

Caring

HEADLINES

November 18, 2004

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Chaplaincy celebrates Pastoral Care Week, welcomes new director

—by Marianne Ditomassi, RN, interim administrator, Chaplaincy

Patient care is by its very nature, spiritual. Although spiritual care may differ from hospital to hospital, being sensitive to the traditions, culture, religion, and spiritual practices of everyone under our care and in our employ

is a high priority at MGH. Spiritual care can be religion-based or, as in the case of individuals with no religious affiliation, draw on any deep belief that has profound meaning in a person's life. Spirit-

ual care is offered when individuals are in crisis or simply feel a need for an expression of hope, trust, love, forgiveness, or would like to participate in a particular religious ritual. Using this framework of 'meaning,' chaplains

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Buddhist chaplain, Suzanne Hudson, shares one of her special hobbies, Origami, with a young visitor to Chaplaincy's Pastoral Care Week booth in the Main Corridor

MGH Patient Care Services

Working together to shape the future

It's a great time to be a Red Sox fan; it's great time to be a nurse

On Saturday, October 30, 2004, while thousands of other New Englanders lined the streets of Boston to see the Red Sox world series victory parade, 160 dedicated student nurses from across the state gathered at MGH for the Massachusetts Student Nurses Association (MaSNA) annual convention. Sponsored by MGH, the day-long event was an opportunity for future nurses to network with peers, hear presentations by some of the country's premier nursing leaders, and gain insight into the challenges and rewards of a nursing career. Panel discussions, break-out sessions, tours of the hospital, and a recruitment/exhibit hall gave attendees a broad overview of the nursing profession and a glimpse into specific positions available within various specialties.

Barbara Blakeney, RN, president of the American Nurses Association, spoke about a wide range of subjects from the importance of partnerships, to the power of community, to the essence of the nursing profession and the need to preserve the important work that we do. A passionate advocate, Blakeney stressed the need to advance nursing through

individual clinical practice, research, and participation in professional nursing associations.

Among the more than 30 presenters were MGH clinicians, Susan Wood, RN, clinical nurse specialist, and Lynne Chevoya, NP, nurse practitioner, who participated in a panel discussion on Nursing Pathways.

Throughout the day, student nurses had an opportunity to tour the Medical, Surgical, Burn, and Psychiatric units and ask questions of staff in each area. It was evident that attendees were eager to get an up-close look at nursing practice at MGH.

Given that the Red Sox victory parade was going right by MGH, I chose to focus my remarks on current events: "What do nurses and the Boston Red Sox have in common?"

When you think of Johnny Damon, you think of a player who's steady and reliable. He's there when you need him; he comes through in the clutch. In today's dynamic healthcare environment, nurses play a key role in coordinating the work of the interdisciplinary team. Everything must work in concert to set the right balance. Nurses are the backbone of the healthcare system.

When you think of Orlando Cabrera, the word 'agile' comes to mind. Throughout the 2004 season, in the play-offs and world series, Cabrera navigated the infield making unfathomable plays. I'm often quoted as saying that nursing is not for the faint of heart. Nursing requires constant practice and close attention to quickly changing situations. Nurses need to listen, be present, and modify plans to meet the individual needs of each patient.

Manny Ramirez is focused and driven. When Manny Ramirez comes to the plate, he is 100% focused on the task at hand—hitting the ball. In the field, he's equally focused. And on those rare occasions when he makes an error, his teammates know it's not for lack of trying; it's not for lack of commitment. There is no blame among teammates at this level. In a hospital setting, patient safety is paramount. To ensure that every clinician can function at his/her highest level, we must create a blame-free culture. Clinicians must feel supported in their practice—when things go well and when they don't.

David Ortiz represents power. Experienced nurses are well aware



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

of the power of the nurse-patient relationship.

Jason Varitek is the unmistakable leader of the Red Sox. From his key position behind home plate, he is the heart and soul of the team. Nurses play a pivotal role at the bedside. Strong leadership, collaboration, and composure are key to success.

Kevin Millar is the Red Sox cheerleader. He knows the importance of positive thinking; he appreciates the rewards of his profession. Nurs-

ing is a noble profession. It's up to us to promote the image and practice of nursing to the next generation.

Trot Nixon is the embodiment of perseverance. He overcame a serious back injury and worked tirelessly to regain his strength and mobility so he could contribute to the team's ultimate success. Nurses are constantly identifying ways to raise the bar on care delivery, looking for opportunities to in-

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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) or
Catherine Griffith, RN, (cgriffith@partners.org)
or visit:

www.mghnursingresearchcommittee.org

On the importance of clinical narratives

Question: What are clinical narratives?

Jeanette: Clinical narratives are detailed descriptions of a patient-care situation that include the clinician's thoughts, intentions, and actions. Narratives can be written about:

- a situation where an intervention made a difference in a patient's outcome, either directly or indirectly
- an intervention that went unusually well
- a situation where events may not have gone as planned
- a typical or ordinary situation
- a situation in which you learned something that changed your practice

Question: Why are we shifting from the term, 'exemplar' to 'clinical narrative'?

Jeanette: When Patricia Benner, RN, published her seminal work, *From Novice to Expert*, in 1984, she was able to discover how knowledge is embedded in practice by asking nurses to share stories of their practice. She called these stories exemplars. Over time, the term exemplar has changed to clinical narrative because it better reflects the story-telling aspect of this written account of events. It also takes the pressure off clinicians who may think an exemplar has to be about a commendable or 'exemplary' situation.

Question: Why are narratives important?

Jeanette: Clinical knowledge is embedded in practice. It is developed over time, embodied by clinicians, and evoked in clinical situations. As clinicians share narratives about particular patient-care situations, their knowledge and practice become visible. Clinical narratives provide an opportunity to reflect on practice. With this reflection comes an opportunity to identify areas of strength and areas that need further development, enhancing overall practice.

Question: Narratives published in *Caring Headlines* seem so dramatic. Those situations

don't reflect my practice. What if what I choose to write about isn't interesting to the reader?

