

Caring

August 18, 2005

HEADLINES

Council on Disabilities

Awareness summer internship

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On Wednesday, August 3, 2005, the MGH community had an opportunity to hear a special presentation by summer intern, Joey Buizon, entitled "Unlimited Vision." Buizon, a graduate of Bridgewater State College (with a bachelor of Science degree in Social Work and a minor in Psychology) is participating in a summer internship program sponsored by the MGH Council on Disabilities Awareness and the Massachusetts Commission for the Blind. Buizon is visually impaired, but you'd never know it by looking at his impressive list of accomplishments. In college Buizon was an active member of the school community, a mentor for visually impaired students, and a tour guide for prospective students at Bridgewater State. Buizon says that students and families were always amazed to see him and learn that a blind person was going to be giving them a *tour of the campus!*

—by Carmen Vega-Barachowitz, SLP
co-chair of the MGH Council on Disabilities Awareness

Buizon has been involved with the organizations: Students Accepting a Challenge, and the Children's Physical Development Clinic.

As an intern at MGH, Buizon is working on a number of projects. He's working with Interpreter Services on a project called, "Bits of Culture,"

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Joey Buizon, summer intern

Personal appearance: an extension of professional acumen

I am happy to report that after many months of constructive discussion, the department of Nursing has developed guidelines for professional attire in the workplace. The guidelines are not intended to be a complete list of 'dos' and 'don'ts,' but rather a broad outline defining the level of professionalism we strive to achieve.

The issue of professional dress first came up when I received a letter

from a staff nurse voicing her concern about some fashion 'extremes' she'd seen in various areas of the hospital. The issue was quickly picked up by the Staff Nurse Advisory Committee who saw it as an opportunity to put forth a formal statement describing their position on professional attire. That position is: "As MGH nurses, we set the professional standard for nursing at its best. In a healthcare setting, inappropriate

dress can unknowingly cause hard feelings, misconceptions, and/or present health and safety hazards for staff and patients. When patients and families come to MGH, we want to make sure they see the best that health care has to offer."

Having sat in on many discussions with staff nurses and nurse managers, I can tell you that a lot of thought and care went into creating these guidelines. Recom-



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

mendations were based on research, safety, customer service, and an overriding sense of professional integrity. I can't tell you how proud I am

that staff took the initiative to bring this issue to the forefront. As chief nurse of the first Magnet hospital in Massachusetts, I wouldn't have expected anything less.

Guidelines for Professional Attire

Do wear...

Your MGH identification badge at all times where it can be seen easily by colleagues, patients, and visitors

Clothes and accessories that represent your professional best (this includes good personal hygiene)

Uniforms and scrubs, preferably in a solid color

Lab coats or jackets, preferably in a solid color

Close-toed, rubber-soled, or athletic shoes, or shoes/clogs designed for healthcare workers

A limited amount of jewelry; and keep hair back and away from patients

Little or no perfume, cologne, or scented soaps

Clean, trimmed fingernails

Don't wear...

A name tag *instead* of your MGH identification badge; don't wear your ID badge where it cannot be seen by colleagues, patients, and visitors

Torn or ill-fitting clothes; bare midriffs; low necklines; low-hipped pants; tight clothing; multiple body piercings; or soiled clothing

Jeans; T-shirts or sweatshirts with logos or sayings; loud patterns/colors

Yellow precaution gowns unless clinically warranted

Open-toed shoes, sandals, or flip-flops

Long, dangling jewelry; an excessive amount of jewelry; or straggly, unkempt hair

an excessive amount of perfume, cologne, or scented soaps

Long fingernails (natural or artificial) including wraps, acrylics, tips, tapes, or appliques

Because...

Patients have a right to know the name and role of those providing care and services. MGH requires all staff and employees to wear an official identification badge that is easy to see and clearly identifies them as a member of the MGH community

How we present ourselves has an effect on patient morale and the public perception of the hospital and MGH Nursing. In some situations, physical appearance can make or break a patient-caregiver relationship and impact how clinical opinions are received.

Loud colors and patterns can be upsetting and/or disorienting to patients; some units maintain unit-specific dress codes to meet the needs of their patient populations

Lab coats and jackets indicate a certain professional standing and help patients identify/differentiate between caregivers

Certain footwear is unprofessional and unsafe in a hospital setting. Slips and falls are more likely to occur when wearing inappropriate footwear such as open-toed shoes, sandals, or flip-flops

Inappropriate jewelry (long, dangling jewelry, excessive piercings) can present an infection-control problem, distract from professional exchanges, and/or be a hazard to you and your patients

Strong scents can unintentionally create an unpleasant environment or trigger allergic reactions

Long fingernails (both natural and artificial) increase the risk of transmitting infection. Please see the Fingernail Policy developed by Infection Control at <http://infectioncontrol.massgeneral.org/icu/>

Preventing and reducing falls while reducing the use of restraints

Question: Patient safety is increasingly of concern to patients and families. What are we doing to help prevent injury to patients while they're in the hospital?

