June 12, 2003

Caring HEADLINES

Inside:

Volunteer pet therapist, Celia Sewell (left), with her dog, Keno, and patient, Heidi Bairos.

Unleashing the healing power of pet therapy

(See page 4)

MGH Patient Care Services

Working together to shape the future

Improving health care for older adults

Did you know?

Older adults account for 60% of all ambulatory hospital visits; 80% of home-care visits; patients 65 years old and older account for 48% of all hospital days; 85% of all nursing-home residents are over 65; and older adults consume 25% of all prescription drugs in this country.

Did you know?

Less that 1% of America's nurses are certified in Geriatric Nursing; research throughout the health professions largely ignores older adults; and federal research funding (NIH) mandates that children be included in research studies yet no requirements exist for older adults.

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

Some facts about elder care in America

Older Americans

- 13% of Americans (35 million) are over age 65; this will reach 20% (78 million) by 2050
- 6,000 people a day reach their 65th birthday; this will climb to 10,000 people per day by 2012
- 65,000 people are 100 years old or older; this will reach 381,000 by 2030
- Older adults use 23% of all ambulatory care visits, 48% of all hospital days, 69% of home-care services, and represent 90% of nursing home residents
- Older adults make more than 18 million ambulatory visits annually to nurses or nurse practitioners

Geriatric Nursing Care

- Older adults, especially frail older adults, cared for by geriatric nurse practitioners or clinical specialists are *less likely* to be:
  - physically restrained
  - delirious in the hospital
  - in pain
  - re-admitted to the hospital from home or from a nursing home

Geriatric Nursing Workforce

- Less than 1% (21,500) of 2,2 million practicing nurses are certified in geriatrics
- Less than .002% (5,700) of nurses are geriatric nurse practitioners or clinical specialists
- Only 23% of nursing schools have a required course in geriatrics
- 60% of baccalaureate nursing programs have no geriatric faculty

I recently had the opportunity to consult for the John J. Hartford Foundation to review a grant that was being processed for the Institute for Geriatric Nursing at New York University. I was impressed by their dedication to, and recognition of, the important role clinicians play in providing the highest quality care to our older patients. The center is now called The Hartford Institute for Geriatric Nursing.

The New York University School of Education offers a specialized program of clinical education and research aimed at providing clinicians with the most up-to-date information and best practices in caring for older adults. They call the program, NICHE: Nurses Improving Care for Health System Elders. While the curriculum was originally designed with nursing practice in mind, I think the program has application for clinicians in all disciplines who care for older adults.

Established in 1992, NICHE has evolved into a national geriatric nursing program encompassing more than 100 hospitals across the country. Its goal is to achieve systematic change that will benefit hospitalized elders by providing institutions with the tools and services they need to advance sensitive, exemplary care.

NICHE promotes evidence-based geriatric care by addressing issues that most impact elders, including:

- sleep disturbances
- eating and feeding difficulties
- incontinence
- cognitive function
- confusion and delirium
- falls
- depression
- medication safety
- pain management
- restraints
- advance directives
- discharge planning

Hospitals that have implemented the NICHE program report greater patient satisfaction, decreased lengths of stay, a reduction in re-admission rates, and a reduction in costs associated with care of the elderly.

I was so impressed by the program, I invited associate chief nurses, Debra Burke, RN, Theresa Gallivan, RN, and chief nurse at Spaulding Rehabilitation Hospital, Tim Quigley, RN, to accompany me to an educational meeting to learn more about it.

We all came away with the same impression—there is so much more we could and should be doing as a clinical community to effect positive change in the way we care for older patients.

Theresa's comments were, "I was impressed with the application this program could have for the extensive population of complexly ill elders we serve. Particularly exciting is the fact that the program is a nursing-led initiative that brings all disciplines together in the design of specialized care for this growing and increasingly challenging patient population."

Deb observed that, "The program is designed to cultivate a whole new way of thinking and caring for elders that alleviates both the phy-

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The PCS Clinical Recognition Program

Question: It's been one year since we implemented the Clinical Recognition Program. How is it going?

Jeanette: Every month the program becomes better known and understood by clinicians. More and more staff are taking the time to reflect on their practice and be recognized at one of four levels (entry-level clinician, clinician, advanced clinician, and clinical scholar).

Almost 50 clinicians have been recognized at the advanced-clinician and clinical-scholar levels of practice, and there are many more clinicians within Patient Care Services practicing at those levels. I'm hoping more staff will put their portfolios together over the next year.

Question: I'm considering developing my portfolio and applying for *advanced clinician* or *clinical scholar* recognition. What is the review process like?

Jeanette: A copy of your portfolio will be given to each member of the CRP review board. Each member reads and reviews the portfolio and identifies any issues they might want to bring up for discussion. At the next review board meeting, the board considers each component of your portfolio and determines whether it addresses all three themes of practice—clinician-patient relationships, clinical knowledge and decision-making, and teamwork and collaboration. They will decide whether your portfolio demonstrates the practice criteria specific to your discipline at the level you're seeking recognition. The board will identify any questions they want to discuss with you in the subsequent interview.

The interview will be conducted by three members of the board, including one person from your discipline. During the interview, you'll be given an opportunity to discuss your practice, address questions raised by board members, and provide other examples of practice that would qualify you for recognition at the level you're seeking.

After the interview, the interview team will present a detailed summary of their findings to the review board. The board will determine whether your portfolio and interview show evidence that your practice embodies the three themes of practice and meets the criteria for the level you're seeking. On the basis of this evidence, the board will decide whether or not to grant recognition. All board decisions are made by consensus.

Question: How important is the interview, and how do I prepare for it?

Jeanette: The interview is an important part of the application process since it affords clinicians the opportunity to describe their practice in person. Board members understand that some people find it easier to express themselves in writing, while others are more comfortable talking face to face. The interview becomes even more important if evidence of themes of practice and practice criteria are not clearly represented in an applicant's portfolio.

I suggest you review the themes of practice and examine the criteria of the level for which you're seeking recognition. Reflect on your practice and think about how you want to describe it during the interview. Be prepared to talk about how the themes of practice are reflected in your portfolio and be ready to provide additional examples.

Question: Are new staff eligible to apply to the Clinical Recognition Program?

Jeanette: As soon as you complete orientation you're eligible for recognition at the entry or clinician level. An applicant may apply for advanced-clinician or clinical-scholar recognition within six months of employment. Because the CRP program celebrates practice, length of employment is not the focus. The focus is on the level of expertise. The program recognizes that valuable contributions are made by staff at every level and that excellence is a goal common to all.