Jeanette: Insight into practice is always interesting. Write about what you do; your care of patients and families; the knowledge you bring to the bedside; how you work with the rest of the healthcare team to provide the best possible care to your patients. Every day clinicians at MGH make a difference in the lives of patients and families. They allay fears, they help patients regain mobility and independence, they teach patients how to care for themselves at home. It may not *sound* exciting, but every clinician brings something unique and special to patient care. Very often, the ordinary really *is* extraordinary. And we all learn from

listening to the stories of our colleagues.

Question: The narratives in *Caring Headlines* are so tight and well-written. I'm afraid my writing wouldn't measure up.

Jeanette: *Caring Headlines* is read by MGH employees, patients, families, visitors, members of the community, and others all over the country. Because of this diverse readership, narratives that appear in *Caring Headlines* are edited for grammar, content, and style to ensure they can be understood by clinicians and non-clinicians alike. While narratives are first-person accounts of a clinician's thoughts, intentions, and actions, they are edited to be suitable for a broad audience.

For more information on writing clinical narratives, contact Mary Ellen Smith, RN, at 4-5801.

Jeanette Ives Erickson

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fuse new and innovative thinking into our practice.

When you think of Bill Mueller, you think of quiet strength and determination. Mueller consistently and effectively keeps all his options open to ensure he can make the best possible play in the heat of the moment. In nursing, there can be many options when working toward a positive patient outcome. Gathering information, working with

other members of the team, weighing options, and making informed decisions in a timely manner is key to determining the most appropriate plan of care for every patient.

Many fans wondered why coach, Terry Francona, kept Mark Belhorn in the line-up. Coach Francona saw in Belhorn a potential that many others didn't see—he believed in Belhorn and helped position him for success. I cannot under-

score strongly enough the importance of having a mentor to guide you in your career, a person who can help you to see and realize your potential.

We could spend hours talking about the Red Sox pitching staff. Pedro Martinez, Derek Lowe, Keith Foulke, Tim Wakefield, Mike Timlin, Curt Shilling, and Bronson Arroyo, to name a few. They were the 'fortress' of the Red Sox team, one cohesive group whose diverse arsenal of skills complemented one another. And because of that, Coach Francona

was able to match their strengths to the needs of the team at any given time.

I reminded the audience of student nurses to keep that concept of 'a fortress' in mind when they begin to look for employment. Wherever they choose to work, they want to see a strong infrastructure in place to support their professional practice. They want to see:

- strong leadership
- evidence that nursing is valued and understood
- opportunities for professional development

- evidence that nursing has a strong voice in clinical decision-making
- the right tools, equipment, and resources available to support practice

It's a wonderful time to be a Red Sox fan, and it's a wonderful time to be a nurse. As you can see, in both cases, all members of the team make key contributions to the success of the organization.

I'd like to thank all MGH employees who helped make the MaSNA annual conference the great success that it was.

MGH celebrates Respiratory Care Week

—by Ed Burns, RRT, quality improvement coordinator
Respiratory Care Services

Respiratory Care Week is an opportunity to honor and celebrate the contributions of respiratory care professionals and to take pride in the profession and the individual accomplishments of respiratory therapists at MGH and around the world. It's also an excellent time to educate the public, recruit new staff, and promote good lung health in the community. Respiratory care professionals work to ensure the lung health of all Americans through advocacy, public education, and research.

Respiratory Care Week always falls in the last full week of October. In 2003, the Wednesday of Respiratory Care Week officially became known as Lung Health Day in an effort to bring lung-health awareness to the public, to medical professionals, and to consumers around the world. This year, Respiratory Care Week was observed from October 24–30th. Many hospitals, schools, and other institutions held open houses, sponsored special activities, performed community events, and acknowledged the year-round efforts of respiratory therapists.

Although it had been an annual event locally and regionally for many years, Respiratory Care Week became an official national event in 1982 when executives and officers of the American Association for Respiratory Care (AARC) visited the White House seeking an official proclamation to recognize Respiratory Care Week as a national observance. Then-President Ronald Reagan granted the request, marking an historic event for the AARC. Today, Respiratory Care Week is observed in all 50 states in the US and beyond.

The MGH department of Respiratory Care cele-

brated Respiratory Care Week, on October 27th with display tables in the Main Corridor. Staff, visitors, and patients were given information on lung health and respiratory care and had an opportunity to take a free pulmonary-function screening test.

About respiratory care and respiratory therapists

Most people take breathing for granted. It's second nature, an involuntary reflex. Yet millions of Americans suffer from breathing problems. For them, every breath is a major accomplishment. These people rely on respiratory therapists and

the profession of Respiratory Care to improve their breathing and make a significant difference in their lives.

What is respiratory care?

Respiratory care is a life-supporting, life-enhancing, healthcare profession practiced under qualified medical direction. It promotes optimal cardiopulmonary function and health, and uses scientific principles to identify and treat acute or chronic dysfunction of the cardiopulmonary system.

Who needs respiratory care?

People who have chronic lung problems such as asthma, bronchitis, and emphysema may need respiratory care. People who've had heart attacks, been involved in accidents, or were born prematurely may need res-

piratory care. People with cystic fibrosis, lung cancer, other types of cancer, or AIDS may need the special services provided by respiratory therapists in order to breathe easier. People of all ages need respiratory care to keep their lungs healthy.

Who are respiratory therapists?

Respiratory therapists are important members of the healthcare team, working in hospitals, skilled nursing facilities, emergency and urgent transport centers, physician's offices, specialized care hospitals, home health agencies, medical equipment supply companies, and in patients' homes. There are more than 110,000 respiratory therapists practicing in the US.

Most respiratory therapists work in hospitals providing intensive care, critical care, and performing crucial neonatal procedures. Respiratory therapists are typically part of the life-saving response team for patient emergencies. Of the more than 7,000 hospitals in this country, approximately 5,700 have Respiratory Care departments.

Respiratory therapists are uniquely trained to treat conditions of the cardiopulmonary system. The minimum requirement to become a respiratory therapist is an associate's degree from an

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Respiratory therapist, Neila Altobelli, RRT, offers pulmonary-function screening test to visitor during Respiratory Care Week

Respiratory Care Week

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accredited respiratory care program. Many respiratory therapists have a four-year (or higher) degree from an accredited program. Once they graduate, respiratory therapists are required in many states to earn continuing education credits to meet state licensure requirements.

