe Products and Worker Safety Committee has been concerned about these challenges in preventing

back injuries. In reviewing the problem, the committee identified the following needs:

- A standardized tool for nurses to use to identify patients who should be moved with mechanical aids
- The availability of mechanical-transfer aids for patients who pose a lifting challenge for nurses
- A reference guide to assist nurses in using mechanical aids and

**Moving or lifting larger than reasonable loads, often under awkward conditions, is the primary cause of back injury among nurses. Generally speaking, to prevent injury, loads of 50 pounds or more should be lifted only with the assistance of co-workers or lift devices.**

### Did you know ?

- Lifting a load of more than 50 pounds is considered unsafe for most workers.
- Body mechanics and proper lifting technique are only helpful when the load being lifted is within a safe range.
- Patient-related activities most likely to cause back injury are moving or repositioning a patient in bed, transferring him/her from a bed to a stretcher or chair, or vice versa.
- Despite the availability of a new generation of lifting aids, many nurses continue to lift patients without these aids.

other equipment while caring for morbidly obese patients;

- The availability of equipment specific to morbidly obese patients' needs including, but not limited to, commodes, stretchers, wheelchairs, beds, and walkers

As a result of this review, the committee has developed reference materials and obtained equipment to help nurses move patients who may put them at risk for back injury. Some specialized equipment such as wheelchairs, commodes, and stretchers are just larger, sturdier versions of the day-to-day equipment. Mechanical aids are the result of new technology. Two types of aids are available for moving patients (see shaded box at left).

This equipment can be obtained by calling Equipment Services at 6-2255, 24 hours a day, 7 days a week. Call Equipment Services to request a delivery or pick-up of

any mechanical-aid device.

A Nursing Practice Guideline for Caring for Obese and Morbidly Obese Patients is being developed and will be available shortly. The guideline contains valuable information to help caregivers identify the special needs of this patient population so that an appropriate plan of care can be developed. This information will be useful to healthcare workers in selecting and using equipment, maintaining skin integrity, and moving patients safely. When completed, it will become part of the Nursing Procedure Manual, Volume 2, Section 16.

The Safe Products and Worker Safety Committee will continue to look at ways to prevent back injury associated with moving and handling patients. For information on back-injury prevention or the work of the MGH Safe Products and Worker Safety Committee, contact Susan Loomis at 4-3905.

### About mechanical aids...

Device	Description	Advantage
Airpal	A nylon mattress that when placed under the patient allows lateral transfer by release of low air pressure through a chamber in the mattress. (Use two motors when moving patients who weigh 500lbs. or more.)	Less drag for the patient, less pulling and pushing from a bent position for staff.
EZ Lift	Newer version of the Hoyer lift used previously that can safely lift patients up to 1,000lbs. This is a sling apparatus that is placed under the patient then attached to a motorized lift.	More comfortable for the patient and safer for staff.

## Medical students shadow nurses: a hands-on learning experience

—by Jan Duffy, RN, staff specialist

Research shows that effective communication and collaboration between nurses and physicians positively affects patient outcomes. Positive nurse-physician relationships are characteristic of magnet hospitals, known for their excellent patient care and ability to attract and retain highly competent nurses. Educational programs that prepare nurses and physicians traditionally don't include opportunities for nurses and physicians to work together or gain understanding of one another's field of knowledge and skills. Without this early exposure between disciplines, a real opportunity is lost to develop relationships that would strengthen communication and collaboration.

Katharine Treadway, MD, co-director of the Patient-Doctor II course at Harvard Medical School, recognized this gap in her own education. Says Treadway, "I never really understood what nurses did until I was well into my residency. I wanted to begin to change that for students going through the program today."

Treadway and program co-director, Diane Fingold, MD, approached senior vice president for Patient Care, Jeanette Ives Erickson, RN, and

associate chief nurse, Theresa Gallivan, RN, with a plan for second-year medical students to shadow a registered nurse for several hours during the course of their studies. The program would give medical students an opportunity to gain an understanding of the role of nurses early in their medical education. Ives Erickson and Gallivan enthusiastically endorsed the initiative.

Nurse managers on the Medical and Cardiology services identified staff interested in partnering with medical students. Nurses were anxious to participate, seeing a real opportunity to influence the development of nurse-physician relationships that was

built on mutual trust and respect. The program paired 34 medical students with staff nurses on intensive care and general care units. Following the shadowing experience, students were asked to complete an open-ended evaluation of the experience commenting on what worked well, and what they would like to see changed.