Question: How is it possible for the review board to understand the diversity of clinical practice within each discipline of PCS?

Jeanette: The review board is comprised of members from each of the disciplines within Patient Care Services. Members of the review board are experienced clinicians familiar with the broad range of practice within their own disciplines. If the situation arose where a portfolio touched on a practice issue unfamiliar to board members, the board would bring in expert clinical consultants to help them understand practice in that area.

Ives Erickson

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sical and psychological suffering that often accompanies hospitalization."

I believe we have glimpsed the future of geriatric care in this country, and I know MGH is going to play a big part in shaping that future. We will hear more about the NICHE program as we continue to explore ways to improve care for our older patients.

Magnet Update

After much preparation and anticipation, we are happy to welcome our magnet hospital appraisers to MGH. Their visit, June 10–12, is an opportunity for us to showcase our talent, knowledge, and skill, and I know you'll join me in making them feel welcome.

I want to thank our magnet champions and clinicians from all disciplines for your hard work, vision, and commitment to this important process.

General Updates

I am pleased to announce that Marita Prater, RN, has assumed the position of nurse manager for the White 8 and White 10 general medical units.

Joyce Saturley has accepted the position of GCRC research subject advocate.

Theresa Cantanno, RN, is the new clinical nurse specialist for Phillips House 20 and 21 (effective June 30, 2003).

Julie Goldman, RN, has assumed the role of professional development coordinator in the CCPD.

Pet therapy brings canine friends to MGH


Operations associate, Jessie Lemos, welcomes Keno to the unit.

Don't be surprised if one day soon your doctor hands you a prescription that reads: "Hug your dog and call me in the morning." More and more, studies are showing positive health outcomes associated with animal visits and interactions with pets. These findings have led MGH and many other hospitals across the country to implement pet therapy programs to augment the already wide range of healthcare services they provide.

A collaborative effort between the departments of Nursing and Volunteer Services, the MGH Pet Therapy Program began as a pilot program on a limited number of in-patient units in February of this year. Currently, pet therapy is available to patients on Ellison 7, Bigelow 11 and 14, and White 7 and 11, two afternoons a week.

The program is staffed by volunteers and their pets who have completed an extensive screening and certification process offered by The Pets and People Foundation. All pets must pass a physical and behavioral evaluation before being allowed to participate in the Pet Therapy Program.

Says Volunteer Department program manager, Paul Bartush, "Response from the MGH community has been amazing. Already, dogs and their handlers have become a fixture on units. It's a terrific program, and I'm thrilled we've been able to help make it a reality."

Celia Sewell works as a medical secretary, but she and her dog, Keno, a 5-year-old Labrador retriever-German shepherd mix, volunteer together as part of the Pet Therapy Program.

Says Sewell, "You just wouldn't believe the change that comes over people when they see Keno on the unit. Everyone comes up and wants to pet him and talk to him. He's an instant tension-reliever for staff and patients."

And Keno seems to enjoy the experience, too, taking full advantage of the situation to garner hugs, belly rubs, and even the occasional smooch.

In addition to physical and emotional well-being, it has been shown that pet therapy contributes to a greater sense of relaxation, socialization, motivation, and the ability to cope with the stress of illness. A visit from a canine friend can help patients overcome feelings of loneliness and isolation, and divert attention away from pain or discomfort.

Mandi Coakley, RN, coordinator of the Pet Therapy Program, says, "Nurses report higher morale among patients and staff following pet therapy visits."

The program is still in its early stages at MGH, but there are plans to expand the scope and frequency of visits in the fall (to include Pediatrics, ICUs and Psychiatry). With the overwhelmingly positive response the program is receiving, the big question is going to be how to keep up with requests for visits.

For more information about the MGH Pet Therapy Program, please contact Paul Bartush at 6-8540. If you are interested in becoming a pet therapy volunteer, please contact Mandi Coakley, at 6-5334.


Patient, Priscilla Bodkin, and staff nurse, Elizabeth Browning, RN (center), enjoy a visit from Sewell and Keno.

Ever at the ready: MGH clinicians participate in summer disaster-training drill

On the weekend of May 17, 2003, members of the International Medical-Surgical Response Team (IMSuRT) and Boston's Disaster Medical Assistance Team (DMAT) joined forces for a three-day field exercise on the grounds of the Bedford VA Hospital in Bedford, Massachusetts. Dozens of MGH nurses, doctors, therapists, and others participated in the weekend drill, which simulated an actual disaster (in this case, the bombing of an embassy on a small island.) The simulated disaster gave veterans of the two response teams an opportunity to work together in the field and hone their skills. It was also a chance for newcomers to experience deployment in a situation that was as close to the real thing as it gets!

Friday's activities centered on getting the DRASH (the Deployable Rapid Assembly Shelter) Pharmacy, and other 'portable' medical facilities up and running in the field. Saturday's focus was training new recruits and familiarizing team members with new systems, procedures, and equipment. Many changes and enhancements have been implemented as a result of lessons learned during previous deployments. Team members rotated through inservice training sessions in the Operating Room, the ICU, Pharmacy, Major and Minor Injury Tents, and a New-Equipment Training Module. Cross-training among disciplines was a priority at every station.

Sunday was dedicated to the mock drill, an uninterrupted, simulated response to a major medical disaster. For the purposes of the exercise, team members were told that due to the bombing, there was no transportation on or off the island; their emergency medical facilities were the only medical services available to victims.

