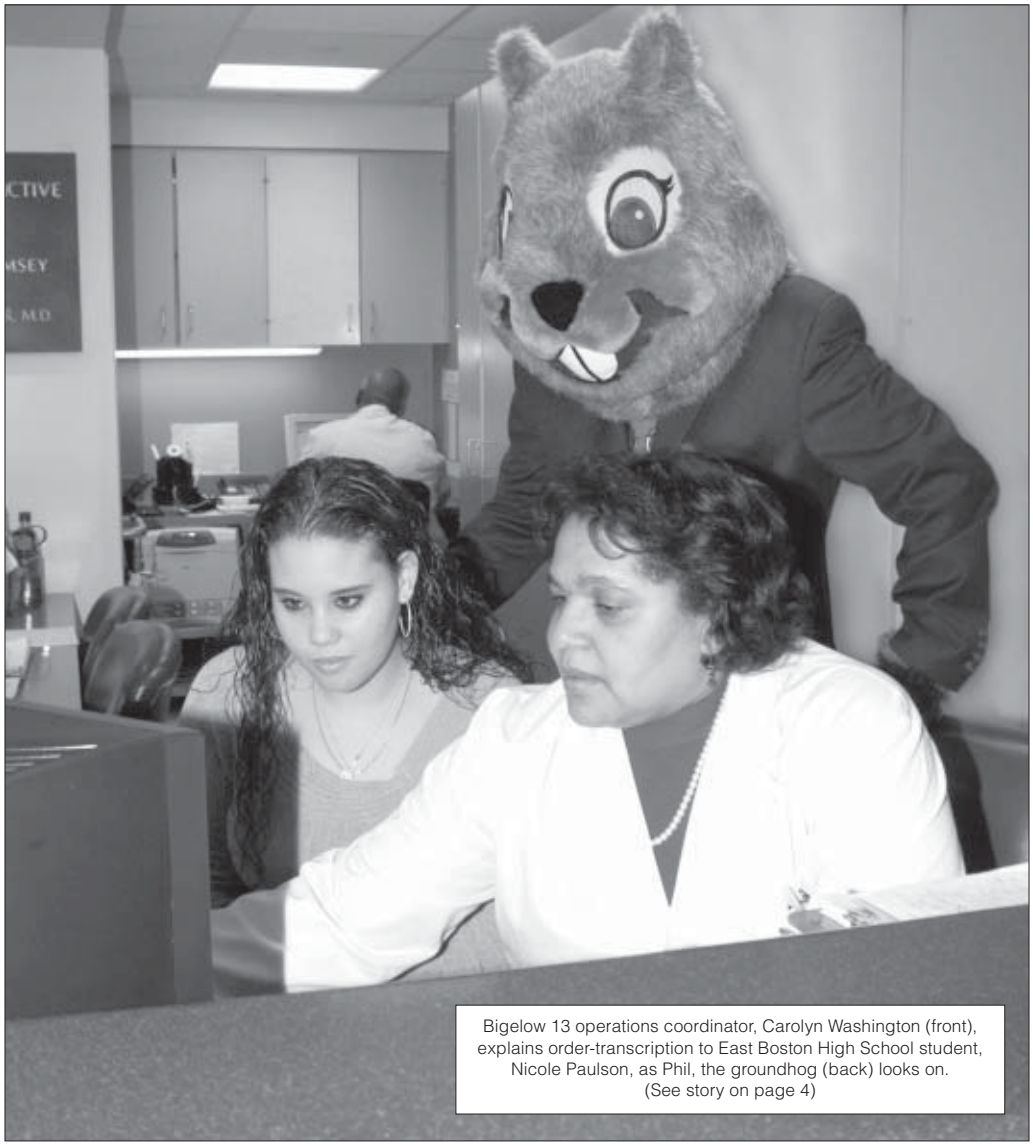
February 17, 2005

Caring HEADLINES

Staff, groundhog, all see shadows on Job Shadow Day

Inside:



Bigelow 13 operations coordinator, Carolyn Washington (front), explains order-transcription to East Boston High School student, Nicole Paulson, as Phil, the groundhog (back) looks on.
(See story on page 4)

MGH Patient Care Services
Working together to shape the future

Strategies for changing organizational culture

meeting the challenges of the current healthcare reality

On February 3, 2005, as part of a series of workshops on executive development and influencing organizational culture, the Patient Care Services Executive Committee attended a day-long session facilitated by Edward O'Neil, PhD, director of the Center for Health Professions at the University of California in San Francisco.