Responses were overwhelmingly positive. Medical students commented that, "Experiences like this will bridge the gap that traditionally exists between physicians and nurses;" "This was the first and only exposure to nursing I've had in two years of medical school;" "I was sur-

prised by the relative autonomy that nurses have;" "I was truly impressed by the breadth of knowledge nurse have, and the integral role they play on the healthcare team;" and, "I watched nurses interact with very sick patients and their families and saw the integral role they have in coordinating care and relaying information between doctors and patients' families."

A number of students commented on the value of seeing unit operations from an entirely different perspective.

Nurses were equally enthusiastic, reporting surprise at the limited amount of information medical students had about the role of nurses in the acute care environment. Some took the opportunity to explain the educational preparation nurses have and the various roles that exist

within the nursing organizational structure.

Nurses explained assessments, interventions, and decisions they made in daily practice and their responsibilities for communicating and coordinating care with patients, families and members of the health-care team.

There was unanimous agreement that the shadowing experience should be an integral part of medical-student education. A soon-to-be-released Institute of Medicine Report, "Health Professions Education: a Bridge to Quality," recommends interdisciplinary training for nurses and physicians centering on core competencies. Our experience supports the wisdom of this approach.

For more information, contact Jan Duffy, RN, staff specialist, at 6-3201.



Second-year medical student, Samantha Goldstein (right), shadows Ellison 10 staff nurse, Virginia Walker, RN.

## Pilot program sees improvement in hand-hygiene compliance

—by Rosemary O'Malley, RN,  
staff specialist

Despite awareness about the importance of hand hygiene in minimizing the spread of nosocomial infections, compliance among health-care workers falls within the 30–50% range.

The Center for Disease Control recently published new guidelines on hand hygiene. At MGH, practice was recently revised to include an alcohol hand-rub both before and after patient contact, including contact with the patient's immediate environment (such as side rails, blood pressure cuff, bedside tables, etc.)

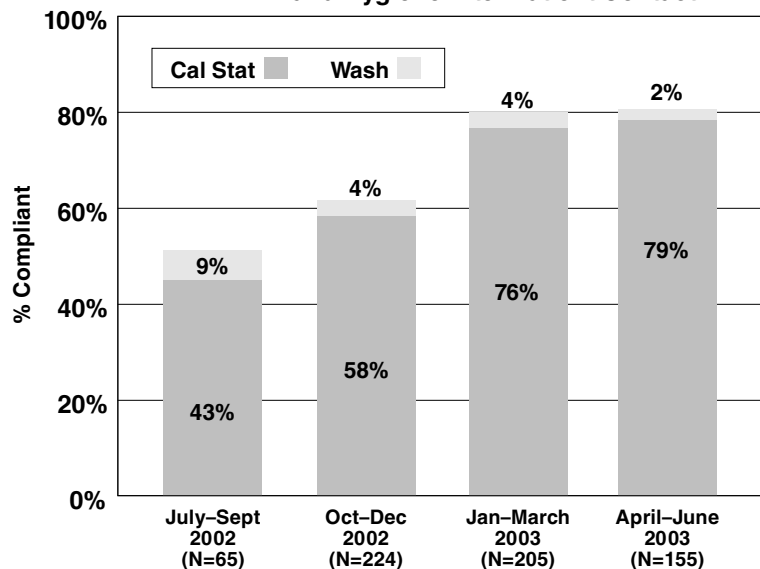
For all the aforementioned reasons, Patient Care Services implemented a performance-improvement project over the past year to enhance

compliance with hand hygiene. Four patient-care units participated in the initiative with the goal of improving hand hygiene and decreasing nosocomial infections, including, Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE). The four units that participated in the pilot project were the PACU, the PICU, White 6, and the RACU.

The program enlisted support from various role groups including unit-based champions, unit-based leadership, and representatives from various committees including the Nursing Practice Committee, the Quality Committee, and the Nursing Research Committee.

Observations of hand-hygiene practices were collected to establish a baseline performance level for each unit. Credit was given when healthcare workers washed their hands with soap and water and/or used

Hand Hygiene After Patient Contact



the alcohol hand-rub both before and after patient contact.

Certain barriers to compliance were identified, including broken dispensers, empty dispensers, inaccessible dispensers, and missing dispensers.

The intervention was multi-tiered and included educating staff about the new guidelines for hand hygiene from the CDC; raising awareness about the importance of hand hygiene; environmental modifications; and feedback to the units about hand-hygiene compliance and nosocomial infection rates.