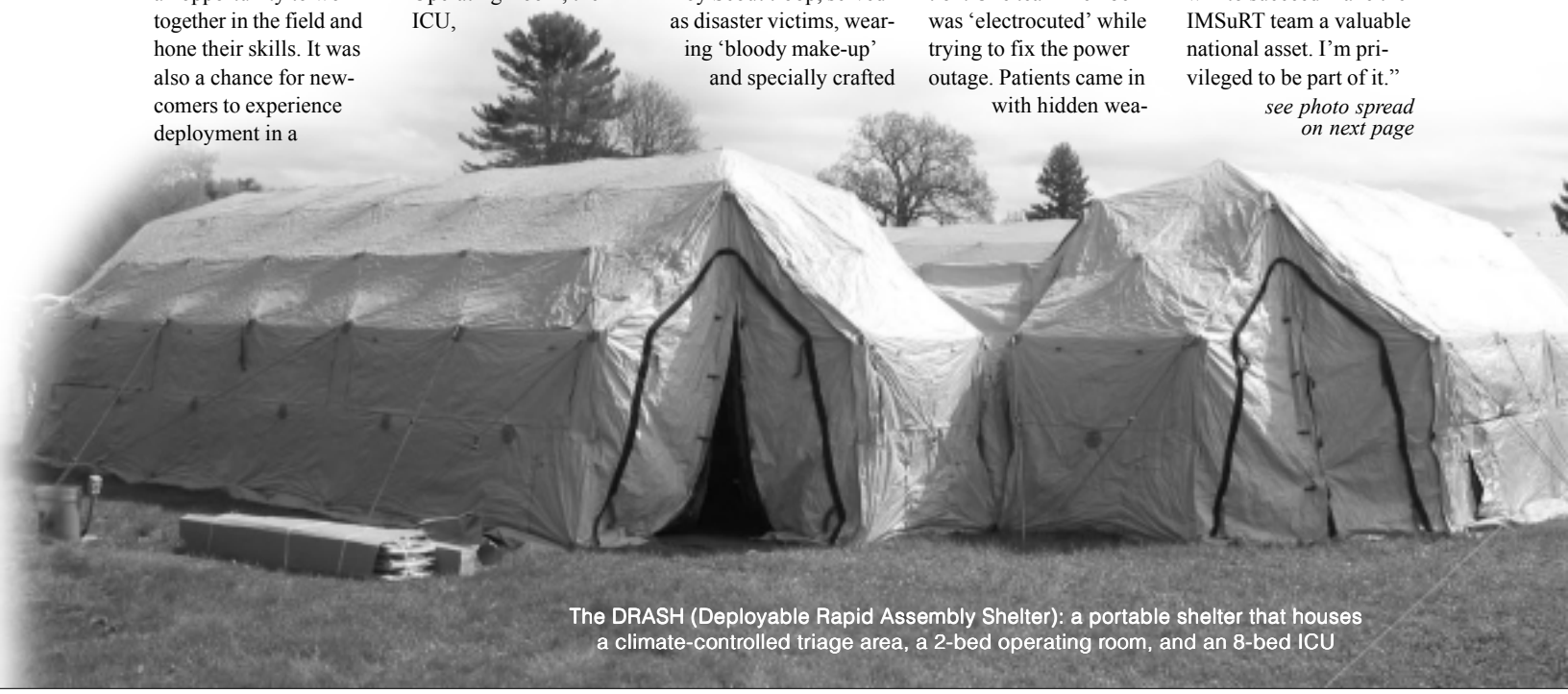
Community volunteers, including a local Boy Scout troop, served as disaster victims, wearing 'bloody make-up' and specially crafted orthotics to make injuries appear more realistic. Each victim was coached on how to act according to the injury he or she presented with. There was coughing, moaning, screaming, limping, and fainting.

Certain 'obstacles' were built in to the scenario (unbeknownst to participants) to lend a sense of urgency to the proceedings and to prepare team members to perform under unexpected, adverse conditions. At one point, there was an unanticipated power failure forcing a shift to emergency generators. Some caregivers 'collapsed' from dehydration. One team member was 'electrocuted' while trying to fix the power outage. Patients came in with hidden weapons; patients simulated escalating complications; one patient was found to have unexploded bomb material in his wound. "Expect the unexpected," was the mantra of the day.

Immediately following the drill, team members came together to talk about the exercise, share their observations, and discuss what they had learned from the experience.

Says Marie LeBlanc, RN, IMSuRT supervisory nurse, "This was an incredible learning experience. As a team, we were able to overcome a lot of adversities and really stay focused on caring for the victims. I continue to be in awe of the clinical expertise demonstrated by members of this group. Truly, their commitment and will to succeed make the IMSuRT team a valuable national asset. I'm privileged to be part of it."

see photo spread on next page



The DRASH (Deployable Rapid Assembly Shelter): a portable shelter that houses a climate-controlled triage area, a 2-bed operating room, and an 8-bed ICU

Photographs

1) Ron Gaudette, RPh, demonstrates improved drug packaging and access in the Pharmacy cache. Pharmacy systems and equipment changes were implemented based on lessons learned during Ground Zero deployment.

2) Sue Briggs, MD, IMSuRT commanding officer, oversees weekend activities.

3) Brenda Whelan, RN, assesses patient in the Major Injury Triage Tent.

4) Mike Spiro, RN, obtains blood sample, demonstrating new portable field blood analyzer; MaryAlyce Romano, RN, looks on.

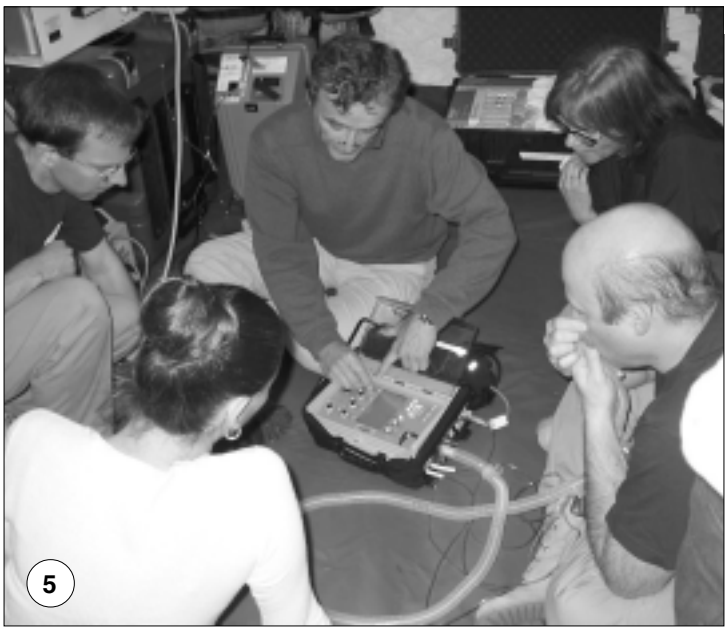
5) Robert Goulet, RRT, leads inservice training on operation of portable ventilator.

6) Barbara McGee, RN, and DMAT paramedic triage head-injury patient.

7) MaryAlyce Romano, RN (left), mentors Leandra McLean, RN, a new IMSuRT recruit.

8) Cathy Drake, RN, tends to pediatric casualty.