Respiratory therapists sit for the Registered Respiratory Therapist (RRT) credentialing exam. The National Board for Respiratory Care bestows RRT credentials on those who successfully complete the rigorous examination.

The professional association for respiratory therapists is the American Association for Respiratory Care (AARC).

Respiratory therapists perform both diagnostic and therapeutic procedures, including:

Diagnostic

- obtaining and analyzing sputum and breath specimens
- taking blood specimens and analyzing them to determine levels of oxygen, carbon dioxide, and other gases
- interpreting data obtained from these specimens
- measuring the capacity of patients' lungs to determine if there is impaired function
- performing stress tests and other studies of the cardiopulmonary system
- studying disruptive sleep-pattern disorders

Therapeutic

- operating and maintaining highly sophisticated equipment to administer oxygen or assist with breathing
- using mechanical ventilation for treating patients who can't breathe adequately on their own
- monitoring and managing therapy to help patients recover lung function
- administering medications in aerosol form to help alleviate breathing problems and prevent respiratory infections
- monitoring equipment and patient responses to therapy
- conducting rehabilitation activities such as low-impact aerobic exercise classes to help patients who suffer from chronic lung problems

- maintaining artificial airways that may be in place to help patients who can't breathe by normal means
- conducting smoking-cessation programs for patients and others in the community who want to kick the tobacco habit.

At this time of year we honor and celebrate the contributions of all MGH respiratory care professionals. The MGH Respiratory Care Department, under the direction of Robert Kacmarek, RRT, is world-renowned in the field of respiratory

care. Since its inception more than 50 years ago, the department has continually set the standard for excellence in the profession. The department provides the highest quality care while supporting and participating in clinical research and education. Says Kacmarek, "I'm extremely proud of our staff. Their dedication and hard work is evident to me and all other members of the healthcare team. MGH is fortunate to have such highly skilled and educated specialists. They are the best."

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.

Who's Driving Your Bus?

Are you in the fast lane but not enjoying the ride? This seminar will help you feel more positive and less stressed by taking charge of your career and your life. Humorous insights and practical ideas will inspire you to find balance in caring for yourself and others.

November 18, 2004

12:00-1:00pm

Wellman Conference Room

Speaker: Suzanne O'Connor, RN, psychiatric clinical nurse specialist

Sponsored by the Employee Assistance Program (726-6976)

Feel free to bring your lunch
Nursing CEUs available



Respiratory therapist, Pamela Brown Early, RRT, staffs educational booth in the Main Corridor

Photos provided by Respiratory Care



Reverend Marcia Marino
new director of the MGH Chaplaincy

Chaplaincy

continued from front cover

work with patients, families, and staff to help them identify and draw on their own spiritual strengths. Chaplains offer support through non-judgmental listening, sharing, and providing sacraments, scripture, and religious rites, as appropriate.

Spiritual care is provided in collaboration with the multi-disciplinary team. Chaplains are often called upon to offer spiritual care to staff members dealing with highly emotional patient-care situations or personal life events. MGH chaplains are available to provide emergency and referral-based spiritual care to patients, families, and staff 24 hours a day, 7 days a week. Requests for chaplaincy services frequently come at times of spiritual distress, when difficult diagnoses are delivered, when making decisions about curative versus palliative care, and as part of end-of-life care.

The Chaplaincy provides training and supervision in spiritual caregiving to volunteers, students, clinicians, and staff chaplains. Recently, the Chaplaincy began offering a first-of-

its-kind Spiritual Care Fellowship for Health Care Providers.

On October 13, 2004, in celebration of Pastoral Care Week, MGH chaplains staffed an educational booth in the Main Corridor showcasing a variety of spiritual and religious information. Musical storytellers and political satirists, Charlie King and Karen Brandow, sang a number of hope-inspired songs. On October 14th, patients, families, staff, visitors, and volunteers were invited to "the Blessing of the Hands," an annual affirmation and show of appreciation for the many things our hands do to provide comfort and care.

The MGH Chaplaincy is currently undergoing a transition. In late 2003, Reverend Mary Martha Thiel stepped down as director to devote her energies to pastoral education. Reverend Priscilla Denham provided interim leadership for the Chaplaincy team, and on December 13, 2004, Reverend Marcia Marino will assume the role of director for the Chaplaincy. Marino comes to Boston from Milwaukee, Wisconsin, where she was the metro region director of Pastoral Care for the Aurora Health Care System.

Welcome, Reverend Marino.



Anneca Philippakis
interfaith chaplain

"As MGH chaplains, we have much to offer. When I walk into a patient's room, I bring my Greek Orthodox theological training, life's experience, God's blessings, and the wisdom and experience of my co-workers and peers at MGH."



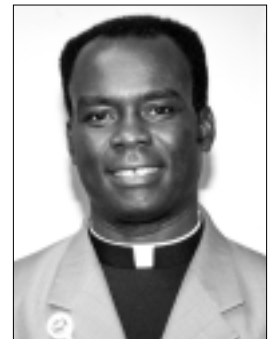
Imam Talal Eid
Muslim chaplain

"It has been a pleasure being a member of this team for more than seven years. Though we are of different faiths we work together in harmony. I wish the troubled world could learn from our experience here at MGH."



Katrina Scott
interfaith chaplain

"I hope the Chaplaincy continues to offer compassionate care, listening skills, and the resources needed to bridge the gap between evidence-based science and the personal experience of each patient."



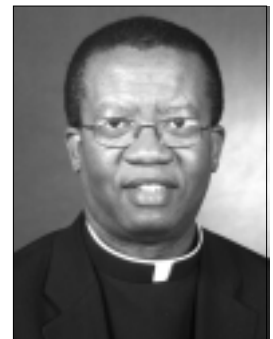
Father Paul Ogoke
Roman Catholic chaplain

"It's an honor to be part of this team providing spiritual care to our patients, families, and staff."



