

Caring

HEADLINES

March 4, 2004

First annual Norman Knight Preceptor of Distinction Award

Inside:

Norman Knight Preceptor of Distinction Award	1
Jeanette Ives Erickson	2
• Staff Satisfaction Survey	
Exemplar	6
• Elizabeth Kelley, RN	
Hand Hygiene	7
• 'Clean Sweep' Sweepstakes	
Collaborative Governance Dinner	8
Patient Safety Awareness Week	9
NERBNA's Nursing Excellence Awards	10
Educational Offerings	11
Fielding the Issues	12
• Precepting	



First Norman Knight Preceptor of Distinction Award recipient, Jennifer Albert, RN (right), with senior vice president for Patient Care, Jeanette Ives Erickson, RN

Thanks to the vision and generosity of businessman, community leader, and philanthropist, Norman Knight, the first annual Norman Knight Preceptor of Distinction Award was presented at MGH on Thursday, February 12, 2004. Inaugural recipient, Jennifer Albert, RN, is a staff nurse in the Ellison 4 Surgical Intensive Care Unit (SICU) where she has practiced for the past seven years.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, presided over the event. She began by introducing Mr. Knight, who was in attendance, as "our new friend." Ives Erickson explained that when Mr. Knight expressed an interest in supporting MGH nurses, the idea of creating an award program to recognize nursing preceptors was born. The Norman Knight Preceptor of Distinction Award

continued on page 4

Staff Satisfaction with the Professional Practice Environment: a good-news story



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

I would like to thank everyone who took the time to complete the Staff Satisfaction with the Professional Practice Environment Survey for 2003. Our response rate over the past three years has steadily increased, giving us a good, reliable source of data on which to base future strategies and systems-improvement initiatives.

The survey measures staff's impressions of eight key organizational characteristics, including:

- Autonomy
- Control over practice
- Clinician-physician relationships
- Cultural sensitivity
- Communication

- Teamwork/Leadership
- Conflict-management
- Internal work motivation

The feedback provided in this survey has become a key indicator, a 'report card' of sorts, on how well we're doing in meeting our goals, finding solutions to our problems, and identifying opportunities for improvement. Data we receive impacts decision-making and serves as a valuable tool for leadership as we craft initiatives for the future.

Managers and supervisors are meeting with staff throughout Patient Care Services to share specific results with their units and departments, but I wanted to touch on some overall results that

I think reflect the sentiment of the majority of staff. Nine hundred and fifteen surveys were returned, which translates to a 33% response rate. Statistically, this is considered a high rate of return. Of those who participated, 87% reported that they were satisfied or very satisfied with their professional practice environment. This is good news.

As you can see from the graph below, a high percentage of staff agree that the goals we have set are important, and that we are doing a good job in meeting them. This is very good news.

Responses to survey questions ranged from one-word comments to short paragraphs to at

least one respondent who typed four insightful pages expressing his/her perceptions. All responses were thoughtful, candid, and reflected a deep commitment to patient care.

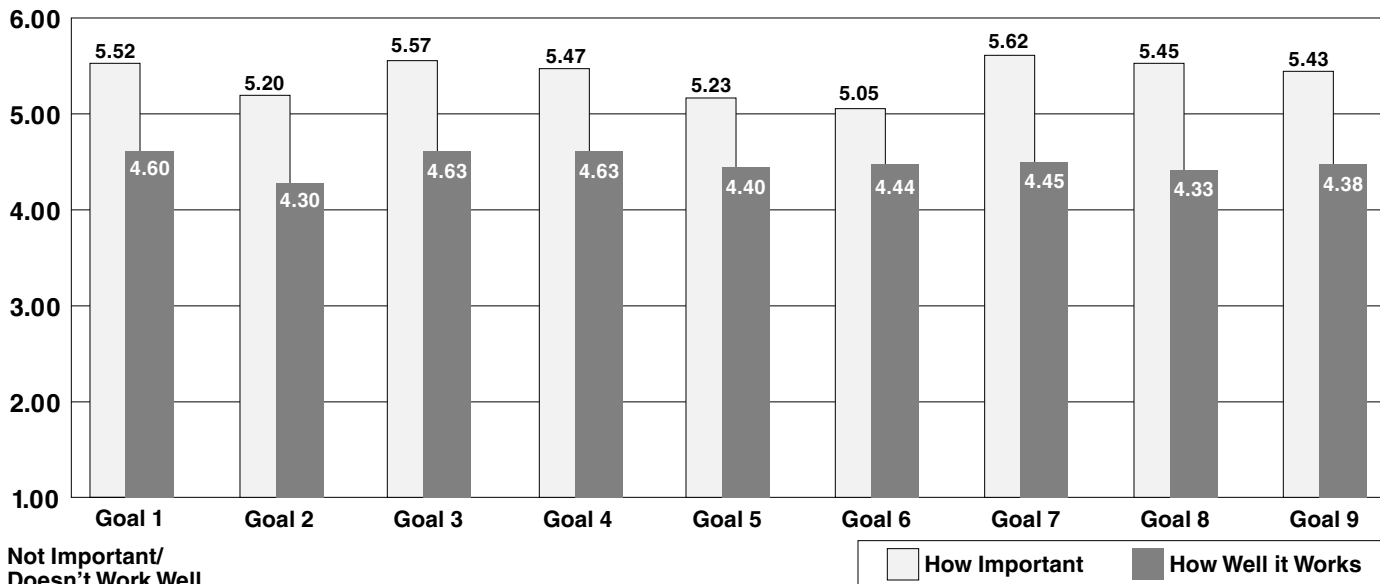
Responses were reviewed and analyzed many times by many individuals and groups who identified themes and trends and then translated the data into a more meaningful, manageable

form. Some of the positive feedback we received indicated that respondents:

- are happy to be working at MGH
 - are proud of the organization and proud to have achieved Magnet status
 - feel that clinical nurse specialists are effective leaders of patient care and staff development
- continued on next page*

How well are we meeting our goals? (See goals on opposite page)

Very Important/
Works Very Well



Not Important/
Doesn't Work Well

Jeanette Ives Erickson

continued from previous page

- believe they have adequate resources to do their jobs
- work well as a team to provide safe, quality care
- work in a practice environment where there is opportunity for professional growth and development
- experience outstanding, supportive leadership
- feel there is great diversity among staff and patients at MGH

But the purpose of the survey is not just to reinforce areas where we're doing a good job; it is to help identify areas where we need improvement. This is where your honesty and candor are so important. This is where real opportunities for change arise. And this is

where your commitment to patient care comes shining through.

It was clear from the feedback we received that patient- and staff-safety are of primary importance to clinicians. Because of increasing patient acuity and increased volume, staff want MGH to do everything possible to ensure we remain the employer of choice. Some comments indicated an interest in expanded opportunities for professional growth and advancement. And opportunities for improvement were identified in areas such as staffing, continuity of services, and continuing education.

All of the data collected in the Staff Satisfaction with the Profes-

sional Practice Environment Survey will be considered as we plan for the future. Your constructive feedback will be an important factor in the decisions we make to ensure continued success.

As I said before, this is a good-news story. I think the take-home message from our staff perceptions survey is that:

- a significant majority of staff are satisfied to very satisfied with the work environment at MGH.
- staff feel that leadership is supportive, effective, and instrumental in optimizing the professional practice environment.
- there are many positive things happening at MGH to promote safe, cost-effective, high-quality care.
- there are opportunities for improvement that

will require our attention as we work to keep MGH the health-care facility of choice for patients and staff

Thank-you again for your participation, feedback, and concern for the well-being of our patients.

Update

Several weeks ago we were informed that the American Nurses Credentialing Center (ANCC) is offering a 10% discount to any Magnet-facility employee who applies to

take an ANCC certification exam. I've received several inquiries about whether the discount applies to re-certification or just initial certification. The ANCC has clarified that the discount is intended for initial certification only.

The ANCC discount will be available through December, 2004, to any nurse employed at a Magnet facility (not only nurses working in the department of Nursing).

Patient Care Services Goals

- Goal 1: We lead the industry in providing patient- and family-focused care.
- Goal 2: We partner with the community to better understand the health-care needs of the diverse populations we serve and establish a shared vision of care and services.
- Goal 3: We are healthcare industry leaders for quality and safety.
- Goal 4: We develop and advance systems, technologies, and programs to promote individualized patient care and support those who provide care.
- Goal 5: We are the 'employer of choice' for all professions and support staff and value diversity in our workforce.
- Goal 6: We work to promote and support the institution in realizing sound financial growth.
- Goal 7: We position nurses, therapists, social workers, chaplains, medical interpreters, and support staff within the hospital to have a strong voice in issues impacting patient care.
- Goal 8: We continuously create through-put systems and processes that drive delivery of safe, efficient, timely, patient-centered care.
- Goal 9: We provide excellent leadership and foster leadership growth opportunities.

The Employee Assistance Program presents

Working and Breast-Feeding

presented by
Germaine Lamberge, RN

This presentation will provide expectant and nursing parents with basic information on how to use breast pumps and continue nursing while working. Session will include a tour of the MGH Mother's Corner.

Tuesday, April 20, 2004
12:00-1:00pm
VBK 401

For more information, contact the EAP at 726-6976.

The Employee Assistance Program presents

Training for Managers and Supervisors

If you spend 80% of your time dealing with 20% of your employees, you might benefit from this training. Learn how the Employee Assistance Program can help with behavioral health, mental health, and substance-abuse concerns. Join us for a presentation that will include case studies and discussion.

Tuesday, May 4, 2004
3:30-5:00pm
Burr Conference Room 5

For more information, contact the EAP at 726-6976.

Norman Knight Award

continued from front cover

was designed to recognize clinical staff nurses who consistently demonstrate excellence in educating, precepting, mentoring, and coaching other nurses. The award will be granted annually.

A very specific list of criteria was developed as a tool by which to evaluate nominees, but simply put, a preceptor of distinction is someone:

- who is caring and non-judgmental
- who possesses a spirit of inquiry
- whose practice is guided by knowledge
- who is a leader
- who values teamwork

All of the nominees (Lisa Bouvier, RN; Lynda Brandt, RN; Ann Eastman, RN; Marites Escano, RN; Kelley Grealish, RN; Gayle Peterson, RN; Christine Swanson, RN; Katherine Swigar, RN; and Lisa Townsend, RN) were deserving in their own right. Albert's portfolio was particularly compelling.