9) Simulated (orthotic) injury

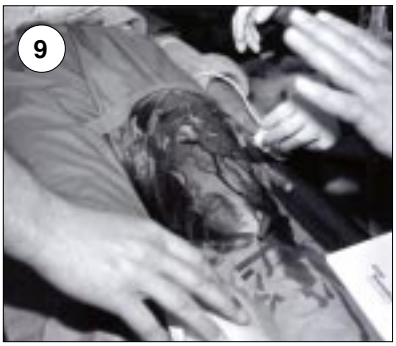


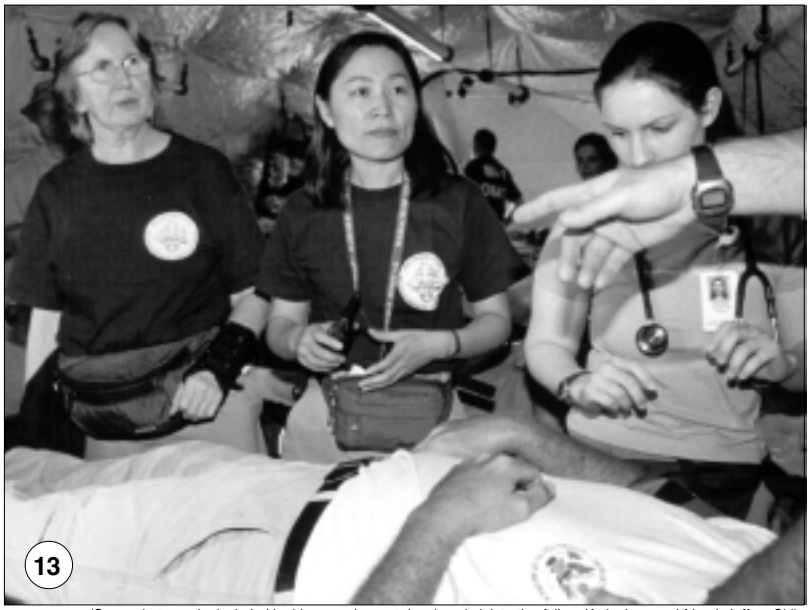
10) Marie LeBlanc, RN, IMSuRT supervisory nurse, oversees flow of patients into DRASH for OR and ICU care.

11) Barbara Walsh, RN, and Rischa Mayes, RN, prepare patient for the OR.

12) Gloria Moran, RN, escorts 'electrocuted' patient to the DRASH after resuscitation in the field.

13) Sheila Burke, RN, Lin-Ti Chang, RN, and new IMSuRT recruit, Heather Waden, RN, receive patient in the ICU.





(Some photographs included in this spread were taken by administrative fellow, Kathy Lee, and friend, Jeffrey Chi)

MICU nurse provides comprehensive care at every stage of illness

Kathy DeGenova, RN, staff nurse, Medical Intensive Care Unit

My name is Kathy DeGenova. I have been a registered nurse for 24 years at MGH, the last 21 of which have been in the Medical ICU. For the last 4 years, I've been the day-shift resource nurse. In this role, I encounter patients in various degrees of illness. My primary goal is to provide the best possible care to patients in the MICU. It's my job to manage the factors that influence that care. Each year I work as a nurse, I continue to grow, personally and professionally. I've come to realize that some of the smallest things in life bring much happiness to people, and that creativity and flexibility are the keys to success.

Recently, on a grey March day, I was assigned to care for Mrs. T, a woman in her early 50s who had been diagnosed with pulmonary hypertension several years earlier. For three years, she had lived at home on continuous IV Flolan, a potent vasodilator requiring central venous administration and medication cassette change every eight hours. Pulmonary hypertension can be a frightening disease, and my experience with it in the past has not resulted in good outcome. Mrs. T's only hope of survival was a lung transplant. She had been on the transplant list for three years. She came to MGH from another state with progressive shortness of breath, hoping we could help maintain her health until organs became available.

I received report from the night nurse who updated me on Mrs. T's progress. She had been stable for a few days, despite ongoing problems with respiratory distress during any sort of activity. She was on strict bed-rest. The night nurse told me Mrs. T had slept poorly so she'd decided to forego washing Mrs. T's hair, which she thought might help her feel better. She asked if would do it. My initial reaction was—this poor woman can't breathe, can't lie flat, how can I possibly wash her hair? Many years ago, I would have said, 'Sorry, that's not possible.' I would have been overwhelmed by the disease process, the equipment, the clinical presentation, and the patient's anxiety. Today, I welcomed the challenge. I looked beyond all the technology to the patient in the bed, and I thought, 'What would she want?'

When I introduced myself, Mrs. T immediately said, "Olivia told me you might wash my hair."

"I'm sure going to try," I said.

Mrs. T could only lie at a 40-degree angle without experiencing shortness of breath, which brought on severe anxiety. I was determined to figure out a way to wash her hair without making her uncomfortable and without getting her all wet. I reassured her that I would not let anything happen to her. I needed to put her at ease and alleviate her anxiety. Just as I was about to start, two respiratory therapists came into Mrs. T's room to change the nitric oxide tanks. (She was on nitric oxide therapy as an adjunct to the Flolan. It helped dilate the pulmonary blood vessels.) Mrs. T immediately became anxious and told me she hadn't done well when they changed the tanks the day before. To take her mind off it, I engaged her in conversation and reassured her that I'd stay with her while they changed the tanks.

When the therapists walked out of the room, Mrs. T asked, "Aren't they going to change it?"

I was happy to tell her they had already completed the task without her even noticing. From that point on, I knew I had won her trust.

I put the shampoo basin, informally called, 'a pork chop,' behind her head preparing to wash her hair. I realized that the water wouldn't be able to drain out at this angle. I needed to think of a way to get rid of the water I'd be pouring over her head. My first thought was to use what we use to collect other substances. I hooked up a suction tube to the pork chop so the water would get sucked up immediately and keep Mrs. T from getting wet and cold and anxious, which could potentially exacerbate her shortness of breath.

Trying to keep her mind off her breathing, I asked her about her family. She talked about her sons and her grandchildren. She was very proud of her family. When I finished, she said she was grateful to feel somewhat 'human' again. She called me an angel from heaven and said, "Wouldn't it be wonderful if they called right now to do my transplant?" This seemingly small act had made such a difference in Mrs. T's outlook.