Nancy Raines
interfaith chaplain

"The MGH Chaplaincy is a very caring and thoughtful group of individuals. I hope to establish a special ministry for Spanish-speaking patients and families, and I'd like to get involved with research on the efficacy of prayer and other spiritual healing modalities."



Father Gabriel Michel
Roman Catholic priest

"As members of the Chaplaincy team, I feel like we are instruments of faith, healing, and hope for the community. I look forward to working with my colleagues, continuing to provide pastoral care to our patients and their families."



Father Felix Ojimba
Roman Catholic chaplain

"I feel privileged to work with this team of professionals representing the major religious, racial, and ethnic backgrounds. I'm proud of the way we embrace every opportunity to serve our culturally diverse patient population."



Father Celestino Pascual
Roman Catholic chaplain

"Being an MGH chaplain is like being part of a big healing, human, fun, supportive, diverse family! We are an integral part of the inter-disciplinary care team."



Reverend Linda Knight
interfaith chaplain

"Whether I'm visiting patients, dialoguing with colleagues, or doing administrative work, I always remember that I'm part of a 'higher team.' Then I have to take off my clogs, realizing the place where I'm standing is Holy Ground."



Karen Schmidt
oncology chaplain

"We are a diverse group of committed chaplains from various faith traditions holding different world views, yet we all share a common goal—to support and care for one another, our patients, their families, and the staff of MGH."



Mike McElhinny
oncology chaplain

"Being an MGH chaplain is like being part of a compassionate fellowship. I always know that wherever I am, whatever I'm doing, I'm not alone. I look forward to sharing our interfaith vision with the whole MGH community."



Edward Todd
Buddhist chaplain

"It's a great privilege to be part of the Chaplaincy team. We feel like we've been welcomed into a big family where every day we have an opportunity to learn something new. We live in an increasingly multi-cultural community. As MGH chaplains, we're in a position to help the hospital respond to the needs of an increasingly diverse patient population."



Suzanne Hudson
Buddhist chaplain



Reverend Ann Haywood
pediatric chaplain

"As a chaplain, I have opportunities to be with people at all points in their life journey. I'm thankful for the profound insight I've gained from the people I serve in ministry. I'm fortunate to have colleagues whose varied perspectives enhance my ability to serve the MGH community."



Sister Joanne Lappetito
Roman Catholic coordinator

"It is so rewarding to be a member of a team that strives to lighten the burden and bring spiritual comfort to patients and their families. It's also a lot of fun to spend time with my colleagues who enjoy life and are so full of good humor."



Rabbi Ben Lanckton
Jewish chaplain

"No two days are alike. Every patient's story is unique. I'm inspired by my colleagues whose support I feel every time I enter a patient's room. I'm buoyed by their ability to meet the challenges we face with both deep emotion and good humor."



Gina Murray
administrative coordinator

"It's an honor and a privilege to work with this incredibly dedicated staff who provide pastoral care to patients, families, and staff. In spite of the intense work we do, we manage to find time to laugh and have fun."

Staff not pictured are:

Father Alfred Dorvil
Roman Catholic chaplain

Father Ron Golini
Roman Catholic chaplain

Duane MacLennan
department secretary

Deacon Daphne Noyes
interfaith chaplain

Father Martin Okwir
Roman Catholic priest

Joyce Spataro
department secretary

Physical therapist employs creative strategies to ensure best possible outcomes

My name is Jennifer Podesky, and I have been a physical therapist for ten years, the past three at MGH as an inpatient therapist working primarily with patients admitted to the neuroscience units. After working for many years at a rehabilitation hospital whose patient population was largely homogeneous, the first thing I noticed about MGH was the great diversity among patients I was treating. Learning new things about other cultures is an aspect of my job I really enjoy. On the other hand, patients who speak little or no English pose a special challenge to the healthcare team. Imagine how frightening it must be for a person to be the sickest she's ever been; potentially confused due to her neurological diagnosis; and unable to understand what I'm saying or communicate her needs to me. It's difficult to obtain information or provide the patient with my best efforts when there is a language barrier. Working with a medical interpreter is essential, not only in obtaining necessary information, but in connecting with patients and families, establishing trust and rapport.

Never has collaboration been so rewarding as it was with Mr. B and

his family. Mr. B is a 38-year-old man who was admitted to the Neuroscience ICU after sustaining a traumatic brain injury due to an assault. He required an emergent craniectomy to evacuate an epidural hematoma in the posterior aspect of his brain as well as intervention to reduce a facial fracture. In addition to the posterior hematoma, Mr. B also sustained contusions to both frontal lobes and focal hemorrhages within the deeper structures of his brain. Information in his medical record indicated that Mr. B was from Brazil originally and had only been in the US for a few months. He spoke no English and was staying with family in the Boston area.

Before even meeting Mr. B, my review of his medical record revealed that he had sustained a very serious brain injury. I knew from the literature that his prognosis for a full recovery was guarded given the fact that he had sustained bilateral frontal lobe injuries as well as a diffuse axonal injury. Given the lesion locations and type of injuries he sustained, I was expecting a slower recovery in terms of arousal response and likely significant impairments related to initiation and control of movement—all essential for

recovering function. Mr. B had demonstrated little change on his Glasgow Coma Scale score since being admitted, another poor prognostic indicator.

Over time, Mr. B required a tracheostomy and placement of a gastrostomy tube to sustain his ventilation and nutrition, and he was experiencing frequent seizure activity and high temperatures. I noted that he was requiring substantial anti-epileptics to control the seizure activity and added this to my list of potential factors that could impact his arousal response.

When I first met Mr. B, he was in the Neuroscience ICU. My initial examination revealed that he was in a minimally conscious state. He was opening his eyes spontaneously, but with no signs of awareness to his self or his environment. He demonstrated no spontaneous movement of his extremities, however he had reflexive movement of both arms and legs to noxious stimuli. His extremities were hypotonic, the opposite of the classic spasticity that we think of with a stereotypical traumatic brain-injured patient.