Jeanette: The Office of Quality & Safety has a number of initiatives geared toward improving patient safety. One initiative is the Patient at Risk for Injury (PAR) Committee, a multi-disciplinary team with representation from Nursing; Case Management; Police, Security & Outside Services; Physical Therapy; Occupational Therapy; Speech, Language & Swallowing Disorders; The Knight Center for Clinical and Professional Development; and the Office of Quality & Safety.

The PAR Committee has oversight of our fall-prevention program and restraint-reduction initiative. Among other things, the committee collects and analyzes patient-safety data related to falls and restraint use and communicates trends and issues to the PCS Quality and Practice committees and to Patient Care Services leadership.

Question: One of the National Patient Safety Goals for 2005 is to reduce the risk of harm from falls. How can we reduce or prevent falls?

Jeanette: Integral to preventing and reducing falls is the initial assessment and re-assessment of patients at risk for falling, and the actions we take to address and minimize those risks. The nursing assessment form and flow sheets are currently being revised to include the Morse Fall Risk Scale (as well as other nursing assessment changes). The revised assessment form and flow sheets will be piloted this month with the expectation that they'll be rolled out in the fall.

Question: How do you determine which patients are at risk for falling?

Jeanette: Patients are at risk for falls if they have:

- a history of falling
- are age 65 or older
- have functional or mobility issues
- are cognitively impaired
- confused
- attached to equipment such as EKG leads, IVs, oxygen, chest tubes, etc.
- incontinent
- experience postural hypotension, dizziness, or vertigo
- are on medication
- are depressed
- have visual or hearing deficits
- have decreased peripheral sensation or neuropathy

Question: What medications increase a patient's risk of falling?

Jeanette: Some drugs or drug classes associated with increased risk of falling include: hypnotics, sedatives, analgesics, psychotropics, antihypertensives, laxatives and diuretics. It's not just the class of drug, but the number and combination of drugs that increase a patient's risk.

Question: What other steps can be taken to reduce falls and injuries?

Jeanette: A comprehensive fall-prevention program is multi-faceted, and starts with the initial fall assessment. The PAR Committee in collaboration with other groups is developing on-line templates to assist clinicians in developing appropriate care plans to reduce the risk of falls and injury. Key to prevention is identifying the source of each patient's risk and selecting the appropriate intervention(s) to reduce or eliminate that risk. If a patient suffers from delirium the template would steer clinicians to one set of interventions. If a patient suffers from alcohol withdrawal the template would steer clinicians to a different set of interventions.

Interventions may include:

- medication evaluation
- pain-management
- promotion of normal sleep patterns
- relaxation techniques

- exercise and ambulation
- food, liquid, and toileting needs
- re-orientation to surroundings
- increased communication
- companionship
- diversionary activities
- orientation to environment
- lighting and noise control
- bed and chair alarms
- floor pads
- assistance devices
- accessibility of needed objects
- padded hip protectors
- increased observation of at-risk patients
- side-rail alternatives
- seating and equipment
- visual signage indicating fall risk
- patient and family education

Question: Despite the above-mentioned interventions, sometimes patients need to be restrained for their own safety. What options are available in this case?

Jeanette: Some options include hand mitts, roll belts, vests, soft-limb restraints, geriatric chairs with locking trays, safe T beds, wedge cushions, and leather limb restraints. In every case, the least restrictive restraint should be used. (The revised Restraint and Seclusion Policy includes restraint application procedures.)

Question: What determines whether medical/surgical care restraint standards or behavioral care restraint standards apply?

Jeanette: That decision is based on the *situation* the restraint is being used to address, not the location or setting of the patient and/or treatment.

The Use of Restraints in Medical and Surgical Care is an intervention used to limit mobility and the patient's ability to pull at tubing, equipment, feeding tubes, airway-management tubing, and urinary drainage devices to prevent injury. Emergency Use of Restraint in Behavior Management is an intervention used to protect the patient and/or others from injury when the patient demonstrates violent, aggressive, or active suicidal behavior and poses an immediate risk to him/herself and/or others.

The PAR Committee is revising restraint and seclusion policies and procedures for clarity and to assist clinicians in selecting the appropriate standard for every situation. Once revisions are finalized, the policy will be available in the on-line Clinical Policy & Procedures Manual.