Shortly thereafter, a couple came to visit Mrs. T. They were dear friends (the woman happened to be a nurse). They both commented that Mrs. T looked better than she had in weeks. I left the room for a moment and when I returned they couldn't thank me enough for the few extra steps I'd taken to make her feel her best.

When the dietician came in, we discussed Mrs. T's poor appetite and the energy it took for her to eat. She could barely breathe with the oxygen mask on, let alone without it. The dietician suggested a small feeding tube be placed so she could get all the calories she needed in that manner. I planned to discuss this with Mrs. T after she visited with her family.

When I returned to the unit after lunch the attending physician was looking for me. I sensed that what he was going to tell me was not good. He called the intern, the resident, the pulmonary fellow and me together.

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Exemplar

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He told us Mrs. T was no longer a candidate for transplant. They had found a pre-cancerous lesion on her pancreas, and that made her ineligible for transplant. He told me the transplant physician was with Mrs. T and her husband right now. I wanted to run in and support her, but I felt it wasn't appropriate to go in at that time.

The transplant physician came out of her room looking totally dejected. My heart ached for him. When I asked how she was, he could barely speak. As caregivers, the challenges we face vary in intensity. We need to think and act quickly. I composed myself and went to Mrs. T. I found her crying, holding her husband's hand.

I expressed my sorrow. She looked blankly in my eyes and said, "I have nothing to look forward to now." I just wanted to cry with her.

I wondered if she wanted or needed to be alone. We know people sometimes say they want to be alone when they really mean 'Don't leave me.' I put myself in her position. Her husband, and soulmate throughout this entire ordeal, was at her side. It felt right to leave so they could share their personal thoughts; share these intense moments as a couple. They didn't need a stranger in the room perhaps preventing them from saying what they needed to say. This news was devastating. There would be time later for me to support her if she needed me. I gave her a hug and told her I'd be no further than a call-bell away if she needed me.

I felt I couldn't help Mrs. T on my own, and I thought about who might be able to help her. When I returned to see her about 20 minutes later, she seemed stronger, but desperate. I informed her that the team taking care of her was not giving up and that we'd do everything possible to get her back to her prior level of functioning.

I called the transplant social worker to inform her of the recent turn of events. I felt Mrs. T could use the support of a person with whom she was familiar, someone who was familiar with the emotions transplant patients endure. The transplant social worker came immediately and sat with Mrs. T and her family.

Multi-disciplinary rounds were convening on the unit. I met with someone from each discipline (OT, PT, Food & Nutrition Services, Social Services, and the Chaplaincy) to seek their guidance. The consensus was to give Mrs. T and her family time to share their grief together as a family. The nutritionist would follow up on what we discussed earlier in the day. The chaplain would stop in later to pray with them and guide them spiritually. OT and PT said they would be available for whatever was needed. But the night ahead proved to be one of her last.

Unfortunately, my shift ended, and I gave the next nurse the plans for the evening, including multiple drug and therapy changes to begin to simplify things so that Mrs. T could return home. We knew Mrs. T would die soon, if not here in the hospital, surely at home. This was not a good feeling for me to leave with. The spectrum of emotions that healthcare professionals endure is sometimes overwhelming.

The next morning, I was informed that Mrs. T had done poorly with the adjustments and required a breathing tube and mechanical ventilation (respirator). My heart sank. Not only had we not made progress, we had taken a step back. Mrs. T was stable enough to be removed from the ventilator later in the day, but she remained sedated and uncommunicative. I knew now that as the days wore on her chances for recovery would dwindle. It was a hard reality to accept. But I have learned to be as supportive as I can in these situations and never give up.

Mrs. T asked that no further extraordinary measures be taken. The next day, Good Friday morning, she passed away with her family at her side. May she rest in peace.

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

This narrative shows the understanding, skill, and compassion of an experienced nurse. Kathy's concern for 'the small things in life' and her unwavering attention to detail are important themes throughout this narrative. Shampooing Mrs. T's hair, her comforting presence during the nitrous-oxide tank change, and her collaboration with other disciplines to ensure sensitive, appropriate care speak to Kathy's deep understanding of Mrs. T's long journey and its impact on her family. Through each passage, Kathy supported Mrs. T with the knowledge, skill, and empathy of a seasoned clinician.

Thank-you, Kathy.

The Employee Assistance Program

Work-Life Lunchtime Seminar Series
presents

"Keeping our Children Safe: Parenting in Unsafe Times"

Presented by
Candelaria Silva, parenting specialist

Parents and caregivers have growing concern about the safety of children in today's world. This session will offer techniques to keep your children safe from stangers and predators, and discuss how to ensure that violence in the media does not affect your children.

Thursday, June 19, 2003
12:00–1:00pm
Wellman Conference Room

For more information, call the Employee Assistance Program at 726-6976.

Educational Offerings and Event Calendar 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 for Clinical & Professional Developmentat 6-3111.

Assessing patient literacy

—by Donna Slicis, RN
Pre-Admission Testing Area

Jim arrives for his appointment 'without his glasses.' He needs help with his paperwork.

Sam arrives with a 'bad hand.' He needs help with his paperwork.

Dorothy comes to her appointment with her daughter. She doesn't need help. "My daughter will fill out the paperwork for me."

Jim, Sam, and Dorothy can't read. They all 'need help' with more than just paperwork.

Jim, Sam, and Dorothy are illiterate. If you don't ask them directly if they can read, you may never find out why they really need help filling out paperwork. Clues from past experiences with patients may intuitively lead you to ask about literacy. Maybe you notice that Jim misses or arrives late for appointments when he's notified by mail. Sam is unable to follow directions regarding his colonoscopy preparation. Dorothy calls to ask verbally how to take medication that is clearly labelled: "Take by mouth twice a day."

There may, in fact, be a medical reason why Jim, Sam, or Dorothy can't complete their paperwork. But you can't be sure of a patient's literacy until you ask.

Jim, Sam and Dorothy are proud adults; they have had years to create a variety of techniques to avoid embarrassment by keeping their illiteracy a secret. Keeping their illiteracy hidden protects them from judgement. Many patients with literacy issues go to great lengths to protect their secret. Good caregivers go to great lengths to create a non-judgmental atmosphere when assessing patients. That non-judgmental approach is especially important when assessing literacy.

Let patients know you're asking about literacy to ensure their safety. Literacy levels should be assessed and documented in all patients' records. It should be part of the initial assessment. Giving multilingual teaching tools to patients who don't know how to read will not be helpful; in fact, it could be harmful. And when you ask an interpreter to inquire about a patient's literacy in the patient's primary language, don't assume a level of literacy based on their ability to speak the language.

