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White 7 blood drive a true team initiative
(See page 4)

MGH Patient Care Services
Working together to shape the future
Coping in the aftermath of tragedy

After the troubling events of the past few months, we are all engaged in a process of healing. We have been deeply touched by tragedy, and we have come together as a hospital, and as a family, to help each other. I’ve witnessed incredible strength and compassion in these past weeks, and I think we’re doing well in our efforts to support one another. I know I speak for the entire leadership team when I say, the best thing we can do to honor the memory of those we have lost is to continue the important work we are doing, caring for patients and serving the community. I thought it would be useful to hear from some of the individuals whose work at MGH helps us feel safe and supported in our work environment.

Evelyn Bonander, ACSW, director, Social Services

Social Services has played a key role over the past few months in helping staff and family members through a particularly difficult time. A number of devastating events presented unique and unprecedented challenges to our entire hospital community. We have all been affected by these events in some way. It’s important to recognize the impact these events have on our own emotional well-being. As healthcare providers, many of us are familiar with the cumulative effect that can result from prolonged exposure to stressful situations. It can lead to feelings of chronic anxiety, an inability to concentrate, sleeplessness, worry, and a general sense of unease. We need to pay attention to those signs and give each other opportunities to talk, together and/or individually; and we need to provide time and space to grieve.

Also, it’s important to understand that every person deals with stress and/or adversity differently. Some people are able to express their feelings immediately while others may hold their emotions in for a long time. Some people may prefer to be alone if they don’t want to be. It’s natural to want to ‘check in’ with co-workers and colleagues periodically following times of great distress. A friendly, “How are you doing?” can open the door to meaningful dialogue and supportive conversation. This is appropriate in the days, weeks, and even months following a traumatic event.

Patients and families are also going through a difficult time as a result of these tragedies. You may find that patients want to talk and tell their stories as part of their healing process. Social workers are available to all patients and family members who need support or want to tell their stories.

Staff should remember that the Employee Assistance Program (EAP) is a valuable resource; don’t hesitate to avail yourself of their services, or refer a co-worker who may be having a difficult time.

Allison Lilly, LICSW, operations manager, and Andrea Stidsen, LICSW, director, Employee Assistance Program (EAP)

The one theme that links these recent incidents is the tremendous loss suffered by the MGH family and the incredible care we’ve been able to provide to each other and to our patients.

Many lives have been touched by these events, in ways we may not even know about yet. One thing we need to keep in mind is that every person’s response is different, unique, and valid. Some people may prefer to grieve in solitude, while others may seek comfort in the company of their families, friends, and co-workers. What ever our coping mechanisms are, we need to call on them now; we need to be true to ourselves and honor our honest response to these events.

Some individuals may have feelings of irritability; they may withdraw from typical interactions or experience other changes in behavior. These can be indications of emotional distress or internal struggle. It’s important for all of us to be more tolerant, more empathetic, and more supportive during these times.

Not everyone is comfortable asking for help. It may be difficult for some of our co-workers to reach out. Now, more than ever, we need to make that extra effort to extend a helping hand. There are so many wonderful resources at MGH, there’s no need for anyone to be alone if they don’t want to be.

It’s natural to want to talk about incidents that affect us deeply. It’s a form of healing. We encourage people to talk openly about their feelings. At the same time, we need to respect the ‘cues’ of those who may prefer not to talk. The important thing is for people to know that there is a safe environment for whatever form of expression their feelings take. The opportunity to talk and share is there if they want it.

It’s also natural to be curious; to seek answers; to ask, ‘Why?’ Knowing answers and having information gives us a sense of control. But we don’t want that curiosity to lead to rumors or false information that can be hurtful to others. When it’s within your power, try to curtail non-constructive conversation and rumors.

The Employee Assistance Program (EAP) is available to all employees of MGH. Employees can call (6-6976) to speak with an EAP worker who may be available for you.

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

continued on next page
Coping After Tragedy
continued from previous page

First I’d like to assure you that the incident that took the lives of Dr. Brian McGovern and Colleen Mitchell was in no way foreseeable. It could not have been predicted; it could not have been prevented. It was a sad, tragic act, but no one in the MGH community should be harboring feelings of guilt or blame.

Also, it’s understandable that employees may feel fearful in the wake of such disturbing events. I’d like to try to allay those fears by sharing some information with you. It’s estimated that there are approximately 115 million people in the workforce nationwide. Of that 115 million, 1,000 people die as a result of workplace violence. Of that 1,000, less than 5% (or an average of 45 people per year) are killed by random acts of violence in the workplace. I don’t tell you this to minimize the tragedy in any way; only to assure you that the chances of it happening again are astronomically small.

We are fortunate that hospital leadership places a high priority on safety and security. Our Police & Security Department is a benchmark of excellence for healthcare organizations across the country. We orchestrate a multi-pronged, multi-dimensional security program that is strong, strategically sound, and rich in professional expertise.

Our department is staffed by an extraordinary team of dedicated and knowledgeable officers and support staff. We employ state-of-the-art technology and techniques to prevent and deter crime. We have designed and implemented policies and procedures to ensure the optimal safety of patients, staff, and visitors. And we offer numerous training opportunities and educational sessions to help prepare staff to handle situations that arise in the workplace.