Education was provided in the form of in-service training by Infection Control practitioners and a staff specialist. Two special sessions were conducted for staff whose primary language

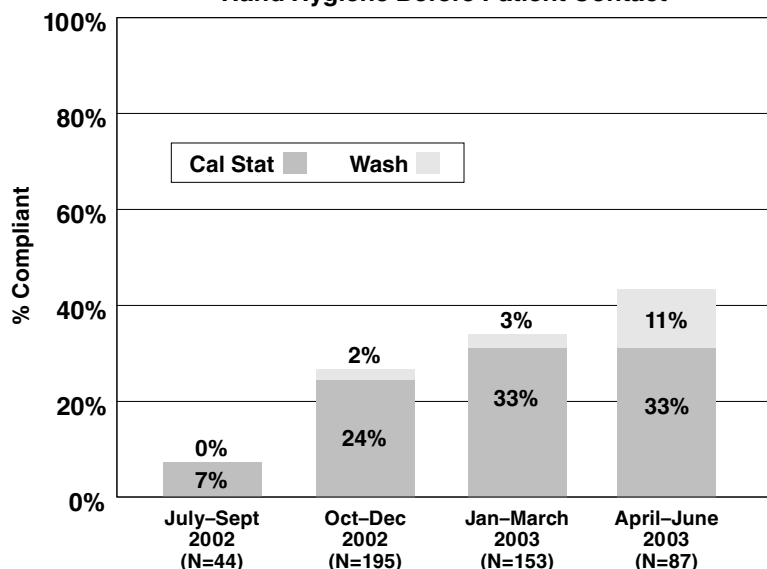
was not English (one in Spanish and one in Cape Verdean). For staff unable to attend in-service trainings, 'Did You Know' hand-outs were made available.

To raise awareness, posters were placed in the clinical setting and updated every 6 weeks. Staff were given badges that read: "Clean hands, good health," as an additional reminder.

Some units received additional dispensers, some dispensers were relocated, some rooms used pump dispensers or pocket-sized containers instead of wall-mounted dispensers. Unit service associates were instrumental in maintaining an environment for success.

Steady improvement in hand-hygiene compliance both before and after patient contact has been seen on the pilot units.

Hand Hygiene Before Patient Contact



## Age-appropriate care and preparation ensure positive outcome for 12-year-old boy

My name is Jane Harker. I have worked as a nurse on the Endoscopy Unit at MGH for almost 11 years. I find it to be a rewarding and challenging experience because of the diverse population we serve on a day-to-day basis. Most of our patients are healthy adults, coming in as outpatients for a 'routine' screening colonoscopy, or upper endoscopy (EGD). But some are more acutely ill—older patients and some children.

One of the most technically difficult procedures we assist with is called an endoscopic retrograde cholangiopancreatogram (ERCP). This is both a diagnostic tool and an intervention. It is the means by which we are able to visualize the biliary and pancreatic ductal systems. We do this by injecting a contrast dye into the common bile duct while using fluoroscopy (x-ray) to determine if there are any abnormalities. Any abnormalities we find can then be corrected with special equipment.

ERCP is a particular interest of mine, and as team captain of the ERCP Resource Team, it is something at which I excel. Incorporating this knowledge into the care

of a 12-year-old patient recently brought many of my clinical skills and knowledge of our diverse population to light.

Tom is a 12-year-old young man who came to the Endoscopy Unit to have an ERCP performed by Dr. K. This was going to be his second. The first was done in November of 2001.

Tom's history is as follows: In 1997, at age 7, he underwent a living, related, liver transplant. He received a liver from his dad due to an alpha 1 antitrypsin deficiency. This is a deficiency in a protein produced by the liver. Ten percent of the neonatal population who have this deficiency develop neonatal liver disease requiring liver transplant, while adults develop emphysema from this deficiency.

Tom had done quite well after his transplant, without any signs of rejection. Recently, however, he had started to wake up with severe upper-right quadrant pain. There was an elevation of liver enzymes. His ultrasound was normal, but a CT-scan showed a calcified mass in the Roux-Y limb of his previous surgery (in the common bile duct). This was thought to be a common bile-duct stone or

stricture. Tom's pediatric gastroenterologist was hopeful that it could be identified by ERCP, and that something could be done to alleviate the problem.

Before I went to meet Tom in our admitting area, I consulted with Dr. K to determine what size 'scope' he wanted to use, and to see what other equipment he anticipated needing to successfully complete the procedure. Dr. K explained that the previous ERCP had been particularly difficult because of the way the donor liver was joined to the native liver. The ampulla, or opening to the common bile duct, was difficult to access because of where it was located, and the opening was quite narrow. We talked at length about equipment, and about how we anticipated the procedure would progress. Dr. K had obtained some smaller equipment from the Cardiac Cath. Lab, and he explained to me how each piece worked. This information was important because I needed to have everything as organized as possible to minimize the amount of time Tom would require general anesthesia. After assembling the equipment, I consulted with the anesthesiologist to see when he would be ready



Jane Harker, RN,  
staff nurse, Blake 4 Endoscopy Unit

to begin. Then I went to the admitting area to meet my patient.