In a letter of support, Albert's nurse manager, Susan Tully, RN, wrote, "Jenn brings to the bedside a wealth of knowledge, a tireless spirit of inquiry, and an ability to ensure that the appropriate thing is done for patients and their families. She is able to contextualize her vast experience in a way that is meaningful to new nurses."

SICU clinical nurse specialist, Katie Brush, RN, wrote, "Observing Jenn as a preceptor is

like watching the sun coax a butterfly out of its cocoon. She envelops orientees with warmth, compassion, and all the ingredients needed for success as a critical care nurse."

The narrative Albert submitted as part of her portfolio was not only evidence of exceptional precepting ability, it was a tribute to the art, science, drama, and joy of nursing. Albert's narrative was too long to be included in its entirety; following are excerpts from her award-winning exemplar.

*

My nursing career at MGH began in 1989, six months before I graduated from nursing school.

As part of my senior practicum, I spent 20 hours a week working one-on-one with an experienced MGH nurse on a surgical-trauma floor. I was blessed to have a preceptor who was warm and welcoming, patient and professional, and above all, had a desire to share her knowledge and expertise with me, a new nurse. I credit my willingness to mentor a student nurse from my alma mater to the positive experience I had with my preceptor.

*

Currently, I am nearing the half-way mark in a six-month orientation process with Sue, a new graduate nurse in the Critical Care Program.

*

Andy is a 39-year-old man with a history of psoriasis who had presented to an outlying hospital two days earlier with an erythematous lesion on his posterior thigh, not unlike one he had had on his back that had resolved with oral antibiotics. Andy was put on oral antibiotics and sent home only to return the next day with worse pain and cellulitis of his thigh. Blood work at the time revealed a significant leukocytosis and acute renal failure. Andy should have been admitted to the hospital for IV antibiotics and hydration, but he refused to be admitted; agreeing instead to a single dose of IV antibiotics, a tissue biopsy, and a promise to return in the morning for re-evaluation.

*

Andy was admitted the next day with a diagnosis of necrotizing fasciitis, a deep-seated infection of the subcutaneous tissue that results in progressive destruction of the tissue, fat and fascia and has the potential to be limb-threatening, and even life-threatening. Treatment for this type of infection is early, aggressive, surgical debridement of the necrotic tissue, antibiotic therapy, hemodynamic support and often hyperbaric oxygen therapy.

Andy would probably be the most challenging and complex patient Sue had cared for thus far in her orientation. But as a preceptor, I knew the circumstances couldn't be more ideal because Sue had already

had some exposure to Andy; she had had an opportunity to observe his surgery, and she had participated in admitting him to the unit.

*

We met outside Andy's room at 7:00am to get report from Ann, the night nurse. I made the calculated, but hopefully inconspicuous, decision to move my seat so that I was sitting next to Sue. It never would have occurred to me that where I sat during report had any relevance, but one of my former orientees had mentioned to me that the nurse giving report tended to address me and not my orientee. I had never made this observation, but as I watched over the next few months, it became apparent that this was indeed true. This was done unintentionally and without malice, but it left my orientees feeling isolated and uninvolved in the report process. So I began to position myself beside my orientees so we were both being addressed during report.

*

Andy was started on Xigris, a new drug that decreases mortality in patients with profound sepsis. His renal function, which was initially of great concern, had begun to show signs of improvement; his creatinine was down to 5.6; and he was producing more than 100cc of urine per hour. Fluid resuscitation became more aggressive overnight and he had received several fluid boluses. In addition

to cardiovascular instability, Andy remained intubated and on high levels of mechanical ventilation support and was sedated with analgesics and propofol for pain control and amnesia. One critical piece of data we received during report was that Andy's platelet level had fallen to 40,000, his hematocrit was trending down, and his leg dressing, which had shown no signs of bleeding during the night, was saturated with blood just one hour after surgeons had changed it.

We entered Andy's room and Sue began the morning routine of zeroing and leveling transducers, setting monitor alarms, checking drug doses and infusion rates, and determining where each drug was infusing and if the drugs were compatible. Sue was at a point in her orientation where she could perform this routine nearly independently. I noted, but didn't verbalize, that there was heparin in all the transducer bags. I wondered if Sue had made the same observation, and if she did, would she make the connection that even this small amount of heparin could be contributing to Andy's thrombocytopenia and should be removed from the transducers.

Sue took his vital signs and performed a thorough physical assessment. Andy's neurological status was difficult to determine as he was heavily sedated.

continued on next page

Recalling that with previous patients we had stopped the propofol drip in order to get a more thorough exam, Sue asked if we should do this with Andy. Her ability to incorporate previous experiences was becoming evident and I agreed with her plan. But I cautiously reminded her of what we had learned in report: Andy became dysynchronous with the ventilator and tended to drop his oxygen saturation when awake or under-sedated. My role as preceptor was to help Sue anticipate this potential instability, and I did so by questioning her about how she planned to react and what interventions she would employ if Andy became unstable.