I think we all recognize that as a society, as a sector in the business world, and as an organization, we are facing unprecedented change. An aging population, a shrinking workforce, and increased diversification in local and national demographics present very real challenges to our current way of doing business. In order to respond to these changes effectively, healthcare organizations need to create and sustain infrastructures that are flexible, functional, and responsive. I think everyone who works in health care would agree that in today's reality, that's a tall order.

Dr. O'Neil and his associates have an impressive record in assisting healthcare organizations to prepare for and engage in strategies to successfully meet these challenges. As part of our work together, we reviewed existing practice models, re-examined our use of systems and technology, looked at current leadership-development strategies, and in a very meaningful way, explored a framework for managing change.

We began our session on February 3rd by describing the existing culture at MGH to get a basis for comparison as we work toward a culture change. Some words used to describe our existing culture included:

- interconnected
- a strong sense of personal accountability
- fast-paced
- relationship-driven
- having a strong presence outside the walls of MGH
- constant sense of urgency/excitement
- an expectation of excellence
- entrepreneurial spirit
- days are getting longer (starting earlier and ending later)
- complex
- dynamic
- a feeling that when you work at MGH you are part of a family

As Dr. O'Neil reminded us, culture is invisible—it's not something you can see or touch—so we rarely think of it in terms of the power it has to advance or curtail change. But organizational culture is the backdrop for all processes, so we need to *make* it 'visible.'

As you can see from the list of descriptions we generated, many aspects of our current culture are positive and desirable, and we want to make sure we preserve those good qualities as we move forward. How do we decide what to preserve and what to change? Dr. O'Neil suggests that any strategy to impact a change in organizational culture needs to be linked to values. And while that may sound simple, a role-playing exercise we engaged in clearly demonstrated the challenges that arise when emerging needs come up against existing culture.

This was a fascinating exercise. Our group was asked to divide into two 'cultures.' One was a remote island population whose healthcare practices revolved around faith-healing, prayer, community and family support, and herbal remedies. This population held a deep cultural fear of the color red. The other group represented an American healthcare delegation who had come to the island to administer medication to help curb a rising infant-mortality rate. But the medication they brought was red. It was a classic case of emerging need clashing with existing culture. Interactions between the two groups spotlighted the delicacy and complexity of what is required to effect cultural change.

Dr. O'Neil stressed that significant change takes time, commitment, and frequently, the development of a 'new language' that is more meaningful in the emerging culture. For instance, 'culturally competent care,' now a common phrase in our vernacular, was unheard of just ten years ago. As we've shifted to a culture that embraces diversity, our language has evolved to encompass that change.

One thing that's true

continued on next page

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

Your Opinion Counts!

Staff Perceptions of the Professional Practice Environment Survey – 2005

Surveys will be mailed to all direct-care providers during the last week of February. If you don't receive a survey by March 4th, please call The Center for Clinical & Professional Development at 726-3111.

All individual responses are kept confidential.

Please complete and return your survey by March 25, 2005.

For more information, call 726-3111

Staff Perceptions of the Professional Practice Environment Survey

Question: What is the purpose of the Staff Perceptions of the Professional Practice Survey?

Jeanette: The survey was developed to obtain feedback from staff about the environment of practice at MGH. We know that to enhance the quality of care, it's important for staff to feel supported in their professional practice. This is a 'report card' on our ability to do that, one I take very seriously. The Patient Care Services leadership team uses the information obtained in the survey to identify ways to improve the practice environment.

Question: Who receives the survey?

Jeanette: The survey is mailed to all direct-care providers throughout Patient Care Services. The survey will be mailed on February 22, 2005. Please be sure to return your survey by March 25th (the day we begin to tabulate the data). Your input is very important. We've always had a high rate of return on these surveys, and I hope this year will be no exception.

Question: Does my opinion really matter?

Jeanette: Absolutely! This survey is one way for me to hear directly from you about how *you think* we're doing in creating an environment where clinicians feel supported in their practice. Feedback from this survey has spurred many changes over the years. The Culturally Competent Care lecture series, the Materials Management Nursing Task Force, pagers for social workers, and the 'Fielding the Issues' column in *Caring Headlines* all originated because of feedback I received from The Staff Perceptions of the Professional Practice Survey.

