

# Caring

## HEADLINES

December 2, 2004

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## Third annual Anthony Kirvilaitis, Jr. Partnership in Caring Awards

—by Nancy DeCoste, training specialist

*M*oist eyes and sad smiles were poignant reminders of the profound impact Tony Kirvilaitis had on the many people whose lives he touched during his tenure at MGH. November 11, 2004, marked the third annual presentation of the Anthony Kirvilaitis, Jr. Partnership in Caring Awards. This year's recipients were Danisa Alonzo, unit service

associate on White 11, and Zakia Chennane El-Idrissi, Ellison 13 patient care information associate.

The Kirvilaitis Awards are given annually to two individuals (operations associates, unit service associates, operating room assistants, unit assistants, patient service coordinators, ED admitting assistants, patient care information associates, and informa-

tion desk associates) who demonstrate reliability, responsiveness, assurance, collaboration, flexibility, creativity, and support in working with others to enhance the patient and family experience.

Nancy DeCoste, training specialist and long-time friend of Kirvilaitis, spoke about the significance of caring among all role

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Kirvilaitis award recipients, Danisa Alonzo (second from left) and Zakia Chennane El-Idrissi (center), with (l-r): Theresa Gallivan, RN, associate chief nurse; Scott Ciesielski, RN, nurse manager; Peggy Settle, RN, nurse manager; and Debra Burke, RN, associate chief nurse

**MGH** Patient Care Services

Working together to shape the future

## Strategic planning for the real world: the PCS strategy retreat

A never-ending process, strategic planning is a continuous effort to re-evaluate, re-assess, and re-define the way we do business. Over the next few months, I want to share with you some of the work the Patient Care Services Executive Committee is doing to ensure that MGH is the most patient-centered, customer-service-oriented organization we can be.

On September 13 and 14, 2004, the PCS leadership team held an off-site retreat as part of an on-going effort to educate ourselves about the current reality of patients and families in the health-care system; and build on our prior work to improve and refine our care-delivery processes.

Our work incorporated the central themes of three important books: *First Break All the Rules*, by Marcus Buckingham and Curt Coffman; *Putting Patients First*, the book that describes the Planetree model of pa-

tient-centered care, by Susan Frampton, Laura Gilpin, and Patrick Charrel; and *Crossing the Quality Chasm*, published by the Institute of Medicine.

Before coming together for the retreat, participants were given a number of readings and handouts in preparation for our work. Two of the most provocative were: "Vision and Strategy," an account of the leadership and accomplishments of Paul O'Neill during his tenure at the OMB (working for the federal government) and as CEO of the Aluminum Company of America (Alcoa); and a case study entitled, "A Hospitalization from Hell: a Patient's Perspective on Quality." Both articles shed light on issues related to quality, safety, and the importance of a strong customer-service focus.

In the book, *First Break All the Rules*, one of 12 key questions indicative of a highly suc-

cessful organization (see box on this page), is: "Do you have a best friend at work?" Building on the 'best friend' premise, participants were asked to partner with another member of the PCS leadership team and act as consultants for one another in solving any unit- or department-specific issues they may be facing. Best friends spent time learning about each other's area of practice and offering a fresh perspective on problem areas. Participants were asked to prepare reports on the outcomes of their best-friend experiences and share them at the retreat.

Once at the retreat, we reviewed our goals from 2003-2004, the elements of patient-centered care (from *Putting Patients First*), and the pillars of quality and safety (from *Crossing the Quality Chasm*). Then, based on the insights and information gleaned from these sources (and others), I asked participants to take part in a special interactive assignment. The leadership team divided into small groups; each group was given the same list of pre-identified local businesses and asked to visit each location. Groups were asked to assess each business' 'attitude' toward customer service based on observations related to human interactions, ef-



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

iciency of operations, how welcoming the physical environment was, the intended image being conveyed, and the accountability and level of engagement projected by employees.

When teams reported back to the group at large, there was unanimous agreement as to the degree of customer service achieved by each business. Clearly, some or-

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### Measuring the strength of a workforce (from *First Break All the Rules*)

- 1) Do I know what is expected of me at work?
- 2) Do I have the materials and equipment I need to do my work right?
- 3) At work, do I have the opportunity to do what I do best every day?
- 4) In the last seven days, have I received recognition or praise for doing good work?
- 5) Does my supervisor, or someone at work, seem to care about me as a person?
- 6) Is there someone at work who encourages my development?
- 7) At work, do my opinions seem to count?
- 8) Does the mission/purpose of my company make me feel my job is important?
- 9) Are my co-workers committed to doing quality work?
- 10) Do I have a best friend at work?
- 11) In the last six months, has someone at work talked to me about my progress?
- 12) This last year, have I had opportunities at work to learn and grow?

### Clinical Recognition Program Clinicians recognized September 1–November 1, 2004

#### Advanced Clinician

- Dana Allison, RN, Blake 13/14
- Beverly Hudson, RN, Cox 2
- Linda Gorham Ryan, RN, Phillips House 22
- Kathleen Larrivee, RN, Phillips House 21

#### Clinical Scholar

- Elizabeth P. West, RN, Blake 13/14
- Sharon Kelly-Sammon, RN, PACU
- Mary Elizabeth McAuley, RN, Blake 4

## Stop the Transmission of Pathogens (STOP) initiative

*Question:* What can you tell us about the Stop the Transmission of Pathogens (STOP) initiative? How is it different from past efforts to promote hand hygiene?

*Jeanette:* The STOP Task Force is a broad-based initiative spearheaded by staff from Patient Care Services and Infection Control that has recently become a CPM Process Improvement Team. The task force focuses on efforts to improve hand hygiene and other practices aimed at stopping the transmission of pathogens. It represents a strong commitment by administration and staff to achieve these important goals.

*Question:* What evidence is there to support hand hygiene as the best practice for decreasing the spread of pathogens?

*Jeanette:* Recently published guidelines from the Center for Disease Control provide significant evidence that hand hygiene is the most important clinical practice in preventing the transmission of pathogens. Evidence supports hand hygiene both before and after contact with patients and patients' immediate environment. The use of a waterless, alcohol-based, hand-hygiene product is the preferred means of hand hygiene for healthcare workers.

*Question:* What programs are currently in place at MGH as part of the STOP initiative?