MGH is a large, urban medical community. Approximately 70,000 people come through our doors every day. We all need to be vigilant and aware of our surroundings. We need to pay attention to the behavior of our patients and coworkers. We need to listen to that little voice inside that tells us something isn’t quite right.

I urge every member of the MGH community to contact Police & Security (6-2121) at the earliest opportunity when and if you suspect anything unusual in the workplace. Trust your instincts; act sooner than later. The earlier Police & Security is notified, the more options we have in preventing or eliminating threats.

I cannot state strongly enough that MGH is a safe place to work and seek care. Please help us maintain this level of safety by continuing to be a proactive member of our community. Ensuring adequate security requires active vigilance, communication, and the vigorous participation of every employee.

Please call Police & Security (6-2121) for issues related to patient restraints, employee escorts, or any patient activities, actions, or behavior you deem questionable or suspicious.

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 strangers 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
Wednesday, June 25, 2003 12:00–1:00pm
Thorn Conference Room, BWH

For more information, call EAP at 726-6976.

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
White 7 nurse coordinates unit-based blood drive

White 7 staff nurse, Barbara Walsh, RN, was checking e-mail one day when she came across an All-User E-Mail from the MGH Blood Donor Center. The message informed staff about a critical blood shortage in the area and in the hospital.

Like everyone else, Walsh was concerned. But unlike a lot of us, Walsh did something about it. She thought it would be a great idea for her whole unit to participate in a blood drive. And in very short order, her idea became a reality.

Walsh visited the Blood Donor Center to pick up brochures and information about donating blood. She used that information to create a poster, which she displayed prominently on the bulletin board directly across from the nurses’ station. Alongside pictures and testimonials of people who have benefited from receiving blood donations, was text that read:

Critical Blood Shortage—Please join White 7 in our blood drive. All are welcome!

According to Walsh, in no time at all, people started volunteering. Says Walsh, “I couldn’t believe how quickly word spread and how eager people were to help. Literally, people saw the poster and volunteered without even having to be asked.” Two student nurses from the IHP and the White 7 dietitian were among the first to volunteer. And, says Walsh, two nurses who had never donated blood before stepped up and are now regular donors.

Every time someone on the unit gives blood a red ‘blood drop’ is added to the poster along with the person’s name. Walsh says she may have drawn some of her inspiration from personal experience. She recalled a time when someone in her family needed blood, and the call went out to his co-workers. “His whole company turned out,” says Walsh. “They came to the MGH Blood Donor Center by the hundreds! It was such a moving display of unselfishness.”

Walsh also thought about police and fire fighters who routinely give blood for their fellow officers.

“If giving blood can be part of their routine,” says Walsh, “there’s no reason it can’t be part of ours.”

It’s necessary to wait 56 days between blood donations. Many of the White 7 staff who gave in the first round of donations are approaching eligibility again. So the unit is gearing up for ‘phase two’ of the blood drive.

With new restrictions on blood donation (people who have visited the United Kingdom for a total of 3 months between 1980 and 1996, or people who have spent more than five years in Europe since 1980, are no longer eligible to give blood) and an increasing shortage of blood and platelets nationwide, says Walsh, “It would be nice if other units got together and started their own blood drives.”

Poster

White 7 staff who participated in blood drive are (standing, l-r): Susan Diehl, Marilyn Healey, Barbara Walsh, Nicole Binette, Kate Patton, Daniel Nadworny, and Bridget Walsh. (Kneeling:) Brenda Fletcher, Chelsea Morello, Erin Simmons, and Sherry Goddard.
As a young girl, Dianna Ploss and her friends would regularly take a short cut from their neighborhood to the bowling alley behind Fenway Park. The route led her through the corridors of Peter Bent Brigham Hospital and Children’s Hospital. Today Ploss has found another short cut that has allowed her to qualify for graduate school in less time than was previously possible.

Ploss is the first to enroll in the MGH Institute of Health Professions’ RN-to-MSN Program through a new admission pathway that permits diploma and associate-degreed nurses to earn a master’s degree in nursing. Applicants must complete specific general education prerequisites, but the new pathway will save Ploss more than two years of schooling and thousands of dollars.

“This initiative opens the door for many students who would otherwise have to complete an RN-to-BSN program or get a bachelor’s degree in another field before applying to the Institute’s Advanced Nursing Program,” says associate director, Carol Picard, RN, who created and oversees the new track.

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On June 10-12, 2003, appraisers from the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association, will conduct a site visit at MGH to see first-hand why the department of Nursing should be awarded the ANCC’s highest nursing honor.

What is a magnet hospital?
In the early 1980s, during a severe nursing shortage, research was conducted to determine characteristics of hospitals that were able to recruit and retain nurses despite the shortage. Because of their ability to attract and retain nurses, these hospitals were called ‘magnet’ hospitals.

In 1993, 14 standards were drafted based on these characteristics, and a certification program was created that is available to all hospitals, across all healthcare settings. This prestigious program is administered by the ANCC, the nation’s largest and foremost nursing accreditation and credentialing organization.