Question: In the past, I've noticed a number on the back of my survey. I thought the survey was anonymous. Is there a way to trace my answers back to me?

Jeanette: The number on the back of the survey is the cost center for each clinician's department. That number allows us to group data into meaningful sub-sets. There is no way to link any response to an individual staff member. All individual results are completely anonymous and confidential.

Question: Who sees the results?

Jeanette: Aggregated data from the survey are shared at three levels: my executive leadership team (the Patient Care Services Executive Committee); discipline-specific staff meetings (Nursing, Social Work, Physical Therapy, Occupational Therapy, and the Chaplaincy); and in staff meetings on individual patient care units. At each level there should be discussion about what the survey tells us and how we can use the information to improve the practice environment. This process helps us to support staff and ensure that MGH remains the employer of choice for all disciplines within Patient Care Services.

Please take the time to complete and return the survey by March 25th. Your input is important. Thank-you.

Jeanette Ives Erickson

continued from previous page

of every culture, is the importance of story-telling. Stories are the way we share values, share practice, and make our work visible. Dr. O'Neil points to story-telling as the single most effective tool in influencing cultural change. He stresses that the stories we tell must be linked to our values and help delineate the change we're hoping to bring about.

We all know the power of story-telling from our own practice of sharing clinical narratives. As we move forward we will look for individuals willing to share their stories. We will look for ways to link our stories to our values. And we will be vigilant in monitoring our environment to ensure that the organization can sustain the changes we implement.

As I said, this workshop was one in a series of sessions focusing on executive development and influencing organizational culture. I'm very excited about this work, and I will keep you informed as we proceed on this journey.

Point, click, and buy with E-Buy

As you may have heard, E-Procurement (or E-Buy) is coming to MGH beginning March 1, 2005. A front-end system for PeopleSoft Purchasing, E-Buy will allow staff to generate requisitions on-line for every vendor (except Standard Register), eliminating the need for cumbersome paper and fax ordering. With its Amazon.com-like interface, E-Buy really is as easy as point, click, and buy. While eliminating paper from the ordering process is an obvious plus, many others benefits make E-Buy an indispensable improvement, including:

- the ability to track your order in real time from creation of the requisition to payment of the invoice
- the ability to access the complete database of items to quickly locate the correct product
- an electronic approval system for improved spending management
- better utilization information at your fingertips for trend-analysis, budget-review, etc.
- E-Buy will *save tim*e!!!

For more information about the new E-Buy purchasing system, contact the operations coordinator on your unit.

Groundhog visits MGH on Job Shadow Day

—by Galia Kagan Wise, manager, MGH and East Boston High School Partnership

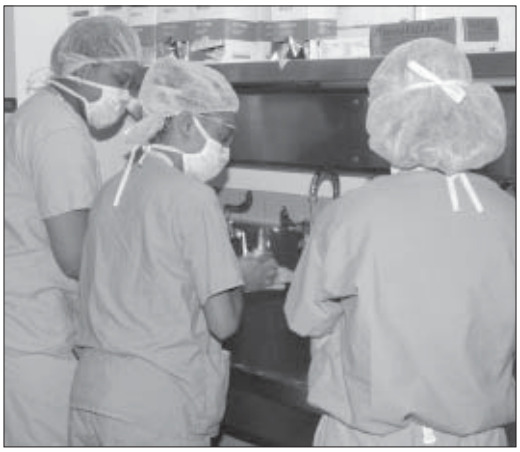
While Punxsutawney Phil was looking for his shadow on Ground hog Day, Wednesday, February 2, 2005, several students from East Boston High School (EBHS), our high-school education partner, 'shadowed' health-care professionals at MGH. Groundhog Job Shadow Day, provides students with an opportunity to see first-hand what a professional work day looks like, and understand in a real way how the workplace can be an extension of the classroom. High-school sophomores who participated in the program will be able to apply to the MGH Summer Jobs for Youth and ProTech programs, for internships offered during the school year.