*
Sue was concerned about Andy's leg, the fact that the bleeding had continued and his leg dressing was now saturated with blood. I shared her concern, but knew from previous experience that this was not that unusual, especially immediately after a dressing change. I attempted to coax from her what she might expect to see in a patient who had lost significant blood volume by asking a series of probing questions. Together, we explored the answers to my questions. Together, we examined Andy's most recent vital signs, and I assisted her in interpreting the readings.

*
I prompted Sue to consider a medication that might be contributing to

Andy's ongoing bleeding. She reviewed Andy's medication list, but was unable to identify the two drugs I found concerning. I suggested she take a closer look at the transducer bags. Without even looking at the bags she realized her earlier oversight—the transducer bags must contain heparin! Sue removed the heparin from the transducers and I recommended she take a 10-minute break to read about Xigris, knowing that once she did, she would be able to identify my second concern—Xigris increases the risk of bleeding and is contraindicated with acute bleeding.

*
Sue was far enough along in her orientation that

she had begun to take an active role in rounds. Today, I took a back-seat role and allowed her to interact with physicians during rounds. In preparation, I assisted her in generating a list of questions she might want to have answered or addressed. When rounds began, I stepped back so that I was close enough to hear the discussion but far enough away not to be directly involved.

*
I made a conscious decision to just observe Sue for the next few hours and allow her to manage Andy's care. Andy spiked a fever and his blood pressure began to drop. Sue titrated Andy's vasopressors to maintain an adequate mean arterial blood pressure. I observed that Andy's leg had continued to ooze and he had soaked through the reinforcement dressing we applied earlier. I wondered if his hypotension was secondary to hypovolemia resulting from ongoing blood loss.

*
My job now was to assist Sue in interpreting the data so she would realize that Andy needed additional fluid. Again, I asked a series of probing questions, after which she looked at me and said, "Do you think he needs additional fluid volume?"

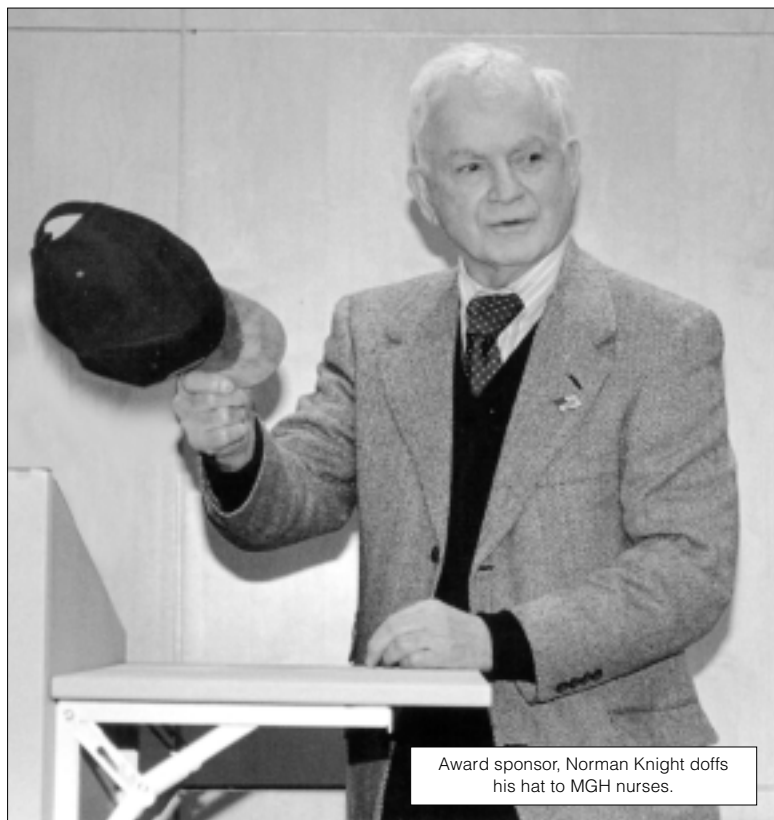
I asked more questions and suggested she compare Andy's cardiac output to earlier readings. Andy's cardiac output and stroke volume had declined significantly, and this, coupled with

the fact that his vasopressor requirement was up indicated he needed additional volume. Sue sought out the resident, presented her findings, and returned with an order to give a liter of fluid. Andy's response to the fluid was favorable

*
I was growing increasingly concerned that Andy was still having excessive bleeding from his leg wound. I shared my concern with Sue and suggested we send a CBC. (When we returned from break) I took one look at the blood pooled around Andy's leg and knew we needed to notify the surgeons immediately. This was arterial bleeding.

*
The surgeon quickly identified the source of bleeding, and ligated the vessels. Sue assisted the surgeon in re-dressing Andy's leg, then focused her attention on the hallway where the next shift was waiting for report. With no time for Sue and I to prepare before report, I encouraged her to take a few moments to review the flow sheet and gather her thoughts. Sue gave report, reviewing Andy's history leading up to his admission and then proceeded to describe in detail the day's events.