*Jeanette:* Data on hand-hygiene compliance is collected regularly, and unit-based results are provided to staff. Hand-hygiene champions work on each unit to help raise awareness.

The Clean Sweepstakes contest has promoted friendly competition among inpatient units to increase adherence. For the last quarter of 2004, units that achieve 50% compliance before and 70% compliance after patient contact are recognized as members of the 50/70 Club and will receive a prize. For

units not currently receiving compliance data, hand-hygiene champions are awarding Coffee Central coupons to staff who demonstrate excellent hand hygiene.

Posters featuring MGH employees encouraging the use of Cal Stat are displayed on units as a reminder of the importance of hand hygiene.

*Question:* How important is hand hygiene in relation to the emerging flu season and the shortage of flu vaccine?

*Jeanette:* Hand hygiene is always important, but with the onset of flu season and the critical shortage of flu vaccine, in-

creased attention to hand hygiene is doubly important. Not only should staff adopt good hand-hygiene practices, they should encourage it among patients and visitors as well.

*Question:* Are our efforts having an effect on patient outcomes?

*Jeanette:* The hospital's nosocomial MRSA and VRE rates steadily declined during the first three quarters of 2004. Our STOP initiative is making a difference thanks to our hand-hygiene champions and all staff who are working hard to stop the spread of harmful pathogens.

### Jeanette Ives Erickson

*continued from previous page*

ganizations had successfully integrated a strong customer-service focus into their philosophy and infrastructure, while others had not.

After thoughtful discussion about this assignment and lessons learned from the 'best-friend' exercise, the real work began. To determine the emphasis and direction of future PCS initiatives, we spent considerable time brainstorming, debating, and weighing the merits of numerous ideas. Quality, safety, diversity, tech-

nology, efficiency, customer service, and ensuring a strong financial future for the organization were central to our work. The importance of human interaction and creating a safe, welcoming environment were recurring themes in all our deliberations.

A number of potential initiatives emerged from our retreat, all of them important, all of them directly related to improving the patient and family experience at MGH. Through a formal

process of evaluation, we have narrowed the field to a select few and are working to develop the initiatives we think will best serve our patients, their families, and the organization.

There is much more to come on our strategic planning efforts, and I'll keep you informed as our work unfolds.

#### Updates

I'd like to announce that Jacqueline Collins, RN, has accepted the position of clinical nurse specialist on Ellison 16, effective November 29, 2004.

Denise Young has accepted a position as clinical supervisor.

### Holiday Gift-Giving Event

On December 9, 2004, the Patient Care Services Diversity Steering Committee will once again sponsor its Holiday Gift-Giving Event. This is an opportunity to bring some holiday cheer to families in our HAVEN Program who are truly in need.

For more information or to participate, please e-mail Beverley Cunningham at: [bcunningham2@partners.org](mailto:bcunningham2@partners.org).

### Call for presenters

The Nursing Research Journal Club invites you to present your original published research at an upcoming Journal Club meeting

Dates available in 2005

January 12th	July 13
March 23rd	September 14
May 11th	November 16

4:00-5:00pm

Wellman Conference Room

For more information e-mail

Mary Larkin, RN, ([mlarkin1@partners.org](mailto:mlarkin1@partners.org)) or Catherine Griffith, RN, ([cgriffith@partners.org](mailto:cgriffith@partners.org)) or visit:

[www.mghnursingresearchcommittee.org](http://www.mghnursingresearchcommittee.org)

## First annual Brian M. McEachern Extraordinary Care Award

—by Julie Goldman, RN, professional development coordinator

**O**n October 20, 2004, Ann Kennedy, RN, nurse manager for Neurology and Neurosurgery, and Joan Collins, RN, IV staff nurse, became the first recipients of the Brian M. McEachern Extraordinary Care Award.

This new award was established in memory of Boston firefighter and MGH patient, Brian McEachern, to recognize extraordinary care and patient advocacy. McEachern is remembered as a quiet hero who went out of his way to help others, never expecting accolades. McEachern fought a long battle with cancer that ended in November, 2000. During his time at MGH, he came in contact with many caregivers and employees whose remarkable caring, expertise, and concern made an impression on the McEachern family.

Award recipient, Ann Kennedy, is well known for her commitment to patients and families. She takes the time to listen and understand each patient situation. Her quiet manner is a source of strength and support to patients, families, and the entire care team.

Collins is dedicated to providing quality, compassionate care. She met McEachern when she performed the placement of his PIC line, a lengthy procedure that required a skilled IV nurse. Colleagues have said that Collins, “leaves patients with the impression that they’re the only person in the world.”

Paul Christian, commissioner and chief of the Boston Fire Department spoke at the award ceremony, saying, “Firefighters, like nurses, are a special group of individuals, with tremendous

bravery, compassion and caring.”

Mary Manning, long-time family friend and nurse, shared stories about McEachern as a loving brother, a quiet man, the unassuming man in the baseball cap who did so many kind deeds for others.

For this, the inaugural award, McEachern’s sisters, Geraldine McEachern and Diane Leason, and close family friends selected the recipients. In the future, recipients will be chosen by a selection committee comprised of MGH em-

ployees and McEachern family members.

Following the ceremony, attendees were invited to a reception in the Trustees Room.

The Brian M. McEachern Extraordinary Care Award will be presented annually in September, close to the time of McEachern’s birthday. The award will recognize staff whose passion and tenacity exceed the expectations of patients, families, and col-

leagues by demonstrating extraordinary acts of compassionate care and service. The criteria for selection are based on patient advocacy, empowerment, commitment to extraordinary patient care and service, compassion, and caring.

For more information about the award, contact Julie Goldman, RN, in The Center for Clinical & Professional Development at 4-2295.

## Caring HEADLINES

Back issues of *Caring Headlines* are available on-line from the Patient Care Services website at:

<http://pcs.mgh.harvard.edu/>

For assistance in searching back issues, contact Jess Beaham at 6-3193



At Brian M. McEachern Extraordinary Care Award ceremony, (l-r): Jeanette Ives Erickson, RN, senior vice president for Patient Care; Diane Leason (McEachern's sister); Joan Collins, RN; Geraldine McEachern (another sister); Ann Kennedy, RN; and Paul Christian, commissioner and chief of the Boston Fire Department.

(Photo by Michelle Rose)

## Kirvilaitis Awards

*continued from front cover*

groups. Said DeCoste, "In today's world, successful healthcare facilities rely on more than the clinical reputation of their physicians and primary care providers. Nowadays, it is essential for every employee to put forth a caring attitude.