Magnet certification brings important national recognition to healthcare organizations that demonstrate sustained excellence in nursing care. The Magnet Recognition Program also provides a vehicle for the dissemination of strategies and best practices among nursing systems. As of April of this year, there are 69 magnet hospitals nationwide, which represents 1% of all hospitals in the US.

Why is being a magnet hospital important?
More than 20 years of research shows that magnet hospitals have: lower patient mortality, fewer complications, improved patient safety, higher patient and staff satisfaction scores, and shorter hospitalizations.

Magnet certification recognizes and rewards the provision of outstanding care; it acknowledges commitment to quality and safety; it allows organizations to market themselves to patients and prospective staff as organizations with a strong nursing service; and it positions organizations nationally as a select few hospitals to achieve magnet recognition.

How do you become a magnet hospital?
Hospitals seeking magnet certification submit written evidence supporting their application and undergo an intensive site visit to determine if they meet the 14 standards of care and professional performance.

What do appraisers look for during the site visit?
Magnet hospitals have what’s called a ‘magnetic personality.’ This means:
- Quality nursing leadership that serves as a strong, knowledgeable advocate for staff
- An organizational structure that is decentralized, with strong representation from nurses
- A management style that invites participation and feedback
- Personnel policies and programs that are supportive, flexible and competitive
- Professional practice models that give

Magnet champions, (left): Emilia Rudowski, RN, of the Main OR; and (l-r): Deb Pereira, RN; Leslie Clark, RN; and Carol Brown, RN, of Ellison 11, participate in recent Magnet Champion Retreat.

continued on next page
Raising Environmental Awareness League (REAL)

The Raising Environmental Awareness League (REAL) was created to address the impact MGH has on the environment. The goal of this new group is to help MGH become an environmental leader among healthcare providers. REAL is volunteer-based and comprised of staff from many departments from Nursing to Biomedical Engineering.

The group came together out of common concern and a desire to examine the role healthcare employees, parents, friends and neighbors play in improving and preserving the environment.

REAL encourages all MGH employees to examine the impact they have on the environment at home, at work, and everywhere they go in their daily lives. For more information about REAL, including the dates of upcoming meetings, send e-mail to: real@partners.org.

Preparing for Magnet Site Visit

nurses responsibility and authority for the care they provide
• Quality of care is an organizational priority
• Performance improvement is ongoing and nurses are involved
• Expert consultation and resources are available to support caregivers
• Autonomy for nurses allowing them to use independent professional judgment
• The hospital and community work together to improve health care
• Nurses function as teachers for patients, the public, and one another
• The image of nursing is held in high regard by other members of the healthcare team
• Interdisciplinary relationships are key, and there is a sense of mutual respect among all disciplines
• Professional development is emphasized and supported

What is the focus of the three-day site visit?
Appraisers will attend collaborative governance meetings to get a flavor for the communication and decision-making structure of Patient Care Services. Collaborative governance allows clinicians to have input into key decisions that impact their practice and the quality of their work life.

Appraisers will attend meetings of the Clinical Performance Teams (CPM)—the multi-disciplinary, performance-improvement teams that identify ways to enhance clinical practice.

Appraisers will meet with staff nurses in a number of forums to learn about what attracted them to MGH and why they stay. They will want to hear about The Clinical Recognition Program, the newly-implemented program that recognizes clinicians for their acquisition of clinical expertise. They will speak to new graduate nurses to learn what strategies are in place to facilitate their transition from academia to practice. They’ll meet with staff nurses who participated in creating the Nursing Image Campaign.

During their visit, appraisers will meet with senior leadership (including members of the Board of Trustees), physicians, and community leaders to hear their perspectives on nursing and nursing practice at MGH.

Patient care units will be a major focus of the site visit. It won’t be possible for appraisers to visit every unit because of the size of MGH and the length of their visit. Visits to patient care units will last approximately 20 minutes and will involve all members of the healthcare team and patients. Appraisers will want to hear about the unit’s strategies on: continuity of care, staffing decisions, nurses’ care-planning, orientation and professional development, interdisciplinary teamwork, evidence-based practice, appropriate delegation, and collaborative performance-improvement activities.

Who will be involved in the site visit?
Staff from nearly every unit will have an opportunity to interact with appraisers in a number of forums scheduled throughout the site visit. Appraisers may stop and speak with any member of the MGH community so all employees should have a basic understanding of the magnet recognition process and be able to describe how their departments work in collaboration with nursing.

How is the final decision made to award Magnet recognition to an organization?
After reviewing an organization’s written evidence and conducting a thorough site visit, magnet appraisers submit a written report to The ANCC’s Commission on the Magnet Recognition Program. The report reflects their impressions of how the organization did or did not meet the standards and whether or not it exhibited a magnetic personality. The Commission makes the final decision based on information contained in the report.
Complex pregnancy presents nursing challenges and learning opportunities

My name is Harriet Nugent, and I work full time on the Vincent Obstetrical Service. I am cross-trained in labor and delivery (including OR), post-partum, antepartum, and nursery practice. I have 14 years of med/surg experience and 8 years of obstetrical experience.