She looked at me to see if she had forgotten any important details. I nodded my head indicating she had been very thorough, then I delighted in telling her what a great job she had done!



Award sponsor, Norman Knight doffs his hat to MGH nurses.

OR nurse uses 'hands-on' approach to conscious sedation

My name is Elizabeth Kelley, and in 23 years of OR nursing, I've found that the best way to care for patients undergoing surgery is with humor and hands-on care. By 'hands-on,' I don't mean applying what I've learned, I mean actually reaching out and touching patients—holding their hand until they go to sleep, comforting them when they're crying, or just letting them know they're not alone at a very difficult time. I'm there to watch over them; I'm there when they wake up; a familiar voice, a friendly face to help ease a scary or trying situation.

One interaction that stands out in my mind is 'Ken,' a 22-year-old plastic-surgery patient here at MGH. Ken was scheduled to undergo chin and bilateral cheek implant surgery under intravenous conscious sedation (IVCS). The purpose of conscious sedation is to minimally depress the patient's level of consciousness, but leave him with enough ability to independently maintain an open airway during the surgical procedure. Under conscious sedation, patients must be able to respond to verbal commands and physical stimulation appropriately.

Before administering conscious sedation, you must assess the patient's status to see if he's an appropriate candidate. There are five factors to consider:

- a baseline health evaluation including a brief history and physical; identification of any allergies, medications, and previous surgeries.
- a physical examination of the patient (height, weight, vital signs, pulse, oxygen saturation, airway status, and pre-operative level of consciousness).
- a risk assessment to determine the ASA class the patient falls into. Classes range from 1 (healthy) to 5 (critically ill). Conscious sedation is only appropriate for patients who fall into class 1, 2, or 3.
- the patient's NPO status (when he last had solid foods or liquids).
- informed consent for the surgical procedure, including conscious sedation, from the patient's doctor

Once you verify that a patient is a candidate for conscious sedation, you have to make sure he has a patent intravenous line through which to administer the medication. You must have the proper monitoring equipment for the procedure and ensure that all emergency

equipment is readily available and in working order (suction, reversal medications, emergency medications, intubation set-up, and Ambu bag).

Once all these steps are completed, and you have determined that the patient is an appropriate candidate, you may begin conscious sedation. I find administering conscious sedation to be a rewarding experience because it gives me the opportunity to interact with the patients on a different level. Throughout conscious sedation, I constantly assess the patient's needs, provide safe sedation, and act as an important support system at the bedside so the patient doesn't feel alone. I really enjoy my role as IVCS nurse in the operating room. It gives me a chance to relate to patients in a unique way and be an active participant in their care during surgery. Unlike patients under general anesthesia who are totally asleep, patients under conscious sedation are able to communicate during surgery. So I am able to assess their needs, comfort them, and help them through a stressful experience. Being present in this way helps patients feel like an active participant in their own surgery.

Ken was a healthy young man with no known allergies. He suf-

fered from a facial deformity caused by an abnormally small cheek and no cheekbones to speak of. He was a handsome boy. I introduced myself to him in the holding area of the Same Day Surgical Unit (SDSU). I reviewed his chart for the appropriate paperwork and explained what was going to happen next. I told him I would be his IVCS nurse. To help relieve some of his nervousness I kidded with him that I was his 'new best friend,' the lady who was going to make him comfortable during surgery. The lighthearted approach worked, and we both laughed. I told him what would happen, step by step, once we arrived in the OR. I described the monitoring equipment that would be needed for surgery and conscious sedation. I explained that for this type of surgery, his head would be at the opposite end of the OR table from where I would be, but I would be station-

ed at his feet for the whole operation. Then I asked him for his help during surgery. I asked him to signal me if he started to experience pain or needed more sedation. Together we worked out a system. He would move his toes up and down to let me know he needed more medication. Periodically throughout the surgery Ken would signal and I would respond either by administering more sedation or letting the surgeon know that Ken needed more local anesthesia. This method of signaling gives the patient a sense of control over his surroundings. I have found that most people are afraid of surgery because of the loss of control.

During the two-hour surgery, I touched Ken's feet or moved his ankles to maintain range of motion and let him know I was still there. The surgery went great. I knew Ken would be very happy with the results. We

continued on next page



Elizabeth Kelley, RN
Same Day Surgical Unit

STOP Task Force makes 'clean sweep' of hand hygiene

The Stop Transmission of Pathogens (STOP) Task Force invites you to take part in the first-ever 'Clean Sweep' sweepstakes, a contest to see which patient care units maintain the highest compliance with hand-hygiene requirements. Studies have shown that alcohol-based, disinfectant gels such as CalStat are more effective than soap and water in removing bacteria from hands, and are equally as effective as medicated soap products.

For the purposes of the Clean Sweep sweepstakes, patient care units



will be grouped into clusters. The same person who regularly monitors hand-hygiene practices on patient care units will issue a quarterly report ranking each unit's hand hygiene compliance. Based on the results, one unit from each cluster will be named sweepstakes winner, and those units will be awarded a

prize (prizes will change every quarter). The first quarterly prize will be a catered meal (breakfast, lunch or dinner) for the winning units.