"Tony taught us so much—but above all, he taught us that caring is pervasive. It spills from one aspect of a person's life to all others, as Tony so aptly personified."

Reading from a letter of support written by Dr. Kayla Zomlefer, Ives Erickson said, "Danisa Alonzo is the essence of sunshine for everyone who works with her." Alonzo's co-workers echoed that sentiment saying, "We can not say enough about Danisa's energy, positive attitude, friendliness, and above all, her excellent work."

When asked what she liked the most about her job, Alonzo said, "All of it! I love the people. I love it here!"

Marianne Burns, RN, wrote of Chennane El-Idrissi, "Even while handling many requests, often simultaneously, Zakia always maintains her wonderful sense of humor, a positive attitude, and a warm, caring presence. She is an extreme-

ly competent, professional, and caring individual who epitomizes all of the values of this award."

Others described Chennane El-Idrissi as pleasant, calm, polite, bright, friendly, and kind to every individual who walks onto our unit." Chennane El-Idrissi was a member of Kirvilaitis' last OA training class.

Ives Erickson thanked the Kirvilaitis Award Selection Committee, chaired by DeCoste and operations coordinator, Carolyn Washington, for

their work in reviewing nominations and selecting two recipients from among many deserving candidates.

Said Ives Erickson, "Tony was a benchmark of excellence. He was passionate about everything he did; his warm smile, genuine concern, and enthusiasm were contagious. Even now,

when I make rounds on patient care units, I see Tony's legacy in the hard work and dedication of our extraordinary support staff."

For more information about the Anthony Kirvilaitis, Jr. Partnership in Caring Award, please contact Nancy DeCoste at 4-7841, or Carolyn Washington at 4-7275.



Photographs  
clockwise from  
bottom left:

Ives Erickson with  
award recipient,  
Danisa Alonzo;

Proud nurse manager,  
Scott Ciesielski, RN,  
watches as Alonzo  
accepts award;

Old friends, Jan Duffy,  
RN, staff specialist, and  
Bruce Gentile catch  
up at reception;

Chennane El-Idrissi  
accepts award



# Humanitarian Aid

## The work

—submitted by Kate Fallon, RN

October 15, 2004

Things are good here in Nyala. The weather is hot but dry and the pace is slow, especially since Ramadan started today. Most of the people here are Muslim; during Ramadan, they fast from sun-up to sun-down then eat and celebrate late into the night. During the long, hot days people move a bit slower. The good thing is that the rebels probably won't attack during Ramadan as they'll be observing, too.

There are so many political, social, and historical reasons for all the fighting here in Sudan. It is a very complex situation. But the bottom line is that many people have been forced from their homes and are living out in the open with no food, very little clean water, and in close proximity to one another (which leads to disease).

Like I said, the pace is very slow here, so it takes a while to get things done. It can be frustrating, but I've been told that the time will come when we'll be so busy we won't be able to keep up. Prior to my arrival, steps had been taken to start a polio-vaccine initiative. For a long time, there were no incidences of polio in Sudan, but recently, cases have been reported in many of the camps. Polio vaccine was obtained and distributed to local health workers who went to clinics and door-to-door vaccinating children under the

age of five. That happened just before I got here three days ago.

It's hard to explain what we're focusing on right now, as I'm still learning the ropes. But our main objective is to establish primary health-clinic sites and implement a system of mobile clinics, as well.

Right now, we're focusing on the 'corridor' between Nyala and Girayda. If Nyala is point A and Girayda is point B, there's one road (if you can call it that) that connects the two cities, which are approximately four and a half hours apart. In Nyala, there is food and water, and life is

generally sustainable. In Girayda, there's only one source of water for about 40,000 people, and life there is very grim.

One of the biggest challenges has been finding an area to work that hasn't already been 'claimed' by another humanitarian organization. But things ultimately get coordinated through a variety of agencies and avenues. And trust me, the need for healthcare services far outweighs our ability to help everyone.

The corridor between Nyala and Girayda is dotted with small villages. Some have been attacked, some have not. The area is still considered 'un-secured.' One village, about halfway between Nyala and Girayda, is called Don-



Kate Fallon, RN  
Thomas S. Durant fellow

ki Dreissa. Prior to my arrival, an old, abandoned clinic was found in Donki Dreissa. Which brings me to our first project. We will be trying to establish a primary health-clinic in Donki Dreissa. We went to the abandoned site yester-

day to re-evaluate its feasibility for use as our clinic. Water and sanitation people have already been deployed to start working on the plumbing.

I'll have more news about our work in Sudan in my next correspondence.



Deveney (center) at refugee camp

(photos provided by Durant fellows)

# The rewards

—submitted by Grace Deveney, RN

November 3, 2004

It's hard to describe what it is like here. Streets are made of sand and houses seem to have sprung up from the very dust they're resting on. I think the thing most people don't realize is that it's impossible to stay clean over here—it's so dusty and hot. I'm covered in dirt and to be honest, I don't even notice the sweat that's constantly running down my back anymore.

Life is surreal. I sleep under a mosquito net and go to the bathroom in a hole in the ground. We drive around in battered old cars. Water is brought into our compound by a man with a donkey, and at three in the afternoon all the men drop what they're doing and pray. At night,

the sound of donkeys, dogs, guns, singing, and praying is 'normal.'

Perhaps the most surreal part of my time here in El Geniena is the laughter. I never expected to laugh so much, or hear so much laughter. The people here are amazing. Children are half-naked and dirty, they have the swollen bellies and tiny limbs of malnutrition, they live in shacks, and have survived the most horrific events imaginable. But they have found a way to hang on to laughter and smiles. It is an inspiration.

I'm in awe of the Sudanese nurse who teaches a new mother how to breast-feed because her family and friends have been killed. I'm in awe of the Sudanese man who gave up a career in engineering to

weigh and measure malnourished children because he 'wants to help.' I'm in awe of the children who play with a plastic bag as if it were the most entertaining toy in the world. Most of all, I'm in awe of the laughter of the people who have been driven from their homes with nothing but the clothes on their backs.

I think about those moments when we're laughing about the silliest thing, and it's as though we've found a common ground. Something we can all relate to. And I realize I'm surrounded by the most beautiful people, refugees and staff alike, that I will ever encounter. I feel blessed to have the opportunity to be here.