Tom, a Harry Potter look-alike with curly hair and glasses, was sitting quietly with his mom and grandmother. I introduced myself and told him I'd be his nurse throughout the procedure. I brought him to a stretcher to begin the admitting process. I pulled a couple of chairs up close to the stretcher for his mom and grandmother, and I sat at the end of the stretcher. I find it's less intimidating for kids if I speak to them at their level. I told Tom that I had 'a bunch of questions' to ask him, that I would explain everything that was going to happen, and I'd answer all his questions (and any questions his family had, too).

The interview went quite smoothly. I addressed my questions to Tom, with only a few clarifications necessary

from his mom. He was very knowledgeable about his condition and medications, and he liked to 'kid around.' He didn't appear to be nervous, but I left ample opportunity for him to voice any concerns he had and, as I'd promised, answer all of his questions. I explained that the anesthesiologist would be out soon to speak with them. Then I paged Dr. K to the unit to obtain informed consent prior to the start of the procedure.

When all the physicians were ready, I accompanied Tom, his mom, and his grandmother into the procedure room with the anesthesiologist.

Tom was very curious about all the equipment and played with the buttons on the x-ray table that move it back and forth. I assured him that was okay, and reinforced what would be happen-

*continued on next page*



## Exemplar

*continued from page 8*

ing to him. As he began to go to sleep, I escorted his family to the waiting room, reassuring them that Tom was being well cared for, and that someone would notify them as soon as he was in the recovery room.

The procedure, although long and technically challenging, went well. Because of my conversation with Dr. K prior to the procedure, and my specialized knowledge of ERCP equipment, I was able to anticipate Dr. K's needs and

suggest other pieces of equipment for him to try. He was able to carefully access the opening to the bile duct, ascertain that there were no blockages or strictures, and successfully dilate the opening in the hopes of preventing similar problems in the future.

Though I was unable to see Tom and his family in the recovery room, I'm confident that because of our interactions prior to the procedure, they left the Endoscopy Unit with a positive feeling about what could have been a very frightening experience for a 12-year-old young man.

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

This narrative is rich with examples of expert practice. Jane gives her full attention to every detail of Tom's care, starting before she even meets her young patient. She respects what Tom has been through and offers age-appropriate explanations of the procedure he is about to undergo. By letting Tom 'play' with the x-ray table, she gives him a sense of control over his environment.

Jane anticipates the needs that will arise during the procedure and collaborates with the physicians to ensure she's prepared to meet them. Jane's comfort in managing this complex procedure and her flexibility in creating an en-

vironment supportive of a 12-year-old boy and his family are critical, not only to the success of the procedure, but to ensuring a positive experience for Tom and his family at MGH.

Thank-you, Jane.

## Educational Offerings available on-line

The Center for Clinical & Professional Development lists educational offerings on-line at: <http://pcs.mgh.harvard.edu>

To access the calendar, click on the link to CCPD Educational Offerings.

For more information, or to register for any program, call the Center at 6-3111.

## CPE Program

*continued from page 4*

self to patients as a friendly, easygoing person without any agenda. But gradually, I became more aware of my own proclivities in this regard. I was a nurse with a pastoral connection, yes, but not one who had come to check up on a family's religious score card or proselytize. On the other hand, I wasn't just popping in for a friendly visit, content to chat about the weather. I wanted to be part of whatever the patient and family permitted me to be part of, and help them see things they might not want to see at first (their relationship with God, for instance) whenever they were ready for it.

Eventually, I began to

notice a connection between how people encounter 'the other world,' the invisible, unknown world beyond death, and how they relate to the spiritual world while they are alive. In other words, how people 'pray' or interact with the spirit world now, prepares them for the moment when it is finally inescapable, at death. By interacting with patients I have begun to see myself as a sort of 'marriage counselor' between patients and this world of the spirit. Helping patients pray what they feel in the way that is most natural for them has become my goal. I want to make their lives and final moments more peaceful.

If anything was engraved on my heart from participating in this program it was this: Don't

put off your dreams until it is too late. Patients who die with the most peace are those who have tried to accomplish their deepest dreams. Those who have the most difficulty are those who regret never having tried.

To those who are present here as well as those who will follow in my footsteps, I say:

Don't be a Buddhist, be Buddha.

Don't be a Christian, be Christ.

More importantly, be yourself!

Whatever your religion or faith, be open and willing to stay with the suffering of your patients—these patients who will hold you with their love and courage.