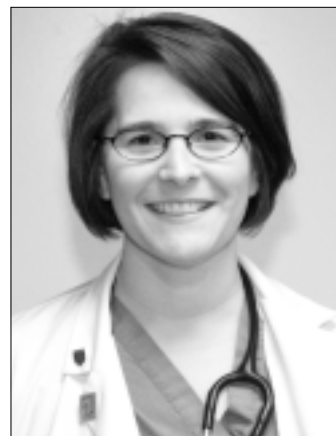
Mr. B had weaned from the ventilator quite easily and was maintaining

good ventilation and gas exchange with supplemental oxygen via a humidified trach mask. Given these findings, my initial focus of physical therapy was to maintain range of motion in his arms, legs, and neck, and protect his joints from damage due to a lack of muscular support as a result of decreased muscle tone. I collaborated with nurses and other caregivers about positioning options to prevent skin breakdown. The location of his posterior craniectomy made positioning his head challenging. I was able to obtain a gel positioning pad from the clinical nurse specialist to assure pressure was avoided on the back of his head, and I incorporated cervical range of motion into my treatment. I routinely assessed Mr. B's arousal response during my physical therapy sessions to determine any changes. Mr. B's seizures were becoming less frequent and over the course of the next week, he demon-

strated signs of improved arousal response. He would open his eyes more frequently and began to vocalize and grimace with passive range of motion.

Knowing that Mr. B spoke no English, I requested an interpreter be present at our next session. Despite instructions in Portuguese, he continued to demonstrate no improvement in his ability to track objects visually or respond to auditory information. I asked the interpreter to write down phrases like, "Open your eyes," "Look at me," "Move your leg," in Portuguese so I could ensure I was getting the best response I could from Mr. B when I re-evaluated his arousal response and his ability to follow commands. At the same time, Mr. B's occupational therapist had made a list of these translated phrases and posted it over his bed so the entire team could communicate with him.

Despite improvement
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Jennifer Podesky, PT
physical therapist

Exemplar

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in his overall medical condition, Mr. B continued to demonstrate very slow improvement in his level of arousal response and ability to follow commands and attend to visual stimuli. He was medically stable and would soon be ready for transfer to a rehabilitation facility to continue his recovery. Given the injuries he sustained and his current presentation, I knew Mr. B would have a long road to recovery. Experience told me that after an injury like this, it would take many months for Mr. B to progress to a functional level where he would need only one person to assist him with basic needs such as bathing and toileting. He would most likely require a wheelchair to navigate out in the community in the long term. Obtaining even these goals would require a lengthy inpatient rehabilitation stay and a long-term commitment from his family. Unfortunately, rehabilitation in the United States was unlikely. Plans were made to transfer Mr. B back to Brazil for rehabilitation near his home.

It was at this point that I met Mr. B's family. My first contact with them was at a meeting with team members, Mr. B's brother, sister-in-law, and cousin. The physician reviewed Mr. B's medical issues to date

and explained the severity of his injury. The family was overwhelmed by this information. Like many families, their impression was that once he 'woke up' he would be fine. Not only was his injury much more severe than they had initially understood, but given this information they were concerned about his transfer back to Brazil and the medical care he would receive there. I knew I needed to use this meeting as an opportunity to start some much-needed family-education.

I listened and tried to determine how much this family was ready to hear in regard to Mr. B's physical therapy program. Based on the questions they asked and their emotional responses, I knew I needed to keep the information simple and focused in the present. I explained the role of physical therapy and described the interventions Mr. B was receiving. I asked them to bring in pictures of other family members and provide information in English and Portuguese about who they were so we could incorporate familiar people and objects into our treatments. I knew that emotionally significant information stimulated the injured brain more effectively than words or objects that held no meaning. I explained this concept to the family and they were eager to help in any way they could.

Mr. B's sister-in-law was the primary spokes-

person for the family. I scheduled a session where she and I could work with Mr. B together. The following Monday she participated in our treatment session. Although Mr. B was still demonstrating poor arousal response, he clearly responded to her voice. I scheduled regular times for her to participate in therapy with us. Over the course of the next ten days, Mr. B began to demonstrate increased visual tracking, initially to pictures of his wife and 13-year-old daughter. He eventually began to smile and reach for the pictures—the first purposeful movement to command I had noted. I continued my family-education by explaining how family members could help Mr. B's recovery when they visited each evening. I encouraged them to tell Mr. B, in Portuguese, where he was, what day it was, to share family news, and support and comfort him. They learned range-of-motion techniques and ways to encourage his emerging motor recovery by using some of the techniques we used during our treatment sessions. Every time we met, Mr. B's sister-in-law reported improvements. He was beginning to nod 'yes' and 'no' to questions, pull the sheet off, kiss her good-bye when she left, all significant improvements for Mr. B. I knew he was responding to the emotional connection he had

with his family, and I'm convinced that that played a significant role in his neurological recovery.

Mr. B remains in our care as discharge planning continues. As in the beginning, he responds best when spoken to in his primary language. His face brightens, he shows more emotion, and it allows Mr. B to participate to the best of his ability. His physical therapy program continues to evolve as his needs change. I continue to focus on range of motion and positioning, and now, managing the increase in muscle tone he is developing as his neurological recovery progresses. Facilitation of movement is best accomplished by having Mr. B participate in 'automatic' tasks and incorporating those into his daily routine with other caregivers. As his arousal response and ability to follow commands have improved, the extent of his impaired motor function has become even more apparent—confirming the long road he has ahead to regain even basic mobility skills.

My education with the family is ongoing as is my assessment of their readiness to hear new information and participate in more hands-on aspects of his care. I see the fatigue and frustration that so many families experience when trying to manage their own life roles while contributing to the patient's recovery. Throughout his

stay, the entire team has continued to support the family, helping them navigate through this challenging time. And, just like my plan for Mr. B, my family-education will continue to evolve and hopefully help both Mr. B and his family move forward toward the best possible outcome.

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

Jennifer's narrative is a wonderful example of holistic practice. Jennifer saw the physical, psychological, and emotional needs of her patient and attended to all of them. Early on, she involved Mr. B's family and used familiar objects and pictures to engage and encourage him; she quickly realized the positive impact this had on Mr. B's attitude and spirit.