Over the past several weeks I've been working with the nutrition team in El Geniena, in Northwestern Darfur. I assist in train-



Grace Deveney, RN  
Thomas S. Durant fellow

ing local staff around the operation and management of Community-based Therapeutic Care (CTC). CTC programs are provided in five refugee camps in and around El Geniena. A relatively new approach to malnutrition, the CTC program brings the treatment of malnutrition into the community. Historically, malnourished children are treated at a therapeutic

feeding center. But treatment in a therapeutic feeding center can take several months, which presents a problem as children are required to be accompanied by a caretaker 24 hours a day. This prevents parents (or caretakers) from caring for other children at home. Some parents are forced to forgo treatment for a malnourished child because of other responsibilities.

With the CTC program severely

malnourished children with medical complications are admitted to a therapeutic feeding center, but once their condition stabilizes, they can be admitted to the CTC program. Children receive medical check-ups, medications, and their height and weight are monitored. They receive a week's ration of 'Plumpynut' (a food specifically developed for the recovery of severely malnourished children) and a week's ration of corn-soy blend.

Bringing the treatment of stable, malnourished children into the community prevents overcrowding in the therapeutic feeding centers leaving space in these facilities for more complicated cases. Right now, we're seeing as many as 500 children at a single CTC site.

The long-term goal is to have people from the community run the CTC program, which is why there is such a strong focus on training community volunteers. If all goes well, our team in Darfur will soon work ourselves out of a job.



Deveney at Community-Based Therapeutic Care site

## ICU nurse transfers skills to neonatal setting with grace and care

*M*y name is Kristen Gallagher, and I have been a staff nurse at MGH since April, 1992. About two years ago I moved to the NICU (Neonatal Intensive Care Unit) after many years in the adult ICU.

It was late morning on a particularly busy day in the NICU. I had a two-patient assignment as did most of my co-workers. The resource nurse had received several 'heads-up' phone calls from another hospital about a baby who might need to come to MGH for ECMO treatment (extracorporeal membrane oxygenation). When it was definite that the transfer was going to happen, we adjusted patient assignments to be able to accommodate a 'one-to-one' admission. The resource nurse asked for volunteers. Though I had been oriented to ECMO treatment before, to be honest, I wasn't quick to step up. I would have liked the experience, but I had never been responsible for putting a baby on the circuit before.

It was decided that I would admit the baby. I reminded the resource nurse that although I had extensive ICU experience, this would be the sickest baby I had ever admitted, and I had never initiated ECMO ther-

apy on a baby before. She validated my understanding of pressors and sedation and my knowledge of the action of the medications. The resource nurse told me she was comfortable with the decision because I would know if I was in over my head, if I needed to ask for help, and I was good at delegating. The decision was made, and it was about to get a lot busier in the NICU. I was excited for the opportunity and hopeful that we could help this baby.

While I was giving report on the other two babies, I started delegating and enlisting the help of my colleagues. After learning the weight of the baby being transferred, I asked a nurse to draw up a round of code meds based on her weight. The resource nurse had taken a brief report on the baby from the transferring nurse via phone. I set up the equipment to be able to suction at the bedside and prepared all the pre-ECMO lab slips and test tubes. I asked the secretary to place a call to the ultrasound lab to facilitate a head ultrasound on arrival. I asked them to notify pediatric surgery of the estimated time of arrival so they'd be available at the bedside for cannulation.

I was expecting the baby to be in respiratory distress with possible

meconium aspiration. I had been told the baby was requiring increased ventilatory assistance, had failed an attempt on the oscillator and inhaled nitric oxide therapy, was on full presser support, and prior to chest tube insertion, had coded for approximately 45 minutes.

The baby arrived in a transport isolette with the transport team. My assessment began immediately. The baby had a stable heart rate in the 150 range and a mean blood pressure that was acceptable. The nurse confirmed that the baby was still on a maximum dose of dopamine, dobutamine and epinephrine. She was being hand bagged by the respiratory therapist and continued on nitric oxide. Oxygen saturations were 86 while lying still (sedated and chemically paralyzed).

I noticed that she was very pale and her lips and the area around her mouth had a distinct bluish hue. As I prepared to move her from the isolette and touched her for the first time, I noted that her hands and feet were cool and her capillary refill was about 5 seconds. Knowing all this, I anticipated that moving her to the warming table might not go smoothly. This concerned me because we had little to fall back on as

she was on maximum support. We hooked her up to monitors quickly to find her oxygen saturations in the 60s. We transduced her arterial line and switched her chest tubes. I had one of my peers send blood work while another documented on my flow sheet. I began my formal assessment as the respiratory therapist continued to hand bag the infant. Her lung sounds were poor with minimal air entry. Her x-ray, to my untrained eye, showed white out bilaterally and good ETT position.

The only thing that was going to help her at this stage was to initiate ECMO therapy immediately instead of trying to stabilize her beforehand. As we prepared to place the cannulas, I reviewed the baby's current sedation with the surgeon. We gave her additional paralytics, and I monitored her vital signs.

Once the cannula was placed, the baby's oxygenation began to improve. Her saturations

were now in the mid-90s instead of 60s, and her lips were starting to 'pink up.' She was beginning to respond to therapy. At this point, I asked a co-worker to stay with the infant while I stepped out to talk with the parents. I wanted to speak to them personally.

Mom and dad had driven from hospital to hospital unsure if their baby would even survive transport. They looked exhausted, teary, and overwhelmed but they held hands, quietly supporting each other. I introduced myself to them and asked what they had named their baby. They said, "Gloria" (not her real name). During our conversation, I tried to refer to her by name as much as possible. I told them that Gloria had arrived safely but was very unstable; that the doctors had seen her, and she had already started treatment. I told them she was 'holding her own.' I wanted to give them hope but also be

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Photo provided by Gallagher

Kristen Gallagher, RN  
staff nurse, NICU



## Exemplar

*continued from page 8*

realistic. I assured them their baby was receiving continuous medication to keep her comfortable and that she wasn't in any pain. I anticipated their concern based on previous experience and tried to put their minds at ease, at least as far as pain-management was concerned.

I wanted to take them in to see their little girl. I remembered what it was like walking into an ICU for the first time as an experienced nurse. I could only imagine what it would be like as a parent. I prepared them that there would be a lot of monitors and equipment and noises, but to let us worry about that; they should try to focus on Gloria.