For more information about fall-prevention and restraints, contact the Patient at Risk for Injury Committee, co-chairs: Christina Gulliver, RN, at 6-7705, or Nancy Goode, PT, at 4-8579.

Beepball, a new American pastime

—by Carolyn Tassini, PT, physical therapist

The crack of the bat, the beep of the ball, the buzz of the bases. Ah, baseball, the great American pastime.

I've always been drawn to athletics, whether as an athlete or a coach. It was my interest in sports rehabilitation that first attracted me to Physical Therapy. In addition to obtaining my physical therapy license, I have completed my certification as an athletic trainer. I chose to work at MGH because of the exceptional work environment. I've been a physical therapist in the acute-care setting for more than two years, completing rotations in Medicine, Cardiology, and most recently, Neuroscience/Neurosurgery.

My work at MGH is challenging and rewarding, but I never lost my desire to be involved with athletics. It was this interest that drew me to the opportunity to work with an extraordinary group of people, the Boston Renegades. The Renegades are a baseball team sponsored by the Association of Blind Citizens, for individuals who are blind or visually impaired. They play an adapted form of baseball called 'beepball.'

Beepball, though similar to baseball, has several differences. In beepball, the ball, which is

more like a softball than a baseball, has a 16-inch circumference and a speaker inside. The speaker emits a beeping sound that allows athletes to hear the location of the ball. The game is six innings long and each side has three outs.

The pitcher and catcher are the only sighted members of the team. When the ball is pitched, the batter swings according to the beeping sound he hears as the ball approaches the batter's box. There are two bases located 100 feet down the first and third base lines. Each base is a four-foot high padded cylinder that 'buzzes' to cue the runner where to go.

The batter must get to the base before the fielder gains control of the ball. If the runner reaches the base before the ball is fielded, a run is scored. If the ball is fielded before the runner reaches the base, the runner is out. Because there are different degrees of visual impairment, all players wear a blindfold to 'level the playing field.'

My involvement with this team is as a volunteer coach, spotter, and physical therapist/athletic trainer (PT/ATC). As the PT/ATC, I assess and treat injuries and provide rehabilitation when needed to keep players healthy. Because players are visually impaired, I have had to adapt some of my assessment and treatment techniques. For example, when assessing a player who had a possible con-

ussion, I was unable to use eye function as an indicator, so I had to use other neurological tests and symptoms to determine the severity of the injury and whether it was safe for the player to return to the game. It's very gratifying to see the results of my treatments when players are able to return to competition.

Working with these men and women has been a phenomenal opportunity. It is truly amazing to see these visually impaired athletes compete at such a high level. Coaches and players have taken me in

and made me a member of the team. I'm fortunate to be able to practice in the acute-care setting at MGH and apply my skills on the beepball field.

For information on how you can support or become involved with the Boston Renegades, contact John Oliveira at The Association of Blind Citizens, or visit: www.blindcitizens.org/renegades.html, or e-mail me at ctassini@partners.org. Pre-season meetings start in February, practices start in March, the season runs through August.



At right: physical therapist, Carolyn Tassini, PT (right) with Boston Renegades player, Kae Ann Rausch. Below and at left, scenes from a beepball game in progress



Council on Disabilities

continued from front cover

which involves researching various cultures and nationalities and writing brief excerpts for Interpreter Services' website. He is compiling a list of community resources for children with dyslexia for the department of Reading Disabilities. And he is serving as a communication partner

for a client with aphasia in the department of Speech, Language & Swallowing Disorders.

One of the most important projects Buizon is working on involves gathering data and making recommendations for how MGH can create a more welcoming environment for blind and

visually impaired individuals. This data will help us improve our presence on the web for visually impaired patients and families and improve signage on campus, making it easier for visually impaired people to navigate the hospital.

During his presentation on August 3rd, Buizon described the many advances in adaptive technology that are helping blind and visually impaired individuals become more mobile, independent, and able to contribute in to-

day's 'high-tech' workplace. Some of the devices, equipment, and computer-based programs he mentioned were:

- specialized eyeglasses and magnifying glasses designed to meet the needs of a variety of visual impairments
- books on cassette and CD
- a 'talking' Palm Pilot called a 'Parrot' that is able to receive verbal commands and information and provide audible output
- a keyboard-operated

notebook called Voice Notes, which is essentially a desk-top computer without a screen. It records and plays back information at very high speeds, allowing the user to audibly 'scan' the output when searching for information



Above left: Summer intern, Joey Buizon, demonstrates how "beepball" is played (see story on opposite page)