Jim

During Jim's initial assessment, he was asked about his vision.

"I have no trouble seeing," he responded.

That was odd for a man who 'needs glasses' to read.

"Is it that you can't see the words, or you have trouble reading the words?"

"I have trouble reading," he said softly.

He shared that he was able to get by using some word recognition, but he didn't know how to read.

Now that illiteracy had been assessed, the plan of care could change to meet Jim's needs. By using pictures, demonstrations, verbal teaching, and always assessing his understanding, we allowed Jim to maintain his pride, while his safety remained our top priority.

Jim's plan of care needed to take into account all the times he would be asked to read instructions or sign his name. Forms were read to him and he was asked to re-state his understanding of what he heard. It was necessary to alert all members of his healthcare team to ensure safety and quality of care and preserve his dignity.

Think about how many times you present patients with papers to read and/or sign, and you'll realize the challenges involved with Jim's care. Consent forms, discharge instructions, prescriptions, menus, and these are only a few of the written forms and documents we expect patients to be able to read.

Put yourself in Jim's place, coming to MGH for the first time, trying to find the Blake Building. If you can't read the signs, how do you know where to go? Imagine what it must be like to sign papers when you don't know what they say. Imagine telling your caregiver you can't read. How far would you go to maintain your pride?

How many times have you been told, "I forgot my glasses."

Did that patient really forget her glasses, or was literacy the real problem?

You'll never know unless you ask.

Staff nurse, Donna Slicis, RN, with patient, Janice Leys, in the Pre-Admission Testing Area.

Some considerations when writing educational materials

Who is your target audience?
- Consider age, gender, culture
- Condier literacy level (The average American reads at a 5th-8th-grade level
- Try to keep written material at a 6th grade reading level.
- Include patients in planning and writing

What do you want the reader to learn from the written information?
- State the purpose of your document as simply and briefly as possible
- Don't overwhelm readers with too much information; limit content to 3-5 concepts.
- Let "need to know" not "nice to know" be your guide

Content
- Use an 'active' voice. Don't say: " Your medicine should be taken with meals (passive). Say: "Take your medicine with meals." (active)
- Use common words. The fewer syllables in a word, the easier it will be to read.

Difficult	Easy
Physician	Doctor
Examine	Look at
Utilize	Use
Frequently	Often
Hypertension	High Blood Pressure
Chemotheraputic agent	A drug that fights cancer
Multidisciplinary team	Healthcare team

- Use short sentences (12-15 words per sentence). Avoid using many phrases separated by commas
- Use pictures or diagrams, clear captions, and ample white space to help convey information. This helps attract the reader's attention and reinforces the message.
- Give examples to explain uncommon words.
- Include space for patients to interact with the document (e.g., space to write down their blood pressure or blood sugar level; a check-list to mark actions they will take; etc.)

Layout and design
- Use 12-14 font size
- Use headers: typically one font size larger than the body text and bolded.
- Use serif type: letters that have little extensions that make them easier to read (Times New Roman is the standard)
- Leave white (empty) space on the page.
- Bullets and graphics are excellent ways to make your point without using a lot of text. Include as few bulleted items as possible. Make sure all graphics are appropriate, culturally sensitive, clear, and on the same page as the text describing them.

Testing documents
- Test your draft with a few patients; ask for their comments and feedback.
  - Usability: Would the document attract their attention? Is it easy to read? Would they use the information?
  - Functionality: Does the document tell them what they need to know? Has anything been left out?

Prepared by Lori J. Pugsley, RN

MGH kicks off new Health and Wellness Channel

The PCS Patient Education Committee in collaboration with The Blum Patient & Family Learning Center recently created the Health and Wellness Channel for patients, families, and visitors at MGH. The Health and Wellness Channel is viewable on any television in the hospital on channel 32. The channel offers 43 different videos including:

- *Healthy Eating for the Whole Family*
- *Relaxing Through the Seasons*
- *Heart-Healthy Exercise*
- *The Best Prevention: Injury Prevention in Children*

The complete list of video titles and viewing times can be found on channel 28. The Health and Wellness Channel was developed to help patients and families understand the importance of health and wellness and make better decisions regarding their own health.

Turn to channel 32 and check out The Health and Wellness Channel. Then tell your patients and their families.

The MGH Cancer Center

presents

The Men's Cancer Awareness Fair

Take a moment to learn about early detection, prevention, and treatment of some of the most common cancers affecting men today

Friday, June 13, 2003
10:00am–2:00pm
Main Corridor

For more infomration call 724-9432

Joint Commission Satellite Network Presentations

July 10th: "Medication Use: Preventing Errors"

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

Two nurse practitioners join renal team

—by Chris Pacheco, NP, and Carol Tyksienski, RN

Chronic kidney disease (CKD) is becoming a worldwide public health problem. It is estimated that CKD affects 20 million adults in the United States alone, and millions more are at risk of developing the disease in the future.

Hypertension and diabetes are the most common causes of CKD followed by glomerulonephritis, cystic kidney disease, and urological conditions. The National Kidney Foundation (NKF) has devised guidelines for the care of CKD patients, and these guidelines have become the standards of practice across the country. The goal of the NKF guidelines is to improve patient outcomes by slowing the progression of the disease, preventing complications, treating comorbidities, and preparing the patient for renal replacement therapy (dialysis). The key to success is early screening of individuals at risk for the disease and referral to a nephrologist. (Referrals should be considered when serum creatinine is 1.5 in females and 2.0 in males.)

My name is Chris Pacheco, and my role as nurse practitioner for Renal Associates is to follow patients between visits to the nephrologist. I work collaboratively with the nephrology team (nurses, physicians, a dietician, and a social worker) in providing holistic care and renal education to our patients with chronic renal failure. Using the prescribed guidelines, I focus on slowing the progression of the disease with careful blood-pressure and blood-sugar control; anemia-management; and early referral for fistula placement.

Blood-pressure and blood-sugar control are extremely important in slowing down the progression of the disease. Guidelines specify 130/85 as the target blood pressure for CKD patients. Lifestyle enhancements, such as diet and exercise, are recommended, and it still may require three or more medications to reach these target numbers. And increasing declines in renal function may alter the patient's response to insulin and oral hypoglycemic medications.