We stood at the top of the warming table near Gloria's head. I encouraged them to touch her hands and feet. I explained in very simple terms about the cannula in her neck, the monitors, and pumps. I assured them that there would be a nurse and respiratory therapist at the bedside at all times. We talked about how difficult it was to be separated from their baby. I assured them they were welcome to be at the bedside whenever they wanted, and they could call the NICU any time to get an update. I didn't want them to feel they were disturbing us with phone calls. They

weren't able to stay long because they had five other children at home and had a long commute ahead of them.

Before they left, I asked if they'd like a picture of their baby to take with them. They smiled for the first time. I encouraged them to bring in some family photos or cards from her brothers and sisters to hang near her bed. Knowing the helplessness they must have felt, I asked them to bring in some lip balm for Gloria so her lips wouldn't get dry while she was on the machine. I mentioned that a small stuffed animal would help provide 'boundaries' for her on the warming table.

Knowing how important it is for a mother to be able to participate in the care of her baby, I congratulated her on her decision to breast-feed and her willingness to pump during the baby's acute phase. I assured her that this was a gift to Gloria and something that no one else could do for her. She smiled again. They kissed their baby softly on the cheek and left with only a Polaroid and each other. Before they left, they turned back to say, 'Thank-you.'

I had purposefully kept the information simple for Gloria's parents. In my experience, there are a few things parents need to hear right away. 'Your baby is okay right now.' 'Your baby is not in pain.' 'We are watching her very close-

ly and doing everything we can to help her.' 'You are always welcome to be involved in your baby's care.' I had covered all that but chose to keep topics like the effects of long-term sedation, initiation of feeds, narcotic weaning, and other issues for another time. I have learned that only so much can be absorbed early on. While this information is important and parents are entitled to know it, it has its time.

It was almost 6:00pm and I had a lot of catching up to do before the end of my shift. I knew I would be giving report to a senior staff nurse with more than 25 years experience, one whose practice I greatly respected. I gave her report along with a list of the things I hadn't been able to get to. When I finished, I asked if she had any questions. She told me that my report was very well done despite the acuity and work load. I reminded her that I'd never started a baby on ECMO before and for my own learning it would be helpful to hear any feedback about the care I had provided. I asked her to point out anything she might have done differently or anything she might have prioritized that I didn't. She gave me some good feedback. The following day, I signed up to be Gloria's primary nurse and recruited this nurse to be on the team.

I may not have raised my hand immediately

when I first heard about Gloria's condition. But at the end of the day, though tired and concerned about the outcome, I felt I had done a good job with her and her parents. I was glad I'd been given the opportunity and pleased to find I was up to the task. I followed Gloria throughout her stay. As her condition improved, I helped get her out of bed despite the ventilator and assorted equipment. And I was there when her mom held her for the first time.

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

Kristen may have momentarily lacked the confidence to volunteer to care for this critically ill infant; but she didn't lack the skill or ability. Kristen brought her considerable knowledge and

talents to the bedside as she assessed and anticipated the needs of her newest patient. Though her past experience was in the adult ICU, her empathy, instincts, and critical thinking allowed her to tap all necessary resources while at the same time educating and comforting Gloria's parents. She judged the parents' readiness to hear certain information and triaged the flow of communication accordingly.

When the time came to give report to the night nurse, a senior colleague, Kristen solicited feedback about her performance, looking for ways to improve her practice. This is the sign of a truly committed professional.

Kristen may have moved outside her comfort zone to care for Gloria, but Gloria and her parents benefited from the calculated risk.

Thank-you, Kristen.

## A service of healing and remembrance

A special service of healing and remembrance will be held for individuals impacted by domestic violence

**Friday, December 3, 2004  
12:00-12:40pm  
in the MGH Chapel**

A reception will follow (with a light lunch). This annual gathering honors the courage and strength of those who lost their lives to domestic violence and the survivors, families, and loved ones of those we've lost.

We acknowledge the committed professionals whose support, wisdom, and expertise continue to save lives. Together we must refuse to accept violence in our homes and in our community.

Please join us

## Healthy behaviors: coaching your patient to success

—by Angela Sorge, RN, and Carol Harmon Mahony, OTR/L

On November 5, 2004, the Patient Education Committee presented an all-day conference focusing on, “Healthy Behaviors: Coaching Your Patient to Success.”

The day began with Nancy Rigotti, MD, director of the MGH Tobacco Research and Treatment Center, who talked about, “Changing Behaviors: Tobacco as a Model.” Rigotti presented an overview of health risks that contribute to the leading causes of death in the United States, including obesity, smoking, and physical inactivity. She reported on the health risks and burdens associated with tobacco use, contrasting them with the benefits of not smoking. Rigotti showed that obesity, physical inactivity, and diabetes rates

all dramatically increased between 1991 and 2000, and she reported that less than a third of American adults exercise for the recommended 30 minutes (of intense movement) five times a week.

Rigotti used the case study of Mrs. V to illustrate the difficulties and challenges clinicians face in trying to help patients change their behavior. In a three-minute video, attendees heard Mrs. V describe her history of smoking. Rigotti talked about withdrawal symptoms, pharmacological treatments, and cessation methods. She described a model of counseling that consists of: ask, advise, assess, assist and arrange. Rigotti discussed the many barriers to quitting and the importance of assessing a patient’s motivation. She

emphasized that changing a person’s behavior, whether it’s around diet, exercise, drug-addiction, or tobacco use, requires a long-term commitment. There is no quick fix.

Karen Sepucha, PhD, presented, “Making the Tough Decisions: Healthy Behaviors.” Sepucha’s research has focused on making informed medical decisions with breast cancer patients. Sepucha outlined what a decision entails, why it’s difficult to make a decision, and how patients and providers can work together to make decisions. She spoke about variations in medical practices in different parts of the country. Should a patient’s medical care depend on where she lives and who she sees, or on who she is and what her values are?

Sepucha outlined the key steps in decision-making:

- preparing for the process
- gathering information
- clarifying values and trade-offs
- implementing the decision.

Patients define the pros and cons during the information stage and determine their own risk and time preferences during the values stage. Decision ‘aids’ can help patients who may be uncertain. Choices are ideally made with better knowledge, more realistic expectations, clearer values, and better communication.