Above right: Carmen Vega-Barachowitz, SLP, co-chair of the Council on Disabilities Awareness, introduces Buizon at educational session

At left: Attendees sample various types of adaptive eyewear that Buizon distributed for hands-on examination during his presentation

- JAWS, a software program that can be installed on any computer to make compatible Internet sites accessible to blind and visually impaired computer users
- an electronic checkbook that allows blind and/or partially sighted individuals to manage their own finances, freeing them from relying on others to handle personal financial matters

Buizon displayed and demonstrated a number of canes used to meet different navigational needs—a collapsible telescopic cane might be preferred in familiar areas while a sturdier, folding cane with a 'rolling marshmallow tip' might be more appropriate in unfamiliar territory. Buizon advises that when offering assistance to a blind or visually impaired person, it's best to *offer your elbow* and approach the person on the side where the cane is *not* being held.

The Council on Disabilities Awareness was formed in 2003 to address issues around disabilities and improving access to MGH for patients and employees. The vision of the council is to address the needs of individuals with disabilities beyond the mandates of government compliance.

For more information on the work of the Council on Disabilities Awareness, contact Carmen Vega-Barachowitz, SLP, at 4-0762.

For pediatric nurse, where there is culturally competent care, there is trust

My name is Kathie Pazola, and I am a staff nurse on the Ellison 18 Pediatric Unit. I started caring for Brian when he was transferred from a local hospital with fever, back pain, and pancytopenia (a blood abnormality). To a seasoned clinician, that triad of symptoms suggests leukemia. But Brian and his parents had no idea on that Saturday evening that leukemia was about to enter their lives.

I knew caring for Brian would be a challenge. He was 16, very private, and self-contained. When I saw him struggling to walk to the bathroom, holding the wall for support, I knew he was in terrible pain. He didn't want help. He didn't complain. He was trying to be brave. My heart ached for him. When his parents arrived, they were clearly anxious and worried. Brian maintained his brave exterior. I sensed that he was minimizing his pain for them.

After admitting him and doing a nursing assessment, I spoke to the oncologist and requested stronger pain relief for Brian. He had been taking Tylenol and codeine, but it was clear he needed more. And it was a priority. I started a morphine PCA (patient controlled analgesic) and

taught Brian how to use it. He seemed relieved to know we were giving him something for the pain. His parents, however, were worried about morphine. I reassured them that the PCA would be safe and that I would closely monitor Brian's response to it. Many parents of teenagers have a similar reaction. I've found that letting them voice their concerns and then clarifying usually helps. I realized I was dealing with two different coping styles: Brian wanted to maintain control and needed personal space. His parents were anxious and needed constant reassurance and comfort.

Brian's temperature was 101.8. We started broad-spectrum antibiotic coverage and intravenous fluids. He was at risk for sepsis due to his low white count. After the oncologist examined Brian and spoke with his parents, we sat together to review his plan of care. The oncologist felt that Brian had leukemia, but a bone-marrow biopsy was necessary to confirm that diagnosis. As a caregiver, suspecting a cancer diagnosis and not yet being able to deal with it is difficult. The doctor shared all diagnostic possibilities, and Brian's parents clung to the hope that he had a spine infection. An im-

portant thing to know about Brian (that would impact everyone if he had leukemia), was the fact that he was a Jehovah's Witness. The challenges were mounting.

For the rest of the evening, I helped Brian and his parents settle in on Ellison 18. I informed them of our open visiting hours—parents can stay 24 hours a day. I oriented them to the unit, got them bedding in case they chose to stay over, and tried to anticipate their basic needs for food, comfort, and rest.

I informed them about the tests Brian would have to have and generally reviewed routines. I've learned that information can decrease anxiety and help parents feel safe and secure. Navigating the hospital system can be daunting. I wanted to remove some of the obstacles. Brian's pain was better. I think that made them *all* feel relieved. As I did my initial teaching, I could sense that Brian used intellectualization as a coping skill. I made a mental note to respect this and always keep him informed. I also noted it in his care plan so that others could do the same.

On Monday, Brian had a bone-marrow biopsy and lumbar puncture under conscious sedation. It was late afternoon when the results

came back. The oncologist asked me to sit with him when he told Brian that he had leukemia. The social worker and pediatric nurse practitioner (PNP) from the outpatient clinic joined us, and with a deep breath, we all went in to do 'the talk.'