I was recently assigned to care for Mrs. G, a Vietnamese woman who had been on our Antepartum Service for several weeks. Mrs. G was pregnant with her second daughter and was experiencing many complications. She had been hospitalized five times for a chronic abruption of the placenta, which manifested itself in intermittent bouts of vaginal bleeding. She also suffered from gestational diabetes, which predisposed her baby to heart defects, lung immaturity, and hypoglycemia. Mrs. G’s baby had been diagnosed with Truncus-Arteriosis, a life-threatening condition that would require immediate NICU care and open-heart surgery shortly after birth. During my care of Mrs. G, I was fortunate to be precepting Sarah, a new nurse on our staff. Mrs. G’s care posed a nursing challenge and a great learning opportunity for my orientee.

I admitted Mrs. G to the Labor & Delivery Unit after she experienced a significant amount of vaginal bleeding. Her pregnancy had progressed to 36 weeks and the decision was made to induce labor. Upon meeting Mrs. G and her husband, I immediately sensed their fear. The pregnancy had been difficult on this family, and they needed someone with a calm demeanor to help them see it through. I felt their need for clear, accurate information and knew I would be an important vehicle in collaborating with the many disciplines involved. My role as a therapeutic practitioner was defined in those early moments. By actively listening and defining clear communication avenues, I was able to establish a strong rapport with Mrs. G and her husband. They needed to feel they were in a safe and caring environment, and I was able to provide that milieu for them. This made the process less daunting for this family.

I engaged Mrs. G and her husband in the induction process by explaining what we were doing and why. My orientee was involved from the start, learning and participating in Mrs. G’s care. I explained the reasoning behind all interventions. There were many factors to consider in Mrs. G’s care. Continuous monitoring of the baby was essential to affirm fetal well-being. Obtaining current blood bank samples and baseline hematology studies would help us be prepared for the strong possibility of hemorrhage. Establishing adequate large-gauge IV access was also necessary in case there was a need for transfusion and/or an emergency C-section. I addressed all these immediate needs prior to beginning Mrs. G’s induction.

As the nurse caring for Mrs. G, I helped facilitate the collaboration of many disciplines. There was consultation with the maternal-fetal specialists, Mrs. G’s primary obstetrician, Neonatology, Pediatric Cardiac Surgery, Social Services, Anesthesia, and Nursing (both in OB and in the NICU). Language was a potential problem, given the complexity of Mrs. G’s condition. A Vietnamese interpreter was made available, though Mr. and Mrs. G didn’t feel it was necessary. I made sure Mrs. G and her husband felt comfortable with the give and take of information and had sufficient opportunity to ask questions. Mr. and Mrs. G were able to hear and understand the information they needed, as the birth of their child became more of a reality. Sarah was able to observe the importance of careful collaboration among healthcare providers and understand the unique role of the nurse as a pivotal member of the interdisciplinary team.

I explained the induction process to Mrs. G. We would start pitocin slowly, and gradually increase the dose to stimulate contractions to prompt labor. Mrs. G had had a vaginal birth with her first child, so she had some idea of what to expect.

“I’m afraid of the pain and the bleeding,” she said.” I assured her that I would keep a close watch on her bleeding. I knew from experience that women of the Vietnamese culture are very stoic when it comes to pain. With careful prompting, I helped her define her needs, knowing she might need assistance in asking for pain relief. While watching for subtle cues, I assured her that I would consult with the anesthesiologists and obstetrician for pain management. Mr. G was very attentive, and I helped him respond to some of his wife’s comfort needs during labor. He helped her with the early contractions with massage, changes, and reassurance.

Sarah and I continuously monitored the fetal heart rate, which was strong. This allowed us to proceed with the induction. Experience told me there was a high potential for things to change quickly. The uterine contractions could exacerbate the placental abruption, causing fetal distress and maternal hemorrhaging. I gave our resource nurse frequent updates in case the obstetrical OR was needed urgently. I took every opportunity to teach Sarah about the care needed during this high-risk pregnancy and delivery. We monitored Mrs. G’s pain, her hemodynamics, her diabetes, and...
Exemplar

continued from page 8

her fluid-volume status, frequently consulting with the physician about our anticipated management, and always including the family in the plan of care.

Approximately two hours after initiating pitocin, Mrs. G began to pass a moderate to large amount of blood. I immediately notified the doctor, shut off the pitocin, administered oxygen via facemask, initiated a fluid bolus to increase volume of the intravascular space, and continued vigilant fetal monitoring. The doctor examined Mrs. G and decided to rupture the amniotic membranes to hasten delivery. If this wasn’t tolerated well by mother or baby, a C-section would be performed immediately. I conferred with the doctor and alerted the rest of the team to prepare for imminent delivery. At the direction of the resource nurse, my colleagues opened the obstetrical OR, alerted the anesthesia staff and prepared the NICU team for immediate delivery. At the direction of the resource nurse, my colleagues opened the obstetrical OR, alerted the anesthesia staff and prepared the NICU team for immediate delivery.