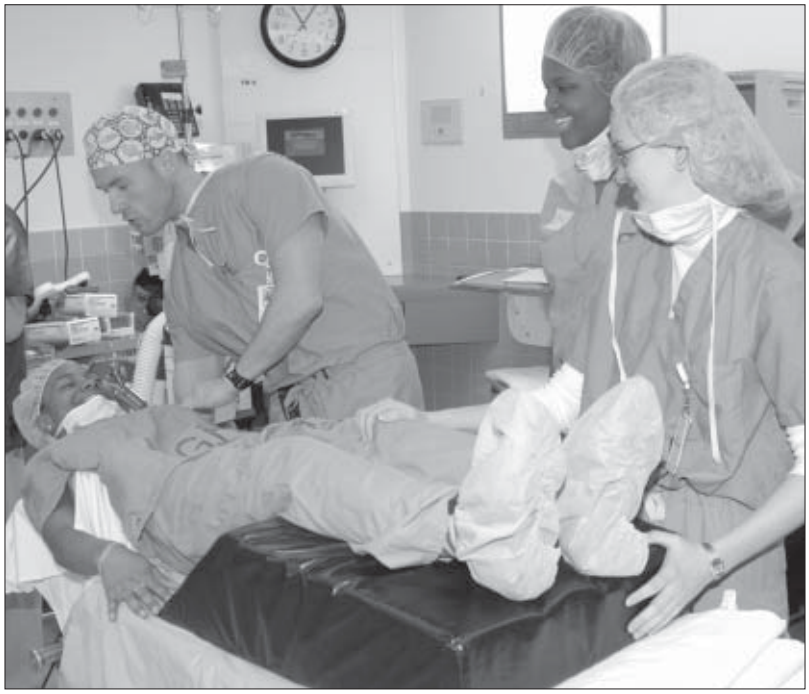
Groundhog Job Shadow Day is also an opportunity for students to begin to think seriously about pursuing a career in health care. This year, a number of MGH departments participated in Job Shadow Day, including: Nursing, the Chaplaincy, the Gillette Center for Women's Cancers, Human Resources, Pharmacy, Radiation Oncology, the MGH Cancer Center and many others. Students were paired with MGH staff members and spent time observing, learning, asking questions, and when appropriate, assisting their job-shadow hosts in performing certain tasks. Not only did the experience provide an up-close look at the dynamic world of health care, it gave students an understanding of the skills and education required to pursue careers in various disciplines. Job-shadow hosts were able to advise and coach students as to how best to achieve their professional goals.

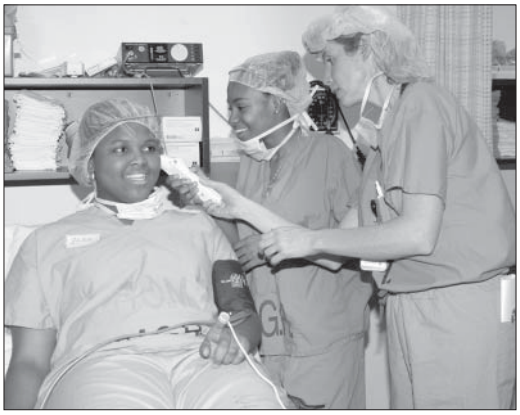
Almost 750 Boston public high-school students shadowed 139 volunteers at Boston-based businesses this past Groundhog Day. Job Shadow Day began in Boston in 1996 and is now observed by thousands of students across the state and hundreds of thousands nationwide. Locally, Job Shadow Day is the result of a partnership among Boston Public Schools, the Boston Private Industry Council, the Massachusetts Department of Education and Junior Achievement.