We always meet as a team when sharing a diagnosis with a teenager and his family. It sends a strong message that we're all working together to help them through treatment. It's always a sad time. No matter how many times I do this, it still takes psychic and emotional energy to see a family in such pain. The team supports each other. Brian was quiet throughout the meeting. His mom was angry, crying in disbelief. His dad sat calmly next to him and tried to be supportive. During the meeting, we discussed the treatment plan, listened for concerns, and answered questions. We sat quietly as the bad news was absorbed. In this 'presencing,' I think

caring and respect are communicated without words. To 'sit' with pain and tears is a deeply human experience of sharing. After a few moments, Brian's mom informed the team that they were Jehovah's Witnesses and that blood products were not acceptable. And Brian agreed. The family was firm in their belief. We listened respectfully.

After the diagnosis was shared, we gave the family time to be alone. After a while, I went in to acknowledge the painful news, and to support them with my presence and by answering questions. Brian was scheduled to start chemotherapy the next day, so I had more teaching to do. I acknowledged that it would probably be hard for them to retain information at this time, but I wanted to talk to them about the drugs Brian had received and discuss symptom-management. I gave them the teaching booklets we have for families. I described the

continued on next page



Kathie Pazola, RN, pediatric staff nurse
clinical scholar, Ellison 18

Clinical Narrative (Pazola)

continued from previous page

'chemo' routine. I wanted to empower them with information. Cancer is a family illness. I discussed ways to talk to their 10-year-old about leukemia. I encouraged Brian to have family, friends, and church members near if he wanted. I told them that no issue or question was unimportant. Mom was concerned about food, nausea, and weight-loss. I assured her I would consult the dietician. Mothers often focus on food—it is a basic way to nurture. I asked the child life specialist to spend time with Brian focusing on his developmental needs. Diversions, a chess game or a video, can normalize life for a hospitalized teenager.

The physician met with Brian and his parents the next day to address the blood transfusion issue. During induction, patients with leukemia often need blood and platelets. Because there was disagreement between the team and the family as to whether to transfuse Brian, the physician informed the family that he was going to petition the court for permission to transfuse. Brian's parents had a lawyer provided by their church who would represent them in court. The need to deal with this issue could have driven a wedge between Brian, his family, and the hospital. Instead, every ef-

fort was made to remain respectful as this issue was sorted out. The judge spoke with Brian and declared him to be a 'mature minor.' This gave him the authority to decide whether he would accept or refuse blood products, and he chose to refuse. That was when the challenge of dealing with ethical differences began for staff.

Brian's physician asked me if I felt I could care for Brian in the event he had a bleeding crisis. The question was dramatic, but important. I pondered it, and my honest response was, 'Yes, I could.' It was essential for caregivers to consider the worst-case scenario in order to truly commit to Brian's care.

I attended interdisciplinary meetings and ethics rounds to discuss the ethical dilemma facing us. The meetings were a chance to clarify, vent, process, and learn. Staff was polarized. Every effort was made to help staff examine their feelings and beliefs to avoid moral distress. Some nurses were fearful that Brian might bleed while they were caring for him. They felt helpless. Some nurses felt he shouldn't be allowed to make his own decision at the age of 16. Some residents were highly frustrated that Brian was refusing a transfusion. I listened to staff concerns. I kept people informed. I

clarified misconceptions. I tried to be an advocate for Brian. I did not want his care to be affected by conflicting opinions. He needed and deserved our support, not our judgments.

I recruited a team of nurses who could work comfortably with Brian. I brought in information about the Jehovah's Witness faith and made it available to staff. I kept an open line of communication with Brian's PNP and oncologist who were modifying some of his treatments to minimize his bleeding.

I did not agree with Brian's decision. I knew that blood could make someone with low counts feel better and more energetic. I knew that platelets could help keep him from bleeding into his brain. But I believed in Brian's right to autonomy and self-determination. He had been fully informed when he made his decision. His religious beliefs guided his life. We needed to respect that.

Fortunately, I don't think Brian's care was compromised by the disparity of opinions. Staff pulled together. He got through induction chemotherapy with low counts, but no bleeding crisis. He achieved remission.

As treatments progressed, Brian and his family adjusted to living with leukemia. They used many of the supports I put into place. Mom focused on food. Brian, his mom, and I

laughed about his many demands and her many trips to the store to satisfy his cravings. He took command of his illness and treatments, becoming knowledgeable and assertive as to how he wanted things done. I anticipated his return to school and sent a referral to the school nurse and spoke with her about how she could help Brian in his transition back to school. Brian came to rely on me more, I believe, because he knew I respected his privacy and 'space.' He allowed me to nurture him. He revealed more of himself to me, playing guitar, writing songs, and trying to teach me about computers. He was able to share his sad feelings at times, and not 'lose face' because he knew I respected him as a person. The connection we shared was very touching to me. When a teenager, 'lets you in,' it is a privilege. When you develop trust, it is a sacred contract. It allows you to be truly authentic, truly human, and alive.