From then on, death and dying will no longer be able to scare you out of living to the fullest.

## Interested in Spiritual Care?

Through the generosity of MGH Nursing, two fellowships are available for the winter 2004 Clinical Pastoral Education Program.

Applicants for spiritual caregiver fellowships must be registered nurses within the department of Nursing in direct-care roles with a minimum of two years nursing experience.

The MGH Clinical Pastoral Education program is a training program accredited by the Association for Clinical Pastoral Education, (ACPE). It is a vehicle for caregivers to expand their knowledge in spiritual care.

The part-time winter program begins on January 5, 2004, and runs through May 17th. Group sessions are held every Monday (except January 19th and April 5th) from 9:00am to 5:00pm. Additional hours are negotiated for the clinical component.

All applications for the program, including the Spiritual Caregiver Fellowships, are due by September 1, 2003.

For more information about the Spiritual Caregiver Fellowship or to receive an application, please call the MGH Chaplaincy at 6-2220.

## Diversity in Childbearing

—by Patricia Connors, RN  
perinatal clinical nurse specialist

The second annual Diversity in Childbearing Conference was held on Friday, June 13, 2003, in O’Keeffe Auditorium. Organized by Germaine Lambers, RN, and Patricia Connors, RN, the conference promoted awareness of the diverse traditions and beliefs surrounding childbearing to help clinicians incorporate socio-cultural considerations into the care of mothers and newborns.

Kim Deltano, director of the Nurse Midwifery Program at MGH, opened the conference with her presentation, “Honoring

all birthing families: honoring ourselves.” Deltano cited the ANA’s definitions of values, cultural diversity, ethnocentrism, and cultural competence. She spoke about the adverse effects for patients, families, and care providers of failing to act in a culturally competent manner. Deltano shared details about her own difficult birthing experience and reminded participants of the powerful influence nurses have on their patients.

As speakers presented on various cultures, they focused on a number of core topics, such

as: language, pain management, family structure, healthcare values, religion, nutrition, and domestic violence.

In African, Asian, Hispanic, Jewish and Muslim communities, families tend to be extended, males dominate, and grandparents are respected for their longevity and wisdom. Presenter, Ruth Amadi-Nwogu, RN, emphasized that when women have babies in Africa, the entire village celebrates. Much of this community support has been lost as tribes have immigrated to the Western world. This is something care-

<i>Conference presenters</i>	
Honoring all families:	Kim Deltano, CNM
African:	Ruth Amadi-Nwogu, RN
Asian:	Lin-Ti Chang, RN
Hispanic:	Kathya Gavazzi, RN, and Linda Kradin, RN
Irish:	Joan Lovett, RN
Jewish:	Bonnie Godas
Alternative lifestyles:	Maureen Carrigan, RN
Muslim:	Ayfer Candeger
Female circumcision:	Kate Chalmers, RN
Breastfeeding:	Germaine Lambers, RN

givers need to be aware of.

Different practices surrounding the childbearing experience were explored. Lin-Ti Chang, RN, stressed that in the Chinese culture, a calm mood is strongly encouraged during pregnancy and the Yin Yang theory is highly regarded. In some Chinese cultures,

the labor support person must be of the same horoscope as the mother-to-be. In the African and Chinese cultures, the male does not routinely participate in labor and delivery.

Religion plays a big part in childbirth in the Jewish faith. Bonnie Godas, described the

*continued on next page*



At left: Kate Chalmers, RN, talks about female circumcision.  
At right: Linda Kradin, RN (left), and Kathy Gavazzi, RN, present on the Hispanic culture at The Diversity in Childbearing Conference.

## Making a Difference Grant Program funds creative ideas

Tapping into the creativity and imagination of the MGH community, The MGH Making a Difference Grant Program provides an opportunity for staff to submit ideas for projects that would improve services to patients, families, and MGH employees. This year, 20 such ideas were approved for funding, and on Friday, May 9, 2003, grant recipients shared poster presentations with colleagues



and hospital leadership at a special reception in the Trustees Room. Staff from Patient Care Services accounted for more than 80% of the funded projects.

Applications are now being accepted for the 2004 Making a Difference Program. All MGH employees are eligible to apply. For more information, call the Service Improvement Department at 4-0203, or e-mail Alex England at [aiengland@partners.org](mailto:aiengland@partners.org).

*Above:* Employees browse at posters on display.  
*At left:* Staff nurse, Susan Gavaghan, RN, explains her proposal to MGH president, Peter Slavin, MD, while social worker, Vanessa Allen, LICSW, looks on.