This is an opportunity for patient care units to educate staff on the importance of good hand hygiene, win prizes, and have fun in the process.

Units will be clustered as follows:

Specialty Units

CCU, SICU, MICU, CSICU, PACU, Neuro ICU

Pediatrics-Gynecology
NICU, PICU, Ellison 17, Ellison 18, Bigelow 7

Exemplar

continued from page 6

took him to the recovery room. I said good-bye, telling him he looked great, and he thanked me for being there.

About a month later, the surgeon stopped me in the hall and asked if I remembered Ken, the boy with the facial implants. I said I did. He told me that Ken had come into the office the day before for his post-operative check-up. He said he looked wonderful and that his confidence was way up since the reconstructive surgery. Ken asked the surgeon to thank the nurse (he didn't

remember my name) who had rubbed his feet. He said it made a big difference during surgery, knowing someone was there who cared. It was a good feeling knowing that a patient thought I had helped him. In all my years of administering conscious sedation, I've found that establishing a signal with patients helps in a variety of ways. It helps me assess their status and allows me to ensure their utmost medical safety. It also helps provide emotional support and enhance the patient's comfort during the procedure. I do this by continuously monitoring and documenting the patient's response to

the sedation/analgesia. This helps us recognize, make adjustments to, and treat possible adverse reactions or problems as quickly as possible.

Conscious sedation is especially beneficial for plastic surgery cases because it helps patients recover faster and with fewer side effects than general anesthesia, which can cause nausea and vomiting.

Teamwork is also a big part of providing comfort and ensuring patient safety. Effective communication between the surgeon, the circulating nurse, the conscious sedation nurse, and the patient makes for a safe, comfortable, pain free

Medicine

Ellison 10, Ellison 11, Ellison 14, Bigelow 9

Medicine

Ellison 16, White 10, Phillips 20 & 21

Medicine

White 8, White 9, White 11, Bigelow 10 Bigelow 11

Ortho/Neuro

Ellison 6, Ellison 12, White 6, White 12

Surgery

Ellison 7, Ellison 8, Ellison 19, Bigelow 6

Surgery

White 7, Bigelow 13, Bigelow 14, Phillips 22

For information about the Clean Sweep sweepstakes, contact Rosemary O'Malley at 6-9663, Victoria Brady at 4-6433 or Christine Johanson at 6-0275.

The Employee Assistance Program

Work-Life Lunchtime Seminar Series presents

"Nourishing your Newborn"

Presented by Germaine Lambergs, RN

Session is geared toward expectant parents, new parents, or employees considering having children. Will include a tour of the Mother's Corner at MGH.

Tuesday, March 23, 2004

12:00-1:00pm

VBK 401

For information, contact the EAP at 726-6976.

surgical experience.

I mentioned earlier that a sense of humor is key to providing good patient care in the SDSU. Whenever I administer conscious sedation for the surgeon who operated on Ken, he tells patients that I'll be touching their feet. He kiddingly tells them he thinks I have a 'thing for feet.' Everyone has a good laugh and it gets the procedure off to a good start. It puts patients at ease as they embark on what can be the scariest experience of their lives.

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

Conscious sedation requires constant, close monitoring of the patient and in-depth knowledge of the surgical procedure being performed. Elizabeth exhibited both with ease as she cared for Ken in the high-tech, fast-paced environment of the SDSU. She used humor and creativity to put Ken at ease before and during surgery. She met his clinical needs, remained technically vigilant at the bedside, all the while comforting Ken and ensuring a pain-free surgical experience.

Ken may not have remembered Elizabeth's name, but he remembered the excellent care she provided. Thank-you, Elizabeth.

Annual collaborative governance celebration dinner

—by Trish Gibbons, RN, associate chief nurse
The Center for Clinical & Professional Development



More than 150 clinicians, support staff, and managers came together for this year's annual collaborative governance celebration dinner on Thursday, February 5, 2004, at the Holiday Inn. Laughter, music, collegiality, and pride in the work of our committee structure were

the order of the evening. Jeanette Ives Erickson, RN, senior vice president for Patient Care, opened the program by alerting attendees that they were in for a surprise. But as it turned out, the surprise was on Ives Erickson and three of her colleagues, as committee members

usurped the agenda and proceeded to honor the leadership team behind collaborative governance, including, Ives Erickson; Marianne Ditomassi, RN; Trish Gibbons, RN; and Dottie Jones, RN. In a surprise tribute, Marilyn Wise, LICSW; Sharon Brackett, RN; Kathleen Grinke, RN; and Lynda

Tyer-Viola, RN, each took the podium on behalf of everyone present, to pay tribute to the four individuals who, each in her own way, has had an important impact on collaborative governance. Ives Erickson was recognized for her visionary leadership in giving clinicians a strong voice in formal decision-making. Ditomassi was recognized for her strong advocacy and guidance in creating the committee structure. Gibbons and Jones were recognized for their leadership and contributions to the continued development of the program.