She was well aware of the limitations suggested by his prognosis but never let that compromise her efforts to help him achieve his highest level of functioning. Jennifer sought assistance from other members of the team to help maintain his skin integrity and the functional status of his extremities. She made use of our medical interpreters. She was sensitive to the needs of Mr. B's family and their need to be involved in his care even as they came to terms with Mr. B's condition.

Thank-you, Jennifer.

Physical Therapy

MGH celebrates Physical Therapy Month

—by Ann Jampel, PT, clinical education coordinator

October is National Physical Therapy Month, and it was a month of professional and community-service activities for the MGH department of Physical Therapy. This year's theme, "Get Fit for Life," was the focus of an information booth in the White Corridor on Thursday, October 28, 2004. Members of the MGH com-

munity had an opportunity to learn about how to achieve and maintain fitness and talk about exercise-related issues with MGH physical therapists.

Two professional presentations highlighted our celebration of PT Month. On October 5th, Gail Jensen, PT, currently a professor in the department of Physical Therapy at Creighton University in Omaha,

Nebraska, presented a lecture entitled, "Theory, Practice and the Development of Expertise: Insights into the MGH Experience." Jensen discussed the continuum of practice from novice to expert and the critical role of reflection in this ongoing journey.

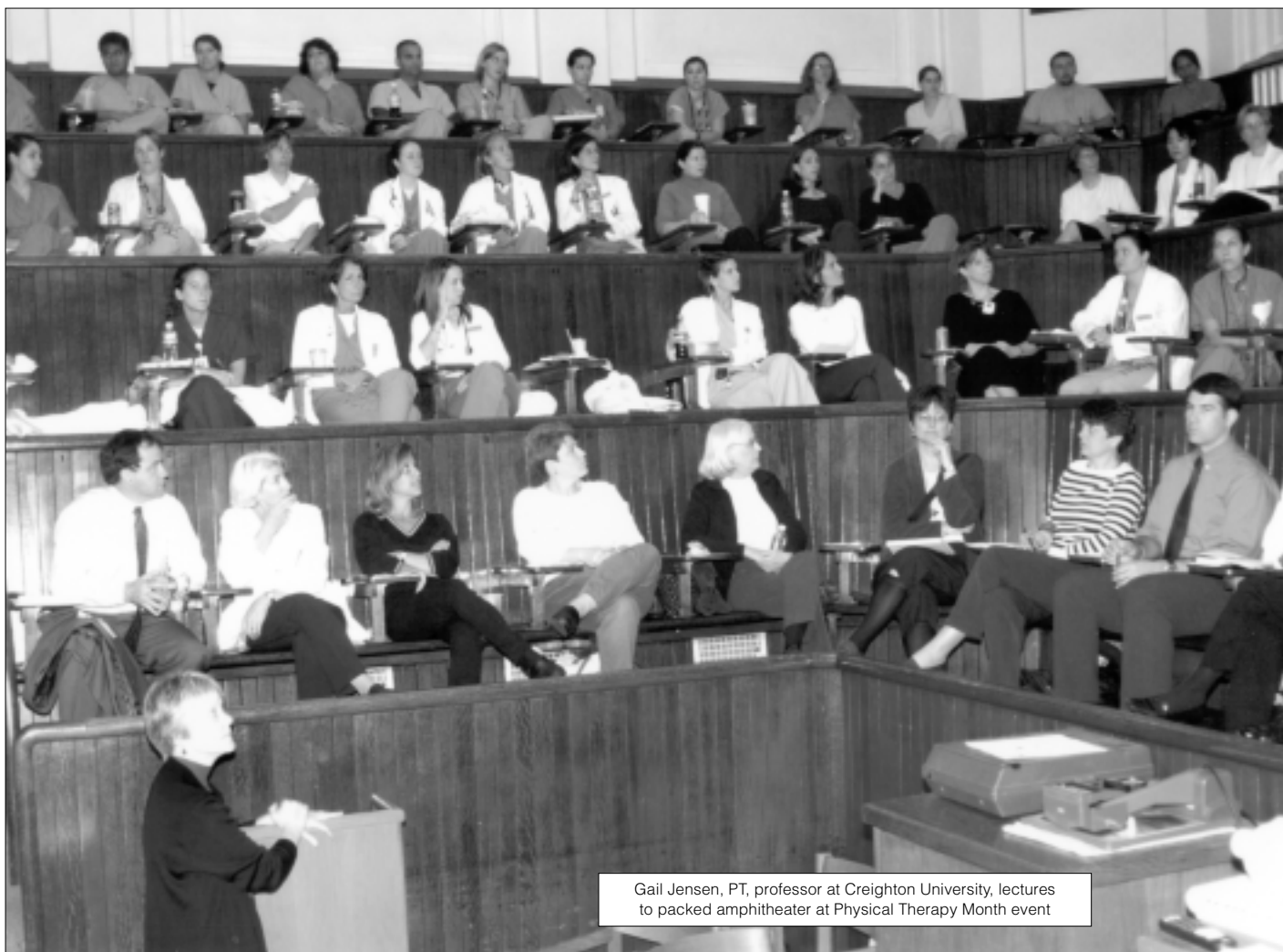
The 22nd annual, Marjorie K. Ionta Lecture was held on October 19, 2004, at the MGH Institute of

Health Professions. Cynthia Coffin Zadai, DPT, presented, "Disabling our Diagnostic Dilemma," which outlined historical and current-day challenges faced by the physical therapy profession in developing a diagnostic classification system that represents the unique knowledge and skills of physical therapists.

Tapping in to the competitive spirit evidenced in last year's Spare Change Challenge to raise money for the MGH Social Services discretionary fund, Physical Therapy joined

forces with Occupational Therapy and launched an inter-departmental, pledge-funded dart tournament. Fourteen teams of therapists and one team of PCS 'executive ringers' paid money for the privilege of throwing three magnetic darts from a regulation distance (or, for a higher fee, from a closer distance). When all the darts had settled, Garth Savidge, PT, staff physical therapist, was declared the winner, and the Social Services discretionary fund was \$1,400 richer.

continued on next page



Gail Jensen, PT, professor at Creighton University, lectures to packed amphitheater at Physical Therapy Month event

If MGH's participation in National Physical Therapy Month taught us anything, it is that education, community service, teamwork, and philanthropy can be a whole lot of fun!