## Diversity in Childbearing

*continued from previous page*

different Jewish sects and explained the practices of each regarding pregnancy. In the Jewish faith, the health of the woman takes precedence over Jewish law. If a pregnant woman has difficulty fasting or performing physical activity on the Sabbath, she may be excused from participating and consult a rabbi to put her mind at ease.

Muslim women prefer female health providers and keep themselves

covered when a male enters the room.

Often, a person's background or culture can influence whether she is stoic when experiencing pain, or freely expresses discomfort. Chinese cultures tend to be stoic, while Hispanics are more expressive.

Domestic Violence exists in all cultures, but how it is handled varies greatly from culture to culture. In Africa, the abused party returns home, and family mem-

bers confront the abuser. Legal authorities don't get involved. In Chinese cultures, it is considered taboo to take personal family problems outside the family, which prevents abused families from seeking help.

Kate Chalmers, RN, provided information on female circumcision (mutilation). Chalmers is a Women's Health nurse practitioner who became interested in female circumcision when the daughter of a friend accompanied a college classmate to Africa to have this ritual performed at the age of 19. The

African girl was a student at Columbia University and had agreed to this 'right of passage' to protect her family's honor. Chalmers' slide presentation captured not only the physical, but the emotional effects of this ritual mutilation. The photographer who took the pictures won a Pulitzer Prize for her photo essay of this experience.

The cultural aspects of breast-feeding were discussed by Germaine Lambers, RN. She emphasized the importance of being sensitive to the woman's background while helping to facili-

tate her ability to breast-feed. Lambers explained that the use of formula in some countries is seen as a status symbol.

Next year's Diversity in Childbearing Conference may be extended to two days to allow more in-depth discussion on individual topics and to include a number of topics that weren't covered this year, such as the role of interpreters, literacy, and the mourning process.

For more information on diversity in childbearing, contact Patricia Connors at 4-9310.

## A team approach to treating alcoholism

—submitted by the members of The Psychiatric Clinical Nurse Specialist Consultation Service

One year ago, the Psychiatric Nursing Consultation Service was initiated as a pilot project on the medical service. In our collaborative discussions with nurses, physicians and colleagues in Psychiatry, it became clear that alcohol withdrawal was presenting unique challenges to the healthcare team. Often, patients going through withdrawal from alcohol created disturbances as a result of agitation, non-compliance with treatment, or belligerence toward caregivers. Early stages of withdrawal were difficult to recognize in these medically ill patients, which led to inconsistencies in the approach to treatment. The medical complications of untreated withdrawal led to delirium tremens, ICU transfers, and increased incidences of injuries to patients and staff. It also contributed to increased length of stay and 'revolving door' admissions.

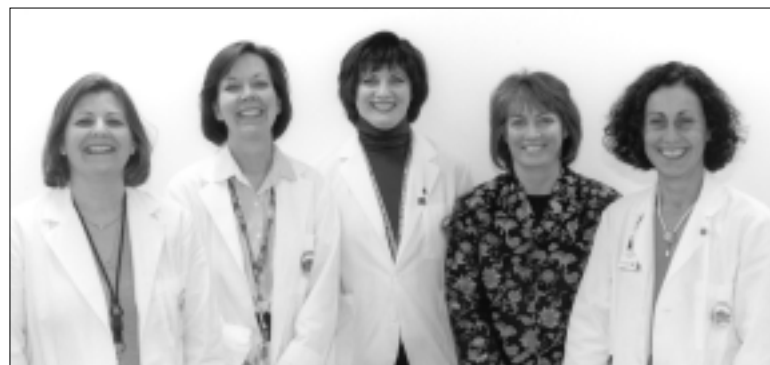
A hospital-wide initiative was undertaken to review the care of patients with alcohol dependence. Experts from Medicine, Psychiatry, Emergency Medicine, Psychiatric Nursing, Pharmacy, Community

Benefits, West End Addiction Services, and Administration convened regularly for a period of several months. The group examined current practice and factors contributing to increased length of stay, and developed new practice guidelines based on evidence and day-to-day clinical experience.

These efforts resulted in the new Alcohol Withdrawal Clinical Pathway. The pathway provides tools for assessment as well as multi-level treatment options to guide the clinician's decision-making. The pathway will be rolled out in the next few months and will include on-line information, educational sessions for healthcare providers, pocket-sized cue cards, and POE order sets.

The goal of the new pathway is to facilitate recognition and aggressive treatment of alcohol withdrawal; increase staff competence and comfort in caring for patients with alcohol problems; increase patient and staff safety, reduce the need for restraints and bedside observers; reduce medical complications; and shorten lengths of stay.