Cardiovascular incidents are the number-one complication of renal disease, so anemia-management is crucial. I usually see patients every week (or every other week) to adjust their medications and order lab work to ensure their iron stores are adequate and their hemoglobins are reaching the target level.

I work closely with Carol Tyksienski, the dialysis nurse practitioner on issues related to vascular access for dialysis treatment. I refer patients to surgeons for evaluation and access-device placement and follow them post-operatively in the clinic.

Renal patient care is complex and requires close follow-up by the nephrology team to ensure positive patient outcomes.

Chris Pacheco, NP, nurse practitioner (left), and Carol Tyksienski, RN, clinical nurse specialist

My name is Carol Tyksienski, and I came to the Dialysis Unit in September of 2002. Having worked in a dialysis unit more than 20 years ago I'm excited to see the advances in technology that have occurred. I remember when nurses mixed their own dialysate bath in a huge water-filled stainless steel tank. Today, the dialysate bath is commercially prepared and available in gallon containers. Today, dialysis patients have far fewer complications during treatment due to the advances in dialysis technology.

My position in the Dialysis Unit is divided between clinical nurse specialist and nurse practitioner. One aspect of the CNS role is to work with unit staff to keep them informed of hospital and nursing changes that may affect their practice. Recently, I have worked with staff in the trial of a new monitor. The monitor allows caregivers to see changes in the patient's blood volume in real time during dialysis. The information available on the monitor allows nurses to intervene during fluid volume shifts before hypovolemia or hypotension occurs. The new monitor provides for a safer and more accurate removal of fluid from the intravascular space during dialysis. As the CNS, I am visible on the unit and available to staff for nursing- and patient-related issues.

Vascular access has always been a problem for patients requiring hemodialysis. One of my responsibilities as the NP in the Dialysis Unit is to manage vascular-access-related issues. I work closely with Chris Pacheco of the Renal Associates Office. We consult each other on patients who are initiating dialysis or who may be in an outpatient facility having access-related issues.

Patients requiring dialysis need to have a vascular-access device placed in order to receive dialysis treatment. Currently, there are three methods by which patients can establish vascular access. Two methods, arteriovenous fistula and graft, require surgical placement. Arteriovenous fistula is the preferred access. Catheter is the third option. Catheters are used in patients when dialysis needs to be initiated before a fistula or graft can be placed, or when it's the only option available to the patient.

continued on next page

Pain Pulse 2003: checking our vital signs

—by Thomas E. Quinn, RN, project director, MGH Cares About Pain Relief

Pain Pulse is the annual 'snapshot' of pain conducted by MGH Cares About Pain Relief. The Pain Pulse Survey has been conducted in 1999, 2000, 2002, and 2003. Most MGH inpatient units, the Cancer Center, The Same Day Surgical Unit, the ER, and outpatient Gynecology participated in the survey this year.

For the purposes of the survey, patients are asked: "Have you had pain in the past 24 hours?" Patients who respond, "Yes," are asked: "What is the severity of your pain now?" and "How much has pain interfered with your ability to enjoy life in the past 24 hours?" Both questions are answered on a scale of 0-10 (where 0=no pain; 10=the worst pain imaginable).

Pain Pulse was implemented to measure the prevalence of pain across the institution and raise awareness about pain-management among patients and clinicians.

While Pain Pulse is not designed to measure outcomes, data indicates that a significant percentage of patients report experiencing pain and/or that pain has a major impact on their quality of life. These results point to a need for increased awareness about pain and pain management on the part of both patients and caregivers.

Currently, only a limited number of outpatients are included in the Pain Pulse Survey. There are plans to expand the survey to include more outpatient sites next year.

For more information about Pain Pulse, or MGH Cares About Pain Relief, call Thomas Quinn at 726-0746, or e-mail tquinn1@partners.org.

Call for Portfolios:

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 and application materials, or speak with your manager or director.

Completed portfolios should be submitted to The Center for Clinical & Professional Development on Founders 6.

For more information, call 6-3111.

Nurse Practitioners Join Renal Team

continued from previous page

The goal of the National Kidney Foundation's Dialysis Outcome Quality Initiative is to decrease the number of catheters being used to initiate dialysis. At MGH, our goal is the same. It is hoped that through careful planning, patient education and collaboration between the nephrologist, the patient, and the renal NP, patients will opt for placement of an arteriovenous fistula early on, so that access will already be established by the time dialysis needs to be initiated.

Recently, I was part of a task force that considered options for patients from community dialysis centers who need assistance with clotted access devices. The task force developed an algorithm that directs patients to the Radiology Unit instead of the Emergency Department (to help alleviate overcrowding in the ED). I am available to assess dialysis patients who come to Radiology, review their cases with the nephrology attending physician, and upon successful outcome, allow them to return to their outpatient treatment centers. Several patients have successfully used this new algorithm and returned to their community treatment centers, avoiding missed dialysis treatments.

As an NP, I am available to write orders on the unit, conduct discharge planning and follow or intervene with access-related problems for hospitalized dialysis patients.

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The Women's Health Coordinating Council

—by Mary Ellen Heike, RN, MMHS staff specialist, Women's Health

May was a month to recognize and celebrate nurses and women. At MGH, the Women's Health Coordinating Council (WHCC) participated in Nurse Recognition Week and National Women's Health Week by sponsoring two events: a presentation entitled, "Managing the menopausal patient in 2003: a practical approach," and an educational booth in the Main Corridor, called, *Five Simple Ways to Stay Healthy*.

The two highly successful events provided vital health information to clinicians, employees, patients and visitors. They were the first of many to be launched by the WHCC.

The WHCC was created in the late 90s when Jeanette Ives Erickson, RN, senior vice president for Patient Care, Isaac Schiff, MD, chief of Obstetrics and Gynecology, and Dennis Ausiello, MD, chief of Medicine, wondered if MGH was doing all it could to meet the specialized needs of women. They knew women comprised about half the population, made most of the healthcare decisions for their families, spent almost two thirds of all healthcare dollars, and accounted for six of every ten physician visits. What they didn't know was how women viewed the care they received at MGH.

A committee was formed to look at women's perceptions of care at MGH to determine their overall needs, and assess whether there were opportunities for improvement.

The committee's findings showed:

- Women believed they would be listened to and better understood at a women's health center. The perception was that they would receive better care at a center dedicated to women.
- Women had a positive image of MGH as a large, urban, tertiary-care hospital able to provide a vast array of services with highly trained clinicians and the most advanced technology.
- Though MGH was viewed in a positive way, other institutions were perceived as showing more interest and sensitivity to the needs of women and having an environment that was comfortable and welcoming to women patients.