For more information about Physical Therapy services at MGH, call Ann Jampel at 4-0128.



Clockwise from top left:

- Marjorie K. Ionta Lecturer, Cynthia Coffin Zadai, DPT, presents, "Disabling our Diagnostic Dilemma"
- Denise Montalto, PT, staffs booth in the Main Corridor
- Director of Physical Therapy, Michael Sullivan, PT, takes aim
- Senior physical therapist, Emily Smith, PT, presents Savidge with first-place prize
- Zadai with inpatient clinical service coordinator, Nancy Goode, PT
- Staff physical therapist, Matt Travers, PT, takes a shot



(Some photos provided by Physical Therapy; some photos taken by Paul Batista)

NICHE Program moves forward with GIAP survey and focus groups

—by Jan Duffy, RN, staff specialist

Perhaps you've heard about the NICHE program coming to MGH. NICHE, Networking to Improve Care for Health-system Elders, is a program designed to help hospitals enhance the care they provide to elder patients and their families. It involves cultivating a new way of thinking and caring for this patient population.

NICHE was developed by the New York University Division of Nursing and originally focused on promoting best nursing practices in car-

ing for the elderly. At MGH, we'll be taking a broader, more multi-disciplinary approach to this effort. NYU provides many tools to assist organizations in this work. By now, many MGH nurses are familiar with one of those tools, the Geriatric Institutional Assessment Profile, or GIAP.

During the first two weeks of November, nurses caring for patients in our adult medical-surgical areas were asked to complete a GIAP survey. Results from the

survey will help us assess the knowledge, skill level, and attitudes of staff toward caring for elderly patients. Staff nurses, nurse managers, clinical nurse specialists, nurse practitioners, and patient care associates throughout Patient Care Services were asked to participate in the survey. Thank-you to all who took the time to complete the survey. Your input will provide valuable insight and direction for future program planning.

Surveys are now on their way to NYU for analysis. Results should be available in early

2005. In addition to learning more about ourselves and our practice, we will be able to compare our results to other hospitals across the country who have implemented the NICHE Program. The NICHE Core Team is looking forward to sharing the results of our survey with staff.

The next step is to conduct focus groups with those who didn't have an opportunity to participate in the GIAP survey. Since the survey was designed specifically for nurses, we were not able to use it with other members of the multi-disciplinary team. So the NICHE Core Team will conduct focus groups over the next few months with staff in oth-

er disciplines and departments throughout the hospital.

All clinicians play a vital role in improving care for hospitalized elders. The information gained from the GIAP surveys and focus groups will be critical in prioritizing and developing educational programs and systems changes needed to improve care of the elderly. It is important to be able to monitor the impact of quality-improvement efforts as we move forward. The GIAP is just the beginning of what promises to be an exciting effort to continuously look at ways to improve the care of patients and families at MGH.

Hand Hygiene

And the winners are...

—by Rosemary O'Malley, RN, staff specialist

The third quarter results of the Clean Sweepstakes Hand Hygiene Contest, sponsored by the STOP (Stop the Transmission of Pathogens) Task Force, are in. Bigelow 9, Phillips 21, Bigelow 10, Ellison 17, Blake 12, White 12, Blake 6, and Phillips 22 are the big winners.

Bigelow 9 and Ellison 17 have won all three contests in their respective clusters over the past nine months. Blake 12 and White 12 won two of three contests in their cluster. And Phillips 21, Phillips 22, Blake 6 and

Bigelow 10 are first-time winners.

Bigelow 9 clinical nurse specialist, Sue Gavaghan, RN, says, "Using a hand disinfectant has become part of our culture, part of our practice."

Hazel Audet, RN, attributes their first-time win on Phillips 21 to "raising consciousness among staff around the use of CalStat before and after patient contact."

Pedro Torres, PCA, and hand-hygiene champion on White 12, says, "We know it's the right thing to do for our pa-

tients and ourselves."

Brenda Eklund, RN, champion from Blake 12, posted laminated cards with the 'STOP-sign' logo on the doors outside patient rooms as a reminder to staff. Says Eklund, "The Clean Sweepstakes competition has been a great motivator for staff."

Jackie Somerville, RN, co-chair of the task force, notes "Hand hygiene is an important initiative for all team members at MGH."

Judy Tarselli, RN, encourages staff to become safety advocates.

"Remember to use CalStat before and after contact with your patients and remind others to do the same. Every time we touch something we can unknowingly pick up pathogens left by others. Fortunately, we can also stop the spread of those pathogens by using good hand hygiene before entering the next patient's room."

This quarter, inpatient units are competing in the 50/70 Club Contest. Units that achieve a compliance rate of 50% before patient contact and 70% after patient contact are eligible to win an additional prize.

Remember, the real winners are our patients.

Infection Control reports a steady decline in nosocomial MRSA and VRE rates over the first three quarters of 2004. The decline coincides with the roll-out of the hand hygiene program and the introduction of the Clean Sweepstakes Rewards Program. This is only the beginning. Ongoing attention to good hand-hygiene has a significant effect on reducing nosocomial infections. Let's see if we can push those nosocomial infection rates down even further!

For more information on the Clean Sweepstakes Hand Hygiene Rewards Program, contact Rosemary O'Malley, RN, at 6-9663.

Standardization and forced function offer big results in the RACU

Humans are not perfect. No matter what level of training or experience, when humans are involved, the *potential* for error always exists—even in health care. Our focus is on ensuring that the *probability* of error is as close to zero as possible, even in the most challenging circumstances.

'Standardization' and 'forced function' are two proven methods of reducing the potential for error in certain circumstances. Through standardization, we increase the likelihood that individuals engaged in particular activities will easily locate what they need when they need it. In a car, for example, (no matter what year, make or model) we know the accelerator will be found on the floor below the steering wheel to the right. The brake pedal is immediately to its left. This standardized placement makes finding the brake in an emergency an almost reflexive response.