Keynote speaker, Dr. James O. Prochaska, presented, “Helping Patient Population at Each Stage of Change.” Prochaska is the director of the Cancer Prevention Research Center and professor of Clinical and Health Psychology at the University of Rhode Island. He is the author of more than 200

publications, including *Changing for Good, Systems of Psychotherapy*, and *The Transtheoretical Approach*.

Prochaska described six stages that individuals go through in their journey to behavioral change:

- pre-contemplation
- contemplation
- preparation
- action
- maintenance
- termination

According to Prochaska, most care providers are oriented to the action stage. But not all patients are ready to take action when a caregiver suggests it. Says Prochaska, completing the action stage should not be our measure of success. Rather, assisting patients to advance from one stage to the next would be more effective (e.g., from pre-contemplation to contemplation). Prochaska encouraged clinicians to look at old methods of changing behavior and complement those practices with some



Sue Cummings



Andrea Stidsen



Martha Kane



Thelma Tisdale

Continued on next page

new paradigms. Instead of being action-oriented, be stage-oriented. Instead of expert clinicians, think in terms of expert systems. Instead of standardized treatment programs, think about tailoring treatment to the needs of each patient.

Afternoon sessions dealt with behavior modification associated with substance addictions, exercise, healthy eating, and smoking cessation.

Operations manager and personal trainer at The Clubs at Charles River Park, Danny Murphy, CSCS, began his presentation with a discussion of the benefits of exercise. Exercise is a behavior that moves through different stages (preparation, action, and maintenance). Ideally, exercise should be comprised of three components: aerobic exercise, stretching, and strength training. Murphy stressed

that for each component, it's imperative to employ the 'FIT' framework: frequency (how many times per week); intensity (how hard); and time (duration). The American Council on Sports Medicine (ACSM) provides FIT guidelines for each component of an exercise program.

During the maintenance stage of exercise, it's important to stay motivated. Murphy suggested exercising with a partner or using an exercise log or journal. He made it clear that exercise needs to be a non-negotiable priority.

Healthy eating was the next topic. Sue Cummings, RD, coordinator of Clinical Programs and Services at the MGH Weight Center, explored different trends in dieting across the United States. She compared the USDA Food Pyramid to other food pyramids including those used by

Asian, Latin, and Mediterranean cultures. Cummings explained that the Mediterranean food pyramid is what Americans now aim for in terms of healthy eating habits. The most important take-home message for clinicians coaching patients to eat healthy was a comprehensive evaluation to assess patients' readiness to change. Treatment recommendations may differ depending on what stage of change a patient is in. During the pre-contemplation/contemplation stage, it's suggested that caregivers employ a non-directive approach—open-ended questions and reflective listening are encouraged. The goal is to help patients explore any ambivalence they may have. Clinicians should resist the urge to *tell* patients what to do. Instead, *ask* how he/she feels about a particular

change. Once the person is ready for the action phase, the focus remains on goal-setting and self-monitoring. Goals should be short-term, realistic, positive, and specific. Cummings shared this quote from Oprah Winfrey: "I don't eat foods I don't like; I just change what I like."

Martha Kane, PhD, clinical director of the MGH Addictions Service Unit, focused on coaching and motivational interviewing as they relate to substance-abuse disorders. Unlike other patient populations, by the time clients arrive at the Addictions Service Unit, they're often already at the action stage of their behavioral-change journey. They've been through pre-contemplation, contemplation, and preparation, and are now ready to seek help. But Kane stressed that relapses and return to earlier stages are not only a possibility, they are expected. Effective motivational interventions include:

- offering gentle advice
- identifying and removing existing barriers
- providing supportive feedback
- actively helping
- establishing a rapport
- remaining genuine.

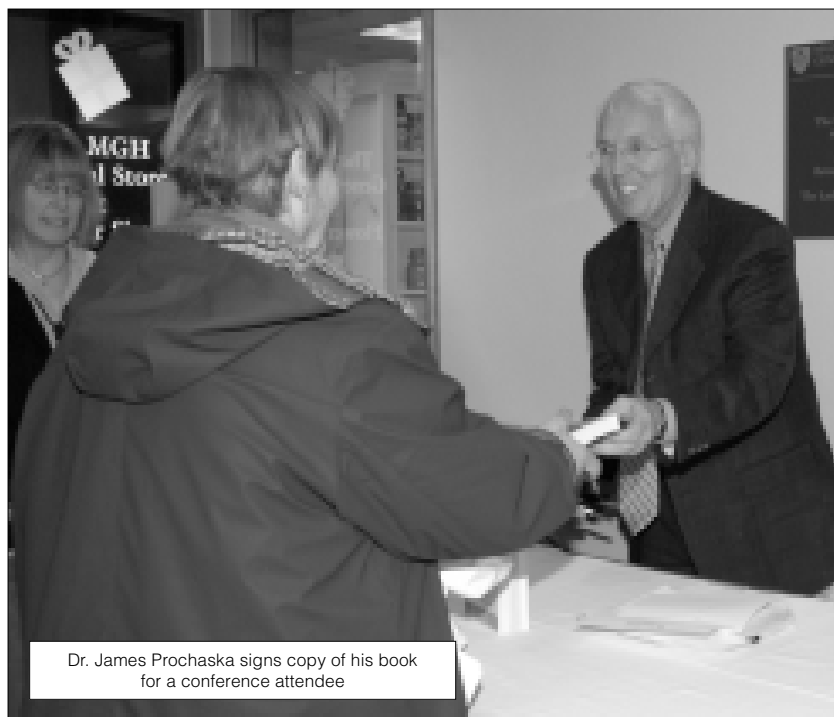
But the most important intervention a clinician can provide is genuine *empathy*.

Thelma Tisdale, RN, counselor at the MGH Quit Smoking Service, was the final speaker, sharing her expertise on how to help smokers quit. Tisdale gave an overview of services provided at MGH.

She provided post-discharge referral information and Internet-based resources for tobacco-dependence treatment. She reviewed the stages of change with respect to smoking-cessation where treatment is largely dependent on what stage a patient is in. According to Tisdale, giving up smoking is a learning process. When a patient has a setback, it's important to review the circumstances surrounding the setback. Ask yourself what could be done differently next time. How can we learn from the setback? Different strategies work for different people, but listening to patients to determine what works best for them is the best approach.