Consider the following case study: Mr. V is a



Members of The Psychiatric Clinical Nurse Specialist Consultation Service Program (l-r): Monique Mitchell, RN; Jenny Repper-Delisi, RN; Barbara Guire, RN; Robin Lipkis-Orlando, RN; and Mary Lussier-Cushing, RN

52-year-old man who was admitted for knee-replacement surgery. His hospital course has been uneventful. On day 2, his blood pressure and pulse are elevated; he is sweating profusely and is slightly tremulous. Yesterday, he was a friendly, cooperative man, but today he is demanding and irritable. His admission assessment describes Mr. V as a social drinker, but upon further questioning, Mrs. V reveals that Mr. V has a couple of high balls every night. Both the patient and his wife deny excessive drinking and minimize any concerns about possible alcohol withdrawal.

This is a common scenario in the care of medical and surgical patients. A patient's physical dependence is revealed to the patient, family, and caregivers only when admission to the hospital necessitates abrupt cessation of the drug. Even when there is little question about the presence of alcohol withdrawal, limited know-

ledge about the patient's history, denial, and the demands of treating concomitant medical problems can delay or complicate efforts to treat.

Alcohol is part of the social fabric of our society. Two out of three American adults drink alcohol. It is used to celebrate achievement and happy occasions, to decrease the stress and frustration of a bad day, it is accepted (and often expected) at many social gatherings, and it plays a role in ethnic traditions and religious rituals. Though children cannot drink alcohol legally, they are exposed to adult drinking, advertising, and peer pressure. Fifty percent of adolescents have their first drink by the time they reach the eighth grade.

Alcohol is the most abused drug in the world, affecting 15-20 million Americans. Alcoholism is an equal-opportunity disease that strikes male and female, young and old, rich and poor. Like many illnesses, it is progressive and has a predictable course.

Alcoholism (or alcohol dependence) can lead to much suffering. Consumed in large quantities over a long period of time, alcohol affects many of the body's systems causing liver disease, gastro-intestinal disease, sexual dysfunction, dementia and cardiomyopathy. Alcoholics are more likely to develop cancer of the liver, esophagus, larynx, and colon. Consumption during pregnancy can cause damage to the fetus (called fetal alcohol syndrome). The emotional life of the alcoholic is invaded by feelings of guilt, shame, and worthlessness. Alcoholics are more likely to commit suicide.

Alcoholism is known as a 'family disease' because every member of the family is affected. Children cannot bring their friends into their homes because of the embarrassment they feel when a parent is drunk. Spouses feel shame at not being able to solve their loved one's problem with addiction. Do-

*continued on next page*

## McPhee named 2003 Outstanding Emergency Nurse



(Photo by Patricia Flanagan)

Emergency Department staff nurse, Tracey McPhee, RN, was named 2003 Outstanding Emergency Nurse by residents from the Harvard Affiliated Emergency Medicine Residency Program. Presenting the award is chief resident, Nate Mick, MD. Residents in the program present the award annually to an ED nurse who demonstrates outstanding collaboration and teamwork and a strong commitment to interdisciplinary teaching and patient care.

### Team Approach to Treating Alcoholism

*continued from previous page*

mestic violence is more common in the families of alcoholics. Compounding the issue is the alcoholic's denial of any dependence on, or problem with, alcohol. The life of the alcoholic crumbles as the disease progresses: health, work, finances, and relationships may all become casualties.

Alcoholics continue to drink despite the inevitable, painful consequences of their drug use because they are psychological-

ly dependent and physically addicted. Withdrawal symptoms occur when alcoholics stop using because the brain cannot function adequately without the level of alcohol it is accustomed to receiving. Symptoms of withdrawal include elevated pulse, blood pressure, respirations, and temperature, shakiness, sweating, nausea, vomiting, diarrhea, restlessness, irritability, insomnia, hallucinations, seizures, and delirium tremens.

Alcohol withdrawal is a potentially life-threatening condition. Prompt recognition and treatment is essential in order to reduce the severity of withdrawal syndrome.

Historically, alcoholism has been poorly understood and often stigmatized by society as well as mainstream healthcare systems. Healthcare providers are often confronted with the complexities and challenges of caring for patients with alcoholism.

Hopefully, the new alcohol withdrawal pathway will help change all that.

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## Student Nurse Oncology Fellowship Program

—by Mandi Coakley, RN, staff specialist

For the third consecutive year, MGH Nursing is offering the Student Nurse Oncology Fellowship Program to two student nurses interested in pursuing a career in oncology nursing. The fellowship takes place in the summer prior to the student's senior year in a baccalaureate nursing program.