Forced function introduces restriction(s) to a system that virtually prevent specific types of errors from occurring. For example, you

can't start your car unless it's in park.

'Constrained function' is another option. Constrained function doesn't eliminate the potential for error, but it limits the probability of error. For example, you can drive a car without wearing a seat belt, but an alarm sounds until your seat belt is fastened.

Examples of standardization and forced function can be found throughout MGH. In the Respiratory Acute Care Unit (RACU), staff have made several relatively simple, but potentially life-saving, workplace redesigns to support practice, particularly during respiratory emergencies. Working with Biomedical Engineering, staff designed special boxes to hold a tracheostomy tube, an ambu mask, and a 10cc syringe. The boxes are hung in the same location in each patient's room. While staff can't predict *where* a respiratory emergency might occur, they can ensure that the appropriate supplies and equipment are immediately available in a standard location in each room. Every staff member knows exactly where to look for emergency supplies.

The RACU team uses forced function to make it virtually impossible, even in the heat of

an emergency, to reach for the wrong size tracheostomy tube. Every patient's box is stocked with the appropriate size tracheostomy tube for the patient in that room. Staff have immediate access to properly sized equipment only. Quality checks are performed on the contents of the box twice a day to ensure correct sizing.

While the RACU team functions exceptionally well during respiratory emergencies, they continue to explore ways to improve patient safety. They have implemented a number of significant and extensive patient-safety initiatives this past year. As you can see by the above examples, relatively simple measures can render big results.

We are all most familiar with our own environment of care. We know where there may be potential for accidents to happen. We need to ask ourselves: Where are safety risks highest? Where can we benefit from standardizing, customizing, implementing forced or constrained functions? How can we make our unit and our practice safer for everyone?

This section constitutes a new column in Caring Headlines. Because quality and safety are such a vital focus of our daily work, Caring Headlines will carry a regular column offering insight into patient-safety issues, trends, research, and stories in the news. I encourage you to read and share this information with your colleagues, and feel free to suggest ideas for future topics. For more information about this column, contact Georgia Peirce at 4-9865.

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MGH Burn Service partners with Boston firefighters

—by Max Gomez, administrative fellow

On September 9, 2004, several members of the Sumner Redstone Burn Service at MGH and the Shriners Burn Institute met with members of the newly formed Boston Firefighters Foundation (BFF) to discuss the creation of a new partnership. Similar partnerships between firefighters and hospitals in other states provided an impetus for this meeting. A long-standing partnership between the New York Firefighters Burns Foundation and New York Weil Cornell Medical Center has spurred a number of community-based educational initiatives and donations for the betterment of the Medical Center's burn service each year.

The relationship between MGH and Shriners burn associates and the Boston Firefighters Foundation began with a visit to a Boston fire station. The visit gave staff an opportunity to share an authentic fire house meal with local firefighters and live out some childhood fantasies having to do with fire trucks and assorted fire equipment and apparel!

Returning the favor, members of the Boston Fire Department were invited to visit MGH where they enjoyed a luncheon with burn associates and a guided tour

of the Burn Unit on Bigelow 13. Some of the topics discussed during the visit were the possi-

bility of providing educational in-services for firefighters and firefighter trainees conducted by

burn associates; conducting co-sponsored community-outreach programs; and developing relationships among and between the two groups to strengthen future interactions (especially in the event that a firefighter is injured in

the line of duty). The Boston Fire Department already enjoys a rich history of hosting pediatric patients from Shriners Hospital for tours and visits at various station houses in the Boston area.

For more information about the MGH-Shriners partnership with the Boston Firefighters Foundation, call MaryLiz Bilo-deau, RN, at 6-8766.



At left: Bigelow 13 nurse manager, Tony DiGiovine, RN (center), gives a tour of the Burn Unit to members of the Boston Firefighters Foundation delegation.

Below: Members of the Boston Firefighters Foundation present MGH burn associates with a commemorative T-shirt.



Educational Offerings

November 18, 2004

When/Where	Description	Contact Hours
November 19 12:00–3:30pm	Basic Respiratory Care Ellison 19 Conference Room (1919)	---
November 23 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)	---
December 1 4:00–5:30pm	Natural Medicines: Helpful or Harmful? Researching the Literature on Herbs and Dietary Supplements Founders 626	1.8
December 2 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
December 6 8:00–2:30pm	Pre-ACLS Course O’Keeffe Auditorium \$100. (to register e-mail: ccatt@partners.org)	---
December 7 8:00am–4:30pm	Chemotherapy Consortium Core Program Wolff Auditorium, NEMC	TBA
December 8 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
December 8 1:30–2:30pm	OA/PCA/USA Connections “Superior Service Skills.” Bigelow 4 Amphitheater	---
December 8 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
December 8 12:30–4:30pm	Pacing: Advanced Concepts Haber Conference Room	4.5
December 8 11:00am–12:00pm	Nursing Grand Rounds “Palliative Sedation.” Sweet Conference Room GRB 432	1.2
December 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
December 10 8:00am–4:30pm	Coronary Syndrome O’Keeffe Auditorium	TBA
December 14 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
December 15 1:30–2:30pm	USA Educational Series Bigelow 4 Amphitheater	---
December 16 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
December 16 8:00am–4:00pm	Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza	8.1
December 17 12:00–3:30pm	Basic Respiratory Care Ellison 19 Conference Room (1919)	---
December 21 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)	---
December 22 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (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>.

POE implementation complete on inpatient units



Reviewing the finer points of the electronic order entry system are (l-r): Eun-Ju Kim, applications analyst; Margaret Mary Finley, RN; Margaret (Mimi) Hassett, support staff (seated); Amy Stoney, RN; and Zakia Chennane El Idrissi, patient care information associate.

Implementation of the electronic provider order entry system (POE) on the Obstetrics Unit and in the Newborn and Special Care Nurseries (Ellison 13 and Blake 13 and 14) marks completion of the roll-out of the POE system in all inpatient services.

POE was originally introduced in the Medical Services in 1998, Surgical in 2000, OB/GYN in 2001, and Pediatrics in 2002.

For more information, call Michele Cullen at 6-6874.

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