Rupturing the amniotic membranes stimulated more bleeding. Mrs. G began to pass large clots of blood, indicating an increase in the placental abruption. The fetal heart rate remained strong, but the amount of vaginal bleeding was deemed unsafe. Mrs. G was taken urgently to the OR for a C-section. I continued to keep Sarah involved in Mrs. G’s care as the situation unfolded. She observed first-hand the importance of keen assessment and anticipation of a patient’s needs. Prompt, calm action on Mrs. G’s behalf helped ensure the best possible outcome for this family. Sarah learned a lot that day about complications of pregnancy, induction of labor, circulating in the OR, and preparation for neonatal resuscitation. But most importantly, she was able to see how caring, intuitive nursing care played an essential role in this family’s care.

With all resources in place to care for mother and baby, the planned surgery went very well. The baby was born with a vigorous cry, bringing tears of relief to her parents (and even some of the staff).

Anticipation of the neonatal resuscitation plan proved to be essential. I had carefully reviewed the infant’s care with Neonatology earlier in the day. The infant’s heart defect had allowed her to thrive in utero when functioning with maternal-fetal circulation. Once born, the baby would be unable to oxygenate her own blood. She would look healthy initially until the patent ductus closed. Withholding oxygen from this baby at delivery was essential so as not to prompt closing of the patent ductus. This allowed safe transfer to the NICU for immediate cardiac care. Some of these concepts were difficult to explain to Mrs. G while she was under so much stress, but a calm voice and warm words helped her understand the essentials of the care we provided to her baby at delivery.

During recovery, many of Mrs. G’s family members visited. There were many generations present, and Vietnamese was the primary language spoken. They were excited about the birth and eager to welcome their newest family member. We escorted Mr. G and his older daughter to the NICU for a visit and to take some pictures. They returned to Mrs. G with a handful of precious photographs of their new baby. Mrs. G expressed relief and gratitude that the pregnancy was over and her baby was in good hands. She felt overwhelmed by the care and expertise that had been made available to her and her family. I helped her to verbalize her experiences over the last few months, culminating with the birth of her daughter. I knew the days ahead would be challenging, but I wanted her to be able to savor this very special birthday.

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

This narrative weaves Harriet’s skilled knowledge and understanding of the quickly changing labor-and-birth experience with her sensitivity to the needs of her orientee and her constant attention to the cultural needs of this family. Harriet anticipated the ramifications of rupturing Mrs. G’s amniotic membranes and was prepared for an emergent C-section. Harriet was right—caring for Mrs. G did present a complex nursing challenge and a wonderful learning opportunity for her orientee.

Thank-you, Harriet.

Ethics Forum:
“Walking Through a Case: Recognizing, Reorganizing, and Responding to Ethical Conflict”
facilitated by Ruth B. Purtill, PhD, Henry Knox Sherrill visiting professor, MGH Institute of Health Professions
Please join us for an interactive discussion
Friday May 9, 2003
12:00–1:00pm
Sweet Conference Room, GRB 432.
Bring a lunch; beverages and dessert will be provided
For more information, e-mail erobinson@partners.org

MGH Chaplaincy

The MGH Chaplaincy is pleased to announce the addition of Jewish and Episcopal services to our regular Chapel schedule. All services are held in the MGH Chapel unless otherwise noted.

Buddhist
Meditation Sitting: Every Wednesday at 5:30pm

Episcopal
Communion Service: Every Tuesday at 2:30pm

Interfaith
Interfaith Service: Monday–Friday at 12:15pm

Jewish
Shabbat Service: Every Friday at 11:00am

Muslim
Prayers in the Masjid, at Founders 109, 24 hours a day, 7 days a week.
(Prayer schedule is posted outside the Masjid)

Roman Catholic
Mass: 4:00pm daily, including weekends
All are welcome!
Family-Centered Care Awards recognize excellence in pediatric care and service

This year’s Family-Centered Care Awards were presented on April 7, 2003, in the recreation room on Ellison 18 before a growing crowd of supporters. Recipients of the award, which recognizes outstanding care and service to pediatric patients and their families, were: Alfredo Galavis, materials coordinator; Anita St. John, RN, Cystic Fibrosis Program; Heidi Jupp, RN, Pediatric Hematology/Oncology Clinic; Karen DaRocha, RN, staff nurse, Ellison 18; and the pediatric care team in the Same Day Surgery Unit.

Said Judy Newell, RN, chair of the award selection committee, “It is appropriate that these awards acknowledge the caring service of so many people in so many departments throughout the hospital. We do not provide care ‘in a box.’ Family-centered care relies on the talents and skills of clinicians and support staff from all disciplines—nursing, the therapies, chaplaincy, medicine, child life specialists, and so many more.” Congratulations to the recipients, and to all who were nominated.
New booklet: Preparing for your Pre-Operative Visit

—by Bessie Manley, RN, nurse manager, Pre-Admission Testing Area

The Pre-Admission Testing Area (PATA) is an integral part of the pre-surgical assessment process for patients and families at MGH. PATA has gone through many changes since opening its doors in the spring of 1991.

PATA is a fast-paced clinic that screens approximately 60 patients per day who will be undergoing elective surgical procedures. The clinic is committed to a holistic practice model. The goal is to evaluate, assess, educate, and prepare patients and families for a safe and successful hospital experience.