Brian continues his two-and-a-half-year protocol in the outpatient clinic. His PNP keeps me updated on his progress. He recently sent me a copy of his living will and asked me to keep it, should he need my advocacy in the future. I feel honored and responsible. It is a testament to his trust in me. He remains his own person, and we remain partners in his care.

In Pediatrics, I feel empowered to 'orchestrate' care for my patients. It is this freedom to orchestrate and think critically that gives me great satisfaction after so many years as a nurse. Teaching and decision-making are a major part of the orchestration. Collaboration and collegiality are also essential. It is this coming together of disciplines that ensures comprehensive care for our patients. Nursing indeed has transformative power.

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

This is an important narrative. Patient-care situations where professional ethics come up against cultural sensitivity are always the most challenging for clinicians. Kathie freely states, "I did not agree with Brian's decision." But that didn't prevent her from providing Brian and his family with the best possible care.

Over and above providing patient-centered care, Kathie acted as a catalyst for her co-workers and colleagues, providing information and clarification, and galvanizing support for this family. At every step in their journey, Kathie respected Brian and his family and their right to make informed decisions about his care.

Thank-you, Kathie.

Developing expert practice: one wound at a time

—by Susan M. Kilroy, RN, clinical nurse specialist

It's a familiar question on many units: "Can you look at this patient's skin? I'm not sure what to do." The resulting consultation can be a five-minute conversation or require complex assessment and planning. In continually assessing their patients, staff nurses are usually the first to notice changes in coloration or the early signs of skin break-down. Given the high acuity and complexity of patients at MGH, many are at risk for skin break-down, which can be caused by friction, pressure, shearing, immobility, moisture, and/or poor nutritional status.

Regular inspection of all pressure points and frequent re-positioning help prevent pressure ulcers. In some instances though, when patients are very ill and have few reserves, pressure ulcers can develop despite preventive measures. Skin ulcers can be an issue with diabetic patients and patients with vascular and venous stasis disease. Often it's cumbersome to sort through all the potential causes. That's where clinical nurse specialists come in, and that's where bed-

side presence is key.

In addition to sharing clinical expertise, clinical nurse specialists have an opportunity to review the principles of wound healing and demonstrate and assist with actual wound care.

If a staff nurse is new to practice, it's a good idea to review the four stages of pressure ulcers, and the mechanism of tissue injury. It may be an opportunity to describe the hallmarks of a diabetic wound and the principles of treatment. It may be the right moment to review the mechanisms of development of vascular ulcers, wound healing and re-vascularization. The ideal situation is one where the nurse and clinical nurse specialist review the theory then apply the theory to practice.

For instance, unit-based clinical nurse specialists are often called upon to assess wounds of patients from other hospitals. It could be a patient who is diabetic and has been bed-bound. There may be more than one wound. A complete assessment and evaluation must be performed. What is the patient's history? How long has

she had the wound? How big is the wound? What treatments have been used, and have they been effective?

The wound bed must be assessed, cleaned, and measured, and a wound-care plan must be established. But it doesn't end there. The wound must be carefully monitored and the response to treatment noted. Other factors to consider are the patient's nutritional status (protein is key to wound healing) and whether the patient may need a special mattress to help relieve pressure on her skin.

Experienced nurses may have different needs. They may understand the staging process and be skilled at wound cleaning, but they may need help determining the best treatment for the wound. Clinical nurse specialists work with nurses to determine what products and/or treatments are called for.

How do clinical nurse specialists develop this expertise? Much is learned through formal education, a review of the literature, and hands-on practice. Almost every clinical nurse specialist has been in the position



Susan Kilroy, RN
clinical nurse specialist

of needing assistance in evaluating a complex wound and determining a course of treatment. Often what is needed is validation by a peer. At MGH, there is a large, informal network among clinical nurse specialists. Consultations are conducted by telephone or in person. For practitioners who aren't experienced in the management of complex wounds, having a colleague to consult and help devise a plan is invaluable.

Because not all clinical nurse specialists have the same level of expertise in wound care, the Wound Care Group was created, and plans are underway for a two-day Wound Care Workshop for clinical nurse specialists. The workshop will be attended and taught by MGH clinical nurse specialists, truly an opportunity to network, share expertise, and dis-

seminate information.

The next phase will be the roll-out of this program to staff nurses. The goal is to educate staff nurses and help them become skilled in the science of wound treatment and healing.