The day ended with an interactive session led by Andrea Stidsen, LICSW, director of the MGH Employee Assistance Program. Stidsen distributed a self-assessment questionnaire and asked attendees to discuss it using the principles that had been presented throughout the day. Stidsen closed by sharing a quote from Henry David Thoreau: "Things do not change. We change."

The Healthy Behaviors: Coaching Your Patient to Success conference provided a lot of helpful information for healthcare providers on coaching and assisting patients toward healthier behaviors. For more information, contact Carol Harmon Mahony, OTR/L, at 4-8162.



Dr. James Prochaska signs copy of his book for a conference attendee

## More from the Quality & Safety tool kit...

There are many quality and safety resources available to complement and enhance the care we provide at MGH. Many of these resources are marketed directly to consumers enabling patients and families to be active participants in their own care. As care providers, it's helpful for us to be familiar with these resources.

The Agency for Healthcare Research and Quality (AHRQ) offers an on-line patient guideline: "Five Steps to Safer Health Care," which can be obtained at: <http://www.ahrq.gov/consumer/5steps.pdf> (no spaces). The five simple steps include:

- Keep and bring a list of all your medications to your medical appointments
- Get the results of all tests and procedures
- Ask questions if you have doubts or concerns
- Talk to your doctor about which hospital is best for your health needs
- Make sure you understand what will happen if you need surgery.

Also available on the AHRQ web site are: "20 Tips to Help Prevent Medical Errors" at: <http://www.ahrq.gov/consumer/20tips.htm>, and "20 Tips to Help Prevent Medical Errors in Children" at: <http://www.ahrq.gov/consumer/20tipkid.pdf>.

The Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) is promoting a new campaign, "Speak up: help prevent errors in your care." The goal of the campaign is to get patients and family members more involved in the safe delivery of their own care. Patients and families are encouraged to:

- ask questions about their care
- pay close attention to their treatment
- educate themselves
- appoint a friend or family member as a health advocate
- understand their medications
- seek care at a facility that has undergone rigorous on-site evaluations of their quality and safety initiatives
- participate in decisions about their treatment

A free copy of the "Speak

up" brochure can be downloaded from the JCAHO website at: <http://www.jcaho.org/accredited+organizations/speak+up/hospital+brochure-eng.htm>, or: [http://www.jcaho.org/general+public/gp+speake+up/speakup\\_poster.pdf](http://www.jcaho.org/general+public/gp+speake+up/speakup_poster.pdf).

Three landmark Institute of Medicine (IOM) reports continue to transform the way we look at healthcare quality and safety. *To Err is Human: Building a Safer Health System*; *Crossing the Quality Chasm: A New Health System for the 21st Century*; and *Keeping Patients Safe: Transforming the Work Environment of Nurses* offer valuable insights and information for everyone in healthcare. These reports can be read at no cost via the National Academies Press website at [http://www.nap.edu/books/03090\\_90679/html/](http://www.nap.edu/books/03090_90679/html/).

*To suggest ideas for future topics, or for more information about this column, contact Georgia Peirce at 4-9865.*

## Clinicians as Educators Certificate Program

Are you a clinician interested in teaching at the college level? The MGH Institute of Health Professions in partnership with Partners in Career and Workforce Development, has developed a Clinicians as Educators Certificate Program designed to prepare clinicians to become adjunct and part-time faculty members in health professions education programs. The certificate program is comprised of two on-line courses and a practicum.

The first course, Foundations of Teaching and Learning, begins in January, 2005.

For information on how to register, visit the IHP website at <http://www.mghihp.edu/>. Click on "Non-Degree Students" under "Especially For..."

For more information, contact the Office of Student Affairs at (617) 726-3140 or by e-mail at [registrar@mghihp.edu](mailto:registrar@mghihp.edu)

## Holiday Resource Table

This is a time of year that many of us look forward to and enjoy with family. It can also be a time of conflicting demands and stressful situations. Come visit the Employee Assistance Program's Holiday Resource Table for information and suggestions on how to manage stress, set realistic goals, take better care of yourself, and enjoy this holiday season.

**Wednesday, December 15, 2004**  
**Building 149 Lobby at CNY**  
**12:30-2:00pm**

**Thursday, December 16, 2004**  
**WACC Lobby**  
**2:00-3:30pm**

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

# In Memoriam

December 2, 2004

## Comfort and Support After Loss Memorial Service

—by Kathryn A. Beauchamp, RN, clinical nurse specialist

On November 7, 2004, the Comfort and Support After Loss Committee held its 13th annual MGH Pediatric, Neonatal, and Obstetric bereavement ceremony. The service is held for those who have experienced the death of an infant, child, or ado-

lescent, and families who have experienced miscarriage, stillbirth, or neonatal loss.

Alan Ezekowitz, MD, chief of Pediatrics, Howard Weinstein, MD, chief of Pediatric Oncology, and Lori Carson, RN, nurse manager of Labor & Delivery, spoke at the gathering.



**Above:** Pediatric clinical nurse specialist, Kathryn Beauchamp, RN, helps child affix memento to special board displaying hearts decorated by families in memory of their loved one(s)

**At right:** Members of the St. Thomas Villanova Church choir and the St. Francis Parish choir sing during the MGH Pediatric, Neonatal, and Obstetric bereavement ceremony



(Photos by Michelle Rose)

Remembering their son Alex, Susan and Tom Walsh shared some memories and milestones recounting their experience with grief and bereavement over the past five and a half years.

Throughout the service, the music and songs of the St. Thomas Villanova Church and St. Florence Parish choirs could be heard under the direction of musical director, Paul Vitale.

During the traditional naming ceremony, parents and family members were given flower bulbs and small pewter hearts in memory of their beloved children. Photographs spanning 13 years were shown during a special slide presentation.

Following the service, a reception was held in the Wellman Conference Room. Parents and family members had an opportunity to view memorial quilts, which were assembled from 1998–2003, and the 2004 memorial scrapbook.

For more information about the Comfort and Support After Loss Committee, or the annual Pediatric, Neonatal, and Obstetric bereavement ceremony, contact Kathryn Beauchamp, RN, clinical nurse specialist, at 4-3888.

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For more information, call: 617-724-1746.

### Next Publication Date:

December 16, 2004



## MGH celebrates National Case Management Week

—by the Case Management Week Committee

As the Case Management Department begins its ninth year, MGH celebrated National Case Management Week with a number of special events during the week of October 13-16, 2004. The theme this year, set by the Case Management Society of America, was 'Case managers, the passion for caring; the power of collaboration; the promise of hope.'