PATA is staffed by a small complement of staff nurses, nurse practitioners, anesthesiologists, operation associates, and patient care associates. The clinic is a small but highly efficient unit.

Staff compile and/or create more than 160 pre-operative charts per day for patients undergoing surgery. These charts contain all the information (lab results, consents, medical work-ups, and consults) that the interdisciplinary team will need to provide seamless care.

Because the services provided in the PATA are specialized, and because pre-admission testing areas are not common to all hospitals, some patients have arrived in the clinic and asked, “What is a Pre-Admission Testing Area? Why am I here?”

To dispel any initial confusion patients may feel about visiting the PATA, staff have created a new patient education booklet, with funding received from the Making a Difference Grant Program. The booklet explains the process and what to expect when coming to the PATA for pre-surgical assessment.

Creating the booklet, Preparing for your Pre-Operative Visit, was a multi-disciplinary effort. Nurses spent long hours writing and revising the content to ensure they were conveying the most important and concise information to patients and families. Ensuring that the language, context, and content were at a level that all patients could understand was a priority. Taryn Pittman, RN, patient education specialist in the Blum Patient and Family Learning Center, was instrumental in helping us achieve an acceptable level to meet the needs of our patients.

The next step was informing surgeons and their staff about our project and securing their participation in disseminating the booklets. They agreed there was a need to educate patients about what to expect in the PATA.

Then, there was the final phase of the project: deciding what the booklet should look like. Al Pulito of Standard Register worked tirelessly to help create a booklet that was attractive, easy to read, and concise. Seven months after our initial idea, we had the new and improved PATA patient-education booklet, Preparing for your Pre-Operative Visit in our hands.

PATA is always striving to improve the patient process and relationships within the medical community. Preparing for your Pre-Operative Visit will soon be available in Spanish and other languages to help meet the needs of our diverse patient population.

For more information about the PATA clinic or the services it provides, contact Bessie Manley, RN, nurse manager, by e-mail.

New patient-education booklet for Pre-Admission Testing Area
Bedside nursing: the role of a lifetime!

—by Joan Marie Stack, RN, MS, CAS, staff nurse, Bigelow 14

I would like to share the amazing journey that led to my return to bedside nursing on Bigelow 14. I’ve had my nursing license for more than 30 years, and have always worked, either full- or part-time as a nurse. I have had many diverse experiences encompassing many roles in nursing, including: head nurse (nurse manager), nursing supervisor, nursing educator, staff nurse, critical-care nurse, charge nurse, clinical instructor for both associate-degree and baccalaureate-degree students, classroom instructor, ACLS and BCLS instructor, graduate student, and graduate nurse practitioner student. Although I learned much with each new role, it has always been the role of staff nurse where I have found the most satisfaction and reward. It is in this role I truly feel I am a “nurse.” I never really examined what that meant until I became a staff nurse at MGH in July of 2001. Since then, I have spent considerable time reflecting on my practice and my current choice of employment.

What led me to this place, at this time? Why do I stay? Because I know I’m in the right place. It wasn’t easy to put my thoughts into words. I turned to the classic definition of nursing written by noted nurse, author, educator, and researcher, Dr. Virginia Henderson, in 1964. I learned this definition as a nursing student many years ago, and I have always tried to incorporate it into my nursing practice. She said: “The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery, or to a peaceful death, that they would perform unaided if they had the necessary strength, will, or knowledge. It is likewise the unique contribution of nursing to help the individual become independent of such assistance as soon as possible.”

I think this description captures the essence of nursing, both as an art and a science. It describes what is unique about nursing and differentiates nursing from other disciplines. We’re all human beings, and we all have the same basic need to be healthy, functional and free. Nursing plays a unique role in achieving these goals.

As I began to examine what it is about nursing I value most, I knew those values would be reflected in my practice. Having worked in numerous roles as a nurse, I still find the essence of nursing is interacting with patients at the bedside. I enjoy both the scientific and humanistic aspects of nursing. I like using my head and my hands. I know I bring strong nursing theory and clinical knowledge to the bedside, and that includes principles of anatomy and physiology, pathophysiology, microbiology, pharmacology, infectious disease processes, human growth and development, and psychosocial theories. I would also include physical assessment skills, clinical judgement, and critical-thinking skills.

Yet in this age of advanced technology, increased patient acuity, complicated health problems, multiple disease comorbidities, patient sensory or sleep deprivation, and the fast-paced environment, patients want and need to feel safe, to feel relief from pain, they want a kind word and a smile, personal attention, reassurance, answers, encouragement, understanding, healing, and hope. How can all this be provided at the same time? I believe the answer is in the direct nursing care provided by staff nurses at the bedside.