This year, Emily Perkins, from Texas Women's University, is a fellow on Ellison 14, and

Lindsay Murray, from Boston College, is doing her fellowship on Ellison 17. The fellowship is a 10-week, paid experience during which students work with a preceptor to learn more about the specialty of oncology nursing. Students are able to choose their desired area of focus. The goal is to provide an opportunity for students to learn about oncology nursing and get a flavor for the many roles available to nurses within the specialty.

### PCS Clinical Recognition Program

The Patient Care Services Clinical Recognition Program is accepting portfolios for advanced clinicians and clinical scholars. Portfolios may be submitted at any time; determinations will be made within three months of submission. Refer to the <http://pcs.mgh.harvard.edu/> website for more details. Completed portfolios should be submitted to The Center for Clinical & Professional Development on Founders 6. For more information, call 6-3111.

In addition to spending concentrated time on inpatient units, fellows rotate to Radiation Oncology, the (outpatient) Infusion Unit, and the outpatient clinics. At the end of the fellowship, students prepare a presentation on a topic of interest to them, which they present here at MGH and in class when they return to

school in the fall. All previous student nurse oncology fellows are employed within the MGH Cancer Center.

For more information, contact fellowship coordinators, Joan Gallagher, RN, at 6-2551; Jackie Somerville, RN, at 4-6317; or Mandi Coakley, RN, at 6-5334.



Student nurse, Emily Perkins (right), observes as preceptor, Michele Myers, RN, educates patient, Joseph Hodapp, about what to expect during the course of his treatment.

# Educational Offerings

July 17, 2003

When/Where	Description	Contact Hours
July 28: 7:30am–4:30pm July 29: 7:30am–4:30pm	<b>Intra-Aortic Balloon Pump Workshop</b> Day 1: MAH. Day 2: (VBK607)	14.4 for completing both days
August 7 7:30–11:00am and 12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
August 7 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Recognizing the Patient with Delirium.” O’Keeffe Auditorium	1.2
August 11 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
August 13 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
August 13 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
August 13 8:00–11:30am	<b>Intermediate Arrhythmias</b> Haber Conference Room	3.9
August 13 12:15–4:30pm	<b>Pacing: Advanced Concepts</b> Haber Conference Room	4.5
August 14 1:30–2:30pm	<b>The Joint Commission Satellite Network presents:</b> “Emergency Management: Creating and Implementing an Effective Plan” Haber Conference Room	4.5
August 19 7:30–11:00am and 12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
August 19 8:00am–4:00pm	<b>Intermediate Respiratory Care</b> Bigelow 9 Conference Room	TBA
August 21 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK 401 (No BLS card given)	---
August 21 1:30–2:30pm	<b>Nursing Grand Rounds</b> O’Keeffe Auditorium	1.2
August 27 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
September 2 8:00am–4:30pm	<b>Chemotherapy Consortium Core Program</b> Wolff Auditorium, NEMC	TBA
September 4 7:30–11:00am and 12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
September 4 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Issues related to Disaster Mental Health.” O’Keeffe Auditorium	1.2
September 8, 9, 15, 16, 22, 23 7:30am–4:00pm	<b>Greater Boston ICU Consortium CORE Program</b> SEMC	44.8 for completing all six days
September 8 8:00–4:30pm	<b>Cancer Nursing Concepts: Building Blocks of Practice</b> O’Keeffe Auditorium	TBA
September 10 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
September 10 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111.  
For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

## Crewe, Hansen, receive Cronin-Raphael Award for Patient Advocacy



The Paul W. Cronin and Ellen S. Raphael Award was established in 1999 to recognize the contributions of clinical and/or support staff on Phillips 21 who demonstrate excellence in delivering 'patient-first' care. The award honors the memory of Paul Cronin and Ellen Raphael, who died within months of each other on Phillips 21 in 1997.



Dietary aide, Sheila Crewe (left), and staff nurse, Andrea Hansen, RN, accept Cronin-Raphael Award from Phillips 21 nurse manager, Keith Perleberg, RN.

This year's recipients of the award, Sheila Crewe, dietary aide, and Andrea Hansen, RN, staff nurse, were recognized on June 16, 2003, in a small ceremony amid family, friends, co-workers, and members of the Cronin and Raphael families.

Colleagues wrote of Crewe, "Sheila has the ability to make every patient feel like they're the only patient on the unit. I could ask any patient who Sheila is, and they would all know her, because she takes the time and effort to make sure patients get the meals they want. She never fails to honor a request."

Of Hansen, colleagues wrote, "In one situation, when family members had decided on comfort measures only for their loved one, Andrea advocated for the patient to remain on Phillips 21 in a setting that was familiar. She provides outstanding care to patients and families throughout the entire trajectory of illness."

Congratulations to Crewe and Hansen for this well-deserved honor.

# Caring

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