In keeping with tradition, the Diversity Committee, now known for its 'creative' contributions to this annual event, performed an original (if not unique) 'limer-rap,' a

musical blending of traditional Irish limericks with contemporary, African-based rap music. Sample verse:

So hooray for the Diversity Committee
And our good work in the hospital and out in the city
If respect is your aim
Then, come join our game
The team that gets down to the real nitty-gritty

A trivia quiz, complete with prizes, lent a fun and competitive spirit to the evening, as each table worked collectively to answer questions such as:

The Four Point Plan was:

- a) an intricate sewing stitch used to hem nurses' uniforms in 1898
 - b) a strategic plan developed in 1996 to insti-
- continued on page 10*



At left: committee members stand to be recognized as Ives Erickson acknowledges their accomplishments over the past year. Above: staff nurse, Ivonny Niles, RN, leads the Diversity Committee in an original 'limer-rap,' a combination of traditional Irish limerick and contemporary, African-based rap music.

National Patient Safety Awareness Week

March 7–13, 2004

Look for posters and banners throughout the hospital spotlighting the Five Steps to Safer Health Care

- Step 1:** Ask questions if you have any doubts or concerns. Make sure you understand the answers. Choose a doctor you feel comfortable talking to. Take a relative or friend with you to help ask questions and process the answers.
- Step 2:** Keep a list of all the medicines you take and bring it with you to your medical appointments and to the pharmacy. Give your doctor and pharmacist a list of all the medicines you take, including non-prescription medicines. Mention any drug allergies you have. Ask about side-effects and what to avoid while taking the medicine. Read the label when you get your medicine, including all warnings. Make sure your medicine is what your doctor ordered and that you know how to use it. Ask the pharmacist about your medicine if it appears different than you expected.
- Step 3:** Get the results of any tests or procedures. Ask when and how you will be notified of test results. Don't assume the results are fine if you're not notified when you expected to be (by phone, mail, or in person). Call your doctor and ask for your results. Ask what the results mean in terms of your future care.
- Step 4:** Talk to your doctor about which hospital is best for your health needs. Ask your doctor which hospital has the best care and outcomes for patients with your condition (if you have more than one hospital to choose from). Be sure you understand the instructions you get about follow-up care when you leave the hospital.
- Step 5:** Make sure you understand what will happen if you need surgery. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation. Ask your doctor, "Who will be managing my care while I am in the hospital?" Ask your surgeon, "Exactly what are you going to do? How long will it take? What will happen after surgery? How can I expect to feel during recovery?" Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

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and chief nurse

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and LVC Retail Services
Pat Rowell

Distribution

Please contact Ursula Hoehl at 726-9057 for all issues related to distribution

Submission of Articles

Written contributions should be submitted directly to Susan Sabia **as far in advance as possible**. *Caring Headlines* cannot guarantee the inclusion of any article.

Articles/ideas should be submitted in writing by fax: 617-726-8594 or e-mail: ssabia@partners.org
For more information, call: 617-724-1746.

Next Publication Date:

March 18, 2004



MGH nurses receive NERBNA's Excellence in Nursing Award



Ines Jackson-Williams, RN
staff nurse, Same Day Surgical Unit



Linda Redd, RN, staff nurse,
ED and Acute Psychiatry Service

Every February, the New England Regional Black Nurses Association (NERBNA) celebrates National Black Nurses Day with the presentation of their Excellence in Nursing Awards. This year, the event was held on February 12, 2004, at the Sonesta Hotel in Cambridge, and two MGH nurses were honored. Ines Jackson-Williams, RN, staff nurse in the Same Day Surgical Unit, and Linda Redd, RN, staff nurse in the Emergency Department and the Acute Psychiatry Service, were among the six nurses recognized.

Redd was nominated by ED nurse manager, MaryFran Hughes, RN, who wrote, "I have the great joy of being Linda's nurse manager. She is an experienced nurse who brings a comprehensive

set of clinical skills to each patient's bedside. Linda's enthusiasm and commitment make her a valued member of our team. Her clinical knowledge, strong interpersonal skills, compassion, collaboration, and willingness to get involved make her a perfect candidate for this award."

Jackson-Williams was nominated by nurse manager, Janet Dauphinee Quigley, RN, who wrote, "As a staff nurse in the SDSU, Ines cares for patients of all ages. She draws on a wealth of clinical experience and

uses it to guide her interventions. She incorporates a deep respect for cultural diversity to further individualize her care. Ines consistently demonstrates professionalism and a caring approach to patients and their families. She is an excellent listener. She receives numerous positive comments from patients and families. Staff members often request that Ines be the nurse who cares for them or their loved ones when having procedures in the SDSU. This is the ultimate compliment!"

Colorectal Cancer Awareness Day

Take a moment to learn about early detection
and prevention of colorectal cancer

Wednesday, March 24, 2004
10:00am-2:00pm
Main Corridor

For more information, call 617-724-9432

Collaborative Governance

continued from page 8

tute a professional practice model at MGH
c) a detailed map that guides hikers through the four corner states

Collaborative governance was introduced to:

- a) improve communication
- b) give clinicians authority, responsibility, and accountability
- c) foster decision-making from an interdisciplinary perspective
- d) promote empowerment of clinicians
- e) all of the above

This year's collaborative governance celebration dinner broke the record for number of people in attendance. Such is the power of the MGH community when it comes together in recognition of hard work, important accomplishments, and unprecedented teamwork.