In response to these findings, the Women's Health Coordinating Council was created and immediately began working to identify the unique and specific needs of women seeking care at MGH.

Says Ives Erickson, "The Women's Health Coordinating Council supports clinicians in their efforts to provide the best possible experience for women patients at MGH. It coordinates initiatives designed to meet the diverse needs of women at every stage of their lives, and it advances our mission to provide individualized care to all patients."

In 2002, Mary Ellen (Mel) Heike, RN, was hired as staff specialist for Women's Health to support the efforts of the WHCC and further define its scope of responsibility. Over the past year, the WHCC Executive Committee has worked to clearly define the parameters of women's health and identify the core values essential to the delivery of culturally-competent care. Women's health at MGH has been defined as "recognizing and accounting for the physical, biological, psychosocial, cultural, spiritual and economic factors that influence a woman's relationship with her healthcare providers."

Deb Burke, RN (left), associate chief nurse, Mel Heike, RN, staff specialist, and Jeanette Ives Erikson, RN (not pictured), are members of the WHCC Executive Committee.

WHCC core values that support culturally-competent care include:

- A woman-centered approach that places value on understanding the critical gender-based variables that create unique differences in the diagnosis, care, and treatment of women. This approach supports the development of programs that combine evidence-based conventional practice with complementary and alternative medical knowledge in the care of women.
- Healthcare programs must address care across the life span, recognizing the changing healthcare needs of women as they transition from adolescence through adulthood to end of life.
- Care for women extends beyond providing problem-focused services. Health promotion and wellness need to be emphasized for women and their families.
- Women have multiple and overlapping social responsibilities that influence their health, the health of their families, and their ability to access care. Women, as active participants, are valued members of the healthcare team.

Building on these core values, the WHCC is working to develop initiatives to enhance the delivery of care, and advance research, education, and policy-writing in the area of women's health.

For more information or to learn how you can participate in the work of the WHCC, contact Mary Ellen Heike at 724-8044 or send e-mail to mheike@partners.org.

When/Where	Description	Contact Hours
June 20 7:00am–12:00pm	**CVVH Core Program** VBK 601	6.3
June 20 8:00am–4:30pm	**Advanced Arrhythmia Interpretation Program** O'Keeffe Auditorium	7.8
June 20 1:00–2:30pm	**Conflict Management for OAs and PCAs** VBK 601	- - -
June 23 8:00–4:30pm	**Neuroscience Nursing Continuum of Care** Bartlett Conference Rooms 5 & 6	TBA
June 24 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK 401 (No BLS card given)	- - -
June 25 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
July 3 7:30–11:00am and 12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
July 3 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
July 8 8:00am–12:00pm	**BLS Certification–Heartsaver** VBK 601	- - -
July 9 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
July 9 1:30–2:30pm	**OA/PCA/USA Connections** Bigelow 4 Amphitheater	- - -
July 10 1:00–2:30pm	**The Joint Commission Satellite Network presents:** "Medication Use: Preventing Errors" Haber Conference Room	- - -
July 15 7:30–11:00am and 12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
July 15, 17, 22, 24, 29, 31 7:30am–4:00pm	**Greater Boston ICU Consortium CORE Program** BIDMC	44.8 for completing all six days
July 17 1:30–2:30pm	**Nursing Grand Rounds** "Pain Management: Equianalgesic Dosage Conversions." O'Keeffe Auditorium	1.2
July 23 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
July 25 8:00am–4:30pm	**Caregiver Skills** Training Department, Charles River Plaza	7.2
July 28: 7:30am–4:30pm July 29: 7:30am–4:30pm	**Intra-Aortic Balloon Pump Workshop** Day 1: MAH. Day 2: (VBK607)	14.4 for completing both days
August 7 7:30–11:00am and 12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
August 7 1:30–2:30pm	**Nursing Grand Rounds** "Recognizing the Patient with Delirium." O'Keeffe Auditorium	1.2
August 11 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -

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.

Golden Pen Award recipients

The third round of Golden Pens have been awarded in the new program that acknowledges staff nurses for exemplary documentation. The following staff nurses received Golden Pens:

PATA: Tammy Harrigan
Ellison 6: Ann Austras and Barbara Carey
Ellison 7: Maureen Boyce and Nancy Ross
Ellison 8: Lauren Kattany, Lois Masters, Barbara Mullen, and Sara Mahoney
Ellison 9: Laura Naismith
Ellison 10: Lori Mazzarelli
Ellison 12: Diana Soldano and Robert Marino
Ellison 16: Erin Bisesti, Mary-Beth Hogan, Kendra Dolloff, Sandra Palladino
Ellison19: Miera Grima Cerventes, Cindy Wong, Nadine Raphael, Elizabeth Harrington, Diana Zographos and Amanda Rosa
Phillips 20: Katie Fallon, Josh McGee, Rebekah Hattery and Kelly Carreiro
Phillips 21: Eileen Godlewski, Betty-Ann Burns-Britton and Lynne McCormack
MICU: Erin Cavanaugh, Shannon Frazier, Denise Young, Margaret Flessner, and Denise Ajewski
Blake 8: Brooke Albertson, Kelly Connor, Marilyn Vitale, Aaron Gendreau, Kerri Woods and Ursula Gunther
Blake 12: Anthony Villenueava
RACU: Ashley Stockman, Catherine Tremblay, and Elizabeth Campbell
Dialysis: Christy McGinley
Bigelow 11: Jennifer Nadeau and Kerrie Macomber
Bigelow 14: Joan Stack, Connie Barnes and Jennifer Robinson
White 6: Ivonny Niles, Cecille Alves and Amy McCarthy
White 8: Lauren Rodrigues
White 9: Deborah Zapolski, Shauna Harris, and Patricia Simoes
White 11: Kathleen McElhinney, Aime Finn, Kim Kane, Sandra Kelly, Tracey Bittle, Mary Paruch, and Sachiko Castleman
White 12: Deb Giampapa, Whitney Foster, Beth Fortini and Colleen Comerford
PICU: Cheri Boulanger, Lisa Henderson and Patricia Lally

Once a month, one Golden Pen recipient is randomly selected from previous and current recipients to receive a $50 American Express gift certificate. This month, the gift certificate went to Tim Sowicz from Ellison 16.

Caring HEADLINES

Send returns only to Bigelow 10
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