When I introduce myself to a patient and ask how she is, what she needs, I’m already performing my initial assessment. I enjoyed a walk in the corridor with patient, Vernon Young, professor of Nutritional Biochemistry, at MIT.
Bedside Nursing
continued from previous page

ment and formulating the focus of my nursing care for that day, for that patient. With ‘Hello,’ I am observing skin color and turgor, facial expression, mood, demeanor, mental status, respiratory status, level of consciousness, and any monitors, intravenous fluids, oxygen devices, or drainage systems that may be in place. Further interaction with the patient provides comprehensive physical-assessment data, including vital signs, status of skin integrity, heart, lung, and bowel sounds, peripheral perfusion and pulses, neurological status, mobility, and the ability to manage personal elimination, nutrition, and hygiene. Pain assessment and management are extremely important. The patient doesn’t notice, but it is this process that contributes to the prevention of complications, to rapid intervention if a problem occurs, and to eventual healing and recovery, or to a humane and dignified death, if that is to be the outcome.

This all relates to the definition of nursing put forth by Dr. Henderson. Her work has withstood the test of time, at least it has for me in my practice.

Staff nurses must be able to do all of the above for several patients at a time, and still provide individualized care for each person. And I’m only focusing on the patient—to address the interactions with families, physicians, and colleagues would require a whole other article.

In the midst of all this are the moments of softly whispered, ‘Thank-yous,’ the squeeze of my hand, the smile of someone going home, the rare but treasured thank-you note from a past patient, and the delight when someone remembers that my nursing care actually made a difference. For all these reasons, I know I am where I am supposed to be. And for the most part, I know it’s all worth it.

I don’t mean to sound idealistic. I know that nursing can be the most terrifying, physically demanding, intellectually challenging, and emotionally difficult work I’ve ever done. There are days, hours, and moments when I’m sure I can’t do it. There have been times I wondered why I ever chose nursing at all. But then I survive the crisis, get through another shift, take care of another patient and those feelings dissipate. I know I’ll continue to practice as a staff nurse until the next adventure in nursing finds me.

I suspect that my amazing journey is not over. There will be other twists and turns in the road and more surprises along the way. There will be more challenges, problems, opportunities, obstacles, fulfillment, and hopefully, more moments of humor, awareness, appreciation, and deep satisfaction.

The current stop on my journey is at the bedside on Bigelow 14. It is exactly the right place for me at this time. I hope I can continue to make a difference in the lives of my patients and share moments of camaraderie and laughter with my co-workers.

Nurse practitioners
in the ED

The MGH Emergency Department is pleased to announce the implementation of its new Nurse Practitioner Program. Experienced emergency nurse practitioners now work collaboratively with EM attending physicians and other clinicians to enhance care for patients in a timely manner.

Nurse practitioners are available during peak-volume times, usually between 9:00am and 1:00pm daily in the Minor Multipurpose Area of the ED. Nurse practitioners are primary providers for select patient populations and work collaboratively with physicians on more complex patients.

As always, it is the patient’s right to request either the EM attending physician or a nurse practitioner. We are pleased to be able to offer this new resource in the Emergency Department.

Celebrate National Women’s Health Week
5 Simple Ways to Stay Healthy
Celebrate National Women’s Health Week with the Women’s Health Coordinating Council. Learn simpler ways to enjoy a healthier life:

• eat better
• move around
• quit smoking
• get regular medical exams and screenings
• be safe

Wednesday, May 14, 2003
9:00am–4:00pm
Main Corridor

Celebrated National
Women's Health Week

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Next Publication Date:
May 22, 2003
New guidelines from the Anticoagulation Task Force

by Katie Brush, RN, MS, CCRN, FCCM, and Harold J. Demonaco, MS, RPh

The Anticoagulation Task Force is rolling out new guidelines for the prevention and management of DVT/PE and other thromboembolic events. These guidelines are the result of research done by Dr. Elaine Hylek of the department of Medicine, and a comprehensive review of the literature by clinical experts. Recommendations have been made for 15 sets of guidelines to lower the risk of clot formation and bleeding by managing anticoagulation differently. The new guidelines can be found at: http://is.partners.org/pathways.

Lowering the risk of clot

DVT prophylaxis can be safely managed in many patient populations using subcutaneous injections of low-molecular-weight heparin, specifically Fragmin®/dalteparin. Doses range from 2,500 to 5,000 units qd for most adult patients depending on the risks of clot. Fragmin®/dalteparin has a lower risk of heparin-induced thrombocytopenia (HIT Type 2) than traditional unfractionated heparin sodium.

Lowering the risk of bleed

A more dramatic change is utilization of LMWH for the treatment of DVT. [Clinicians: dosing with Fragmin®/dalteparin is 100mg/kg sc bid for most patients.] Achieving adequate anticoagulation is much smoother and more sustainable than with typical heparin-sodium infusions. There is usually no need for monitoring the anticoagulant effect with the use of Fragmin®/dalteparin. More importantly, complications from low-molecular-weight heparin are much lower.

Decreasing length of stay

Patients receiving Fragmin®/dalteparin can go home and safely inject themselves daily while completing the transition to oral warfarin therapy. To aid in this transition, downloadable patient-education information is available on unit computers, and patient-education videos are available (in English and Spanish). Educational booklets that reinforce injection techniques are available and will be resupplied as needed by the Blum Patient-Family Learning Center.