As collaborative governance enters its seventh year, committees are focusing their attention on the goals identified for 2004. Once again committee members will work with staff from all units and departments to: "stimulate, facilitate, and generate knowledge to improve patient care and enhance the environment in which clinicians shape their practice." (Collaborative governance mission statement, 2001)

For more information about collaborative governance and the accomplishments of individual committees, pick up a copy of the 2003 Collaborative Governance Annual Report, available in The Center for Clinical & Professional Development on Founders 6.

The Employee Assistance Program

Work-Life Lunchtime Seminar Series

presents

"Anger Management"

Presented by Thilo Deckersbach, PhD

Anger plays a significant role in everyday life. Sometimes it is short-lived. Other times it can be persistent, severe, and highly disruptive.

Anger can lead to conflict, verbal and physical assault, property destruction, and occupational maladjustment. This seminar focuses on the diagnosis and treatment of anger problems.

Thursday, March 18, 2004
12:00-1:00pm
Wellman Conference Room

For more information, call 726-6976.

Educational Offerings

March 4, 2004

When/Where	Description	Contact Hours
March 16 8:00am–4:00pm	Intermediate Respiratory Care Respiratory Care Conference Room, Ellison 401	TBA
March 17 1:30–2:30pm	USA Educational Series Bigelow 4 Amphitheater	---
March 17 4:00–5:30pm	Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements Clinics 262	1.8
March 18 1:00–2:30pm	The Joint Commission Satellite Network presents: “Sentinel Event Identification and Follow-Up: Essentials of Developing Credible and Thorough Root Cause Analysis.” Haber Conference Room	---
March 19 10:00am–4:00pm	A Safer Start: Empowering Pregnant Women Living with Domestic Violence Wellman Conference Room	TBA
March 22 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
March 23 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
March 24 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
March 25 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
March 25 1:30–2:30pm	Nursing Grand Rounds “Celebrating Emergency Nursing.” O’Keeffe Auditorium	1.2
March 25 8:00am–4:30pm	Preceptor Development: Learning to Teach, Teaching to Learn Training Department, Charles River Plaza	7
March 25 7:30–11:30am; or 12:30–4:30pm	Congenital Heart Disease Haber Conference Room	4.5
March 26 8:00am–4:30pm	Substance Abuse and Withdrawal in the Acute Care Setting O’Keeffe Auditorium	TBA
March 29 and 30 8:00am–4:30pm	BLS Instructor Program VBK601	---
April 1 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
April 2 8:00am–4:30pm	Nursing: a Clinical Update—MGH School of Nursing Alumni Program O’Keeffe Auditorium	TBA
April 8 8:00am–4:30pm	Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other Training Department, Charles River Plaza	7.2
April 12 8:00am–4:30pm	Diversity in Childbearing O’Keeffe Auditorium	7.8
April 13 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
February 12 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)

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>.

What we can learn from the Norman Knight Preceptor of Distinction Award

In a departure from our usual Fielding the Issues format, in this issue of *Caring Headlines*, Jeanette Ives Erickson, RN, senior vice president for Patient Care, asks the questions instead of answering them. Answers are provided by the nominees of the first annual Norman Knight Preceptor of Distinction Award (Jennifer Albert, RN [award recipient]; Lisa Bouvier, RN; Lynda Brandt, RN; Ann Eastman, RN; Marites Escano, RN; Kelley Grealish, RN; Gayle Peterson, RN; Christine Swanson, RN; Katherine Swigar, RN; and Lisa Townsend, RN).

Question: What is the role of a preceptor?

Answer: A preceptor is a mentor, a role model, an advisor, a facilitator, and a colleague to the person being precepted. Preceptors need to be caring, patient, empathetic, as well as open and communicative. Although precepting typically involves a lot of coaching on the part of the preceptor, it's critical that precepting be a partnership with a two-way flow of ideas.

Question: Does precepting have an impact on your growth and development as a clinician?

Answer: Precepting encourages clinicians to reflect on their practice, recognize their own limitations, seek resources when needed, and contributes to personal and professional growth and learning.

Question: How does precepting benefit the next generation of clinicians?

Answer: As a preceptor, you can have a positive influence on the practice of new clinicians. You can share your skill and knowledge with someone who's eager to learn. And you can assist novice clinicians to transition successfully into professional roles.

Question: What is the greatest challenge to being a preceptor?

Answer: One of the biggest challenges is teaching new clinicians to cope with emotionally

challenging situations. It's easy to become overwhelmed by the enormity of the needs of some of our patients. Perhaps the best way to do this is to role-model your own practice to new clinicians, acknowledge that we all struggle with complex medical and emotional issues, share strategies that have worked in the past, and always evaluate each patient's needs individually.

Question: How does a clinician know if he or she is ready to be a preceptor?

Answer: I think a person is ready to precept if he or she has a passion for the work, a commitment to excellence in clinical practice, respect for the precepting experience, and a commitment to the ongoing growth and development of individual clinicians.

If you have all that and an interest in becoming a preceptor, you should talk with your manager or supervisor about whether precepting is right for you.

Educational Offerings and Event Calendar now available on-line

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

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

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

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