As a clinical nurse specialist, one of the best indicators of my influence on staff is when a staff nurse comes to me to describe a wound and what they did to manage it, and it's exactly what I would have done. The hope is that our Wound Care Workshop will contribute to the development of more expert staff nurses who can be available as a resource to less-experienced peers. These educational opportunities, coupled with ongoing clinical consultation, provide staff nurses with experiences that engender expert practice and better outcomes for patients.

MGH is committed to improving hand hygiene

Why is hand hygiene so important for healthcare workers?

Patients are vulnerable to infection

They often have wounds, chronic illnesses, diseases, extremes of age, weakened immune systems, and/or other conditions that place them at greater risk for infection

Many pathogens exist in the healthcare environment

They may include antibiotic-resistant bacteria

The hands of healthcare workers can easily pick up pathogens and spread them to patients

Infections that come from the healthcare environment or healthcare workers are called 'nosocomial' infections

Nosocomial infections can be serious

They can cause or contribute to:

- patient illness or death
- prolonged or repeated hospitalizations
- added costs for medications, treatments and follow-up
- increased antibiotic resistance

Hand hygiene is proven to

- stop the transmission of pathogens
- reduce the incidence of nosocomial infections

How will hand hygiene be surveyed and scored by JCAHO?

Compliance with CDC guidelines will be surveyed through interviews with caregivers and direct observation. Caregivers should know what is expected of them regarding hand hygiene and practice it consistently.

- A minimum of 90% compliance is expected
- Surveyors will score by counting observations
- One occurrence of non-compliance with CDC category 1 recommendations equals one observation
- Three occurrences result in a Requirement for Improvement
- There is no such thing as 'partial compliance' with National Patient Safety Goals (revised 1/20/05)

For more information about hand hygiene, contact your nurse manager, operations coordinator, or infection control practitioner, or call Infection Control directly at 6-2036



Stop the Transmission of Pathogens

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Publisher

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

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Patient Care Services, Diversity
Deborah Washington, RN, MSN

Physical Therapy
Occupational Therapy
Michael G. Sullivan, PT, MBA

Police & Security
Joe Crowley

Reading Language Disorders
Carolyn Horn, MEd

Respiratory Care
Ed Burns, RRT

Social Services
Ellen Forman, LICSW

Speech-Language Pathology
Carmen Vega-Barachowitz, MS, SLP

Volunteer, Medical Interpreter, Ambassador
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:

September 1, 2005



Caring

HEADLINES

Back issues of *Caring Headlines* are available on-line at the Patient Care Services website: <http://pcs.mgh.harvard.edu/>

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

Clinical Recognition Program

**Clinicians recognized
May-July, 2005**

Advanced Clinicians:

- Gary Collymore, RRT, Respiratory Therapy
- Judy Pagliarulo, RN, Same Day Surgical Unit
- Angela Sorge, RN, Cardiac Unit
- Erika Ehnstrom-Carr, RN, Cardiac Unit
- Emily Smith, PT, Physical Therapy
- Anne Turner, RN Emergency Department
- Suzanne Curley, OTR/L, Occupational Therapy
- Sara Mahoney, RN, Cardiac Unit
- Donna Lawson, RN, Medical Unit
- Elizabeth Crawford, SLP, Speech, Language & Swallowing Disorders
- Kristin Appel, RN, Same Day surgical Unit
- Heather Coombs, RN, Cardiac Unit

Clinical Scholars:

- Janet Kleimola, RN, Newborn Intensive Care Unit
- Edna Riley, RN, IV Nursing Team
- Maureen Tully, RN, Obstetrics Unit
- Kathryn Pazola, RN, Pediatric Unit
- Erica Edwards, RN, Cardiac Critical Care Unit

Call for Nominations

Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award

Nominations are now being accepted for The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award. The award was created to recognize clinicians within Patient Care Services whose practice exemplifies the expert application of values reflected in our vision.

Staff nurses, occupational therapists, physical therapists, respiratory therapists, speech and language pathologists, social workers, and chaplains are eligible.

The nomination process:

- Direct-care providers can nominate one another. Nurse managers, directors, clinical leaders, health professionals, patients and families can nominate direct-care provider.
- Those nominating can do so by completing a brief form, which will be available in each patient care area, in department offices, and at the Gray information desk.
- Nominations are due by September 30, 2005. Recipients will be selected in November.
- Nominees will receive a letter informing them of their nomination and requesting they submit a professional portfolio. Written materials on resume-writing, writing a clinical narrative, and securing endorsement letters will be enclosed.
- A review board including previous award recipients, administrators, and MGH volunteers will review the portfolios and select award recipients. The board will be chaired by Trish Gibbons, RN, director of The Knight Center for Clinical & Professional Development.
- The award ceremony will be held on December 8, 2005.