The MGH Case Management Celebration Committee geared its activities to help educate the MGH community about the work of the Case Management Department, post-acute

hospital-discharge options, financial responsibilities during hospitalization, and alternative and complementary therapies.

On October 12th and 14th, case managers staffed day-long educational booths in the White Corridor where they disseminated information about the Case Management Department and answered commonly asked questions about post-acute services, Medicare, and other topics of concern to patients and families. Written information and materials were available.

On November 2nd, Case Management sponsored an educational

session entitled, "Alternative Therapies," that combined information about complementary and alternative therapies to conventional Western medicine. The hour-long workshop featured three MGH employees: Lucy Chen, MD; Regina Powers, RN; and Catherine Ulbricht, RPh. Chen, an anesthesiologist, spoke about the benefits of acupuncture and acupressure. Powers, trauma nurse coordinator, shared information on homeopathy, Chinese medicine, nutrition, accupressure, relaxation, and yoga. Ulbricht, senior pharmacist, discussed the efficacy and safety of pop-

ular herbs and food supplements. Speakers and representatives knowledgeable in alternative therapies were available to answer any questions after the presentation.

And proving once again that Meltzer Auditorium is as close as MGH will ever get to Broadway, the third annual Case Management Variety/Change Show was held on October 14th. Before a crowd of friends and

colleagues, the colorful cast of case managers and other MGH staff performed skits, songs, comedy routines, and poked irreverent fun at just about everyone and everything. The show culminated with a special African-themed fashion show and concluded with the now-traditional slide-show montage of Case Management staff.

For more information, contact Anna Carson at 6-8184 or Melissa Robinson at 4-7474.

## December vacation camp at the Back-up Child Care Center

The MGH Back-up Childcare Center will be providing vacation camp for employees' children December 27-30, 2004. Camp will run from 7:00am-5:45pm, with activities and visitors planned for each day. The fee for the week is \$220; individual days are \$60 each.

For more information call The Back-up Childcare Center at 617-724-7100, or stop by the Warren lobby to pick up a schedule of events.



At far left: director of Case Management, Nancy Sullivan (aka Sponge Bob), presents case manager/musical director, Ron Greene, RN, with flowers of appreciation. Near left: case manager/narrator, Donna Bouley, RN, keeps the show moving.

# Educational Offerings

December 2, 2004

When/Where	Description	Contact Hours
December 14 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
December 15 1:30–2:30pm	<b>USA Educational Series</b> Bigelow 4 Amphitheater	---
December 16 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
December 16 8:00am–4:00pm	<b>Psychological Type &amp; Personal Style: Maximizing Your Effectiveness</b> Training Department, Charles River Plaza	8.1
December 17 12:00–3:30pm	<b>Basic Respiratory Care</b> Ellison 19 Conference Room (1919)	---
December 21 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK 401 (No BLS card given)	---
December 22 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
December 23 1:30–2:30pm	<b>Nursing Grand Rounds</b> O’Keeffe Auditorium	1.2
January 3, 4, 10, 11, 24, 25 7:30am–4:30pm	<b>Greater Boston ICU Consortium CORE Program</b> BIDMC	44.8 for completing all six days
January 4 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK 401 (No BLS card given)	---
January 6 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
January 10 8:00am–3:00pm	<b>Advanced Cardiac Life Support (ACLS)—One-Day Re-Certification Provider Course</b> Wellman Conference Room	---
January 12 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
January 12 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
January 12 7:00am–12:00pm	<b>CVVH Core Program</b> Haber Conference Room	6.3
January 12 11:00am–12:00pm	<b>Nursing Grand Rounds</b> Sweet Conference Room GRB 432	1.2
January 13 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
January 13 7:30am–12:30pm	<b>Pediatric Advanced Life Support (PALS) Re-Certification Program</b> Wellman Conference Room	---
January 20 8:00am–4:30pm	<b>Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other</b> Training Department, Charles River Plaza	7.2
January 20 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
January 24 and 25 7:30am–4:30pm	<b>Intra-Aortic Balloon Pump Workshop</b> Day 1: NEMC; Day 2: VBK601	14.4 for completing both days

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>.



**Above:** director of Infection Control Unit, Paula Wright, RN, talks to group of elders at recent Senior HealthWISE lecture on the importance of good health practices in preventing the spread of the flu virus.

**At right:** nurse practitioner, Frank Bellistri, GNP, talks about what to do if you do contract the flu.

For more information on flu-season concerns, call Infection Control at 726-2036.

## Getting through the flu season without a flu shot

### *a Senior HealthWISE presentation*

**A**t a recent special session of the Senior HealthWISE Lecture series, Paula Wright, RN, director of Infection Control, and Frank Bellistri, GNP, nurse practitioner for Senior HealthWISE, presented, "Flu season without the flu shot: what you need to know," to a group of local elders.

Wright explained that the flu is a respiratory illness brought on by the influenza virus (not a bacteria). It is characterized by high fever, headache, extreme fatigue, dry cough, sore throat, muscular aches, and sometimes vomiting and diarrhea (more likely with children). There are tests that can be done to determine whether symptoms are the flu or a common cold; these tests (usually done with a nasal swab) should be performed in the first two or three days of the illness. Since the flu is transmitted through liquid 'droplets' emanating from the nose and mouth, Wright explained that the accepted way to 'cover your mouth' is by coughing into your sleeve at the crook of your arm (to prevent spreading the illness with your hands). The virus can 'live' on a dry surface for up to eight hours.

According to Wright, flu season lasts from October to May, with the peak of the season usually occurring from December to March. Adults can be contagious a day or so before symptoms present until five days or more after the illness takes hold. Children can be contagious as early as six days prior to exhibiting symptoms.

Bellistri explained that vaccination is not the only way to prevent the flu. He suggested:

- avoiding close contact with people
- staying home when you're sick
- washing your hands frequently with soap and water and/or an alcohol rub
- avoid touching your eyes, nose, and mouth
- clean frequently-touched surfaces often

Bellistri advised people to use common sense and maintain good health habits, such as getting plenty of rest, exercising, controlling stress, drinking a lot of fluids, and following a healthy eating plan (fruits and vegetables).

For more information about the flu, or what to do if you get it, contact the Infection Control Unit at 726-2036.



# Caring

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