STAT Pathway and the Anticoagulation Management Service

The Anticoagulation Management Service will be introducing the STAT (Safe Transitions in Anticoagulation Therapy) Pathway and other services to areas of the hospital that discharge patients home over the next year. Last year, a multi-disciplinary group implemented guidelines for the management of patients after acute stroke with the STAT Pathway. In cooperation with Partners Homecare, Nursing, Case Management and Pharmacy, the STAT Pathway redefined how patients were transitioned from heparin therapy to warfarin. Key to the success of the pathway was early use of low-molecular-weight heparin, using Fragmin®/dalteparin, a standardized approach to warfarin dosing using a validated algorithm, and a high level of coordination. Although data is still being collected, after one year, 92% of patients in the pathway met national standards for the heparin (using dalteparin)-warfarin transition. And they did it in fewer inpatient days allowing them to go home earlier with excellent coverage by Partners Home Care.

If you have a patient who is at risk for clotting or bleeding and she is not on low-molecular-weight heparin, you should ask yourself, “Why?” While not for every patient, most patients needing anticoagulation during their inpatient stay can and should be receiving a low-molecular-weight heparin. At MGH, the current choice is dalteparin.

Look for reference materials in your medication room and by e-mail soon. For more information, contact Katie Brush at 4-5889.
# Educational Offerings

**May 1, 2003**

## Educational Offerings

For detailed information about educational offerings, visit our web calendar at [http://pcs.mgh.harvard.edu](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](http://www.hrm.harvard.edu).

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<tr>
<th>When/Where</th>
<th>Description</th>
<th>Contact Hours</th>
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<tr>
<td>May 9 and 19, 8:00am-5:00pm</td>
<td>Advanced Cardiac Life Support (ACLS)—Provider Course</td>
<td>16.8 for completing both days</td>
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<tr>
<td>May 12, 7:30-11:00am, 12:00-3:30pm</td>
<td>CPR—American Heart Association BLS Re-Certification</td>
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<td>May 12, 8:00am-4:30pm</td>
<td>Heart Failure: Management Strategies in the New Millennium</td>
<td>TBA</td>
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<td>May 12, 5:00-9:00pm</td>
<td>Congenital Heart Disease</td>
<td>4.5</td>
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<tr>
<td>May 14, 8:00am-2:30pm</td>
<td>New Graduate Nurse Development Seminar I</td>
<td>6.0 (for mentors only)</td>
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<td>May 14, 1:30-2:30pm</td>
<td>OA/PCA/USA Connections</td>
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<tr>
<td>May 15, 8:00am-4:30pm</td>
<td>Psychological Type &amp; Personal Style: Maximizing Your Effectiveness</td>
<td>8.1</td>
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<td>May 15, 7:00-11:00am; and 12:00-4:00pm</td>
<td>Congenital Heart Disease</td>
<td>4.5</td>
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<tr>
<td>May 15, 1:30-2:30pm</td>
<td>Nursing Grand Rounds</td>
<td>1.2</td>
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<tr>
<td>May 15, 10:00-11:30am</td>
<td>Social Services Grand Rounds</td>
<td>CEUs for social workers only</td>
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<tr>
<td>May 19, 8:00am-12:00pm</td>
<td>Pediatric Advanced Life Support (PALS) Re-Certification Program</td>
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<td>May 20, 8:00am-2:00pm</td>
<td>BLS Certification for Healthcare Providers</td>
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<tr>
<td>May 19, 5:00-9:00pm</td>
<td>Congenital Heart Disease</td>
<td>4.5</td>
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<tr>
<td>May 21, 1:30-2:30pm</td>
<td>USA Educational Series</td>
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<tr>
<td>May 22, 1:30-2:30pm</td>
<td>Nursing Grand Rounds</td>
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<tr>
<td>May 22, 7:00-11:00am; and 12:00-4:00pm</td>
<td>Congenital Heart Disease</td>
<td>4.5</td>
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<tr>
<td>May 23, 8:00am-4:30pm</td>
<td>Wound Skin Care Update: 2003</td>
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<tr>
<td>May 27 and 28, 8:00am-4:30pm</td>
<td>BLS Instructor Program</td>
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<tr>
<td>May 27, 8:00am-4:00pm</td>
<td>Shock: an Overview</td>
<td>TBA</td>
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<tr>
<td>May 28, 8:00am-2:30pm</td>
<td>New Graduate Nurse Development Seminar II</td>
<td>5.4 (for mentors only)</td>
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<tr>
<td>June 3, 8:00am-4:30pm</td>
<td>Chemotherapy Consortium Core Program</td>
<td>TBA</td>
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Students from ConVal Regional High School in Peterborough, New Hampshire, made their annual trek to MGH on March 21, 2003, to learn more about careers in health care. Their visit, coordinated by Julie Goldman, RN, clinical educator in The Center for Clinical & Professional Development, included presentations by representatives from Nursing, Radiology and Pharmacy; and tours of the operating rooms, the Cardiac Surgery Unit, Radiology, Pharmacy, Pathology, and the Burn Unit. Students had an opportunity to observe healthcare professionals at work and reinforce their interest in healthcare careers.

Above: Bigelow 13 staff nurse, Sally Morton, RN (left), gives ConVal Regional High School students a tour of the Burn Unit, explaining many of the highly specialized procedures and techniques used in caring for burn patients. At right: Morton explains the process of skin grafting.