Award and award-related activities

Award recipients will receive \$1,500 to attend a professional conference or course of their choosing. They will be acknowledged at a reception of their peers and family members, and their names will be added to the plaque honoring previous Macaluso award recipients.

Recipients will receive a crystal award from Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse.

For more information or assistance with the nomination process, please contact Mary Ellin Smith, RN, professional development coordinator, at 4-5801.

Educational Offerings

August 18, 2005

When/Where	Description	Contact Hours
September 1 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
September 8 1:30–2:30pm	Nursing Grand Rounds “Conversations with Patricia Benner.” O’Keeffe Auditorium	1.2
September 9 and 12 8:00am–4:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room	16.8 for completing both days
September 12 and 30 8:00am–4:15pm	Neuroscience Nursing Review Course O’Keeffe Auditorium	TBA
September 12 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK401 (No BLS card given)	---
September 13 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
September 14 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
September 14 1:30–2:30pm	OA/PCA/USA Connections “Superior Service Skills.” Bigelow 4 Amphitheater	---
September 14 7:00am–12:00pm	CVVH Core Program VBK601	6.3
September 14 11:00am–12:00pm	Nursing Grand Rounds “Respiratory Nursing Update.” Sweet Conference Room GRB 432	1.2
September 14 4:00–5:00pm	More than Just a Journal Club Thier Conference Room	1.2
September 15 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
September 15 1:30–2:30pm	Nursing Grand Rounds “Illuminating Practice through Nursing Narratives.” O’Keeffe Auditorium	1.2
September 19 8:00am–4:30pm	Intermediate Respiratory Care Thier Conference Room	TBA
September 21 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
September 22 8:00am–4:30pm	Workforce Dynamics: Skills for Success Training Department, Charles River Plaza	TBA
September 22 1:30–2:30pm	Nursing Grand Rounds “Quality & Safety Update.” O’Keeffe Auditorium	1.2
September 23 8:30am–4:30pm	MGH School of Nursing Alumni Program O’Keeffe Auditorium	TBA
September 26 and 27 8:00am–4:30pm	BLS Instructor Program VBK601	---
September 28 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
September 29 8:00am–4:30pm	CCRN Review Day II Haber Conference Room	TBA
September 29 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2

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>.

Reporting critical test results: write it down and read it back

—by Carol Camosso Markus, RN, staff specialist
Office of Quality & Safety

Critical test results are results that, if unaddressed, could prove life-threatening to a patient or place him/her at serious risk. Delays and errors in communicating critical test results present a serious patient-safety risk. To address this potentially serious issue, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) developed a specific patient safety goal that focuses on effective communication among caregivers. The safety goal, which stresses correct and timely reporting of critical test results, will be an important area of review when the JCAHO conducts its

survey of laboratory services at MGH, September 19–October 3, 2005.

Though the safety goal itself is not new, a significant change was made to the goal this year. Prior to 2005, a person who received a result over the telephone could verbally ‘repeat back’ the result to the caller. Now the person receiving the result must *write down the complete result and then read it back*. The critical test result should be written in an appropriate location, such as the flow sheet, progress note, or designated book on the operations associate’s desk.

During the upcoming site visit, the surveyor will visit inpatient and outpatient areas observing procedures and talking with staff about the process of obtaining and communicating critical results. The “Laboratory Results: Guidelines for Retrieving and Reporting Policy” in the *Clinical Policy & Procedure Manual* describes the MGH process in detail. Also, a list of critical values is available on the MGH Laboratory Handbook website: <http://mghlabtest.partners.org/criticalvalues.htm>.

For more information about the upcoming JCAHO laboratory survey, call the Office of Quality & Safety at 6-9282.

MGH Photography Department 8th annual Photo Contest

This amateur competition is open to all Partners and MGH employees. Contestants may submit up to two photographs. Photographs should be in printed form (no slides or electronic files please), no larger than 8"x10", unmounted, and unframed.

Please submit *only* photograph/s.

All submissions will be displayed, and winners will be announced on September 29, 2005, at the POPPS Fair under the Bulfinch Tent. Prizes will be awarded to the winning entries and to those receiving honorable mention.

Entries should be delivered or sent by in-house mail to the MGH Photography Department no later than September 16, 2005. All entries will remain with contest organizers until October 3, 2005, when they will be returned to entrants.

For more information and/or to receive an entry form, call the MGH Photo Lab at 6-2237, or visit them in the Bulfinch basement (BUL045)

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