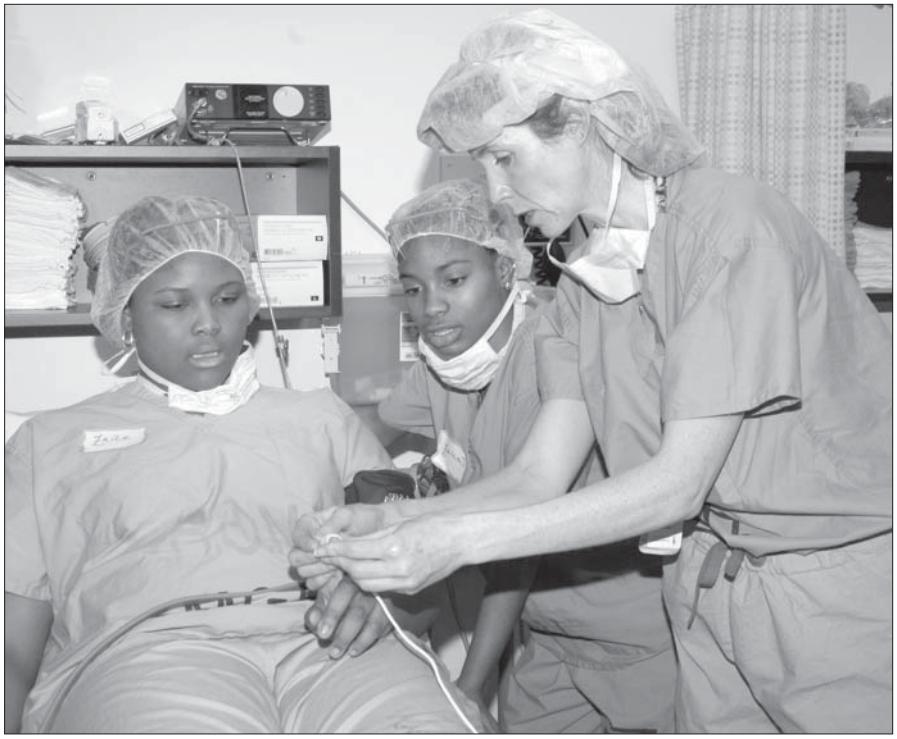
Punxsutawney Phil saw his shadow and so did many MGH employees.

Groundhog Job Shadow Day is supported by the MGH/EBHS partnership and is a program of the School Partnership Initiatives in the MGH Community Benefit Program. For more information about the MGH-East Boston High School Partnership, please call 4-8326.









Opposite Page: East Boston High School students, Fritzkeysha Chery (taller), and Fallon Holloway-Lewis, learn about life in the Same Day Surgical Unit from clinicians, Matthew Powers, RN, and Marie Collins, RN (right).
This Page: Above, Patricia Lynch, RN, familiarizes Chery and Holloway-Lewis with some of the pediatric procedures performed in the SDSU.
Center: Student, Nicole Paulson (left), learns about some of the specialized supplies used on the Burn Unit from nurses, Laurie Eiermann, RN (center), and Brook Holmes, RN.
At left: Burn nurse, Dawn Heffernan, RN, shows Paulson how pain medications are administered in the Burn ICU; Phil, the groundhog, looks on.

Endoscopy staff nurse helps raise awareness about health literacy

Mary Elizabeth McAuley, RN, staff nurse, Endoscopy Unit

My name is Mary Elizabeth McAuley, and I have worked on the Endoscopy Unit for three years. Prior to Endoscopy, I worked in the Medical Intensive Care Unit (MICU) as the permanent night resource nurse. As a senior staff member, I was involved with a number of unit-based committees, but transitioning to the Endoscopy Unit (and the day shift) has allowed me to become involved with collaborative governance.

For the past 18 months I've been a member of the Patient Education Committee. I attended two workshops on "How to Write in Plain Language" that emphasized the need to create patient-education materials in language that's understandable to the average person. I've become increasingly aware of the number of individuals affected by healthcare literacy and the need for healthcare providers to be able to recognize when an individual is at risk. This awareness has enhanced my practice.

Gastroenterology holds a serious and important place in health care. Colorectal cancer kills more than 56,000 people a year. Research shows that removal of rectal polyps dramatically reduces the incidence of subsequent rectal cancers. As a preventative tool, endoscopic screenings are key to early detection of deadly gastrointestinal cancers. The American Medical Association recommends endoscopic screenings at age 50 (younger if there is a family history). Working on the Endoscopy Unit allows me to teach preventative health measures to patients on a daily basis.

Mr. J came to Endoscopy because he was scheduled for a screening colonoscopy. Our unit secretary asked me to speak to Mr. J because she was concerned he might not have a ride home. Since patients undergoing a colonoscopy receive intravenous conscious sedation and are still drowsy after the procedure, they're required to make arrangements for a ride home prior to having the procedure.

Mr. J was a well-kept, pleasant, distinguished-looking 74-year-old man who assured me he had carried out all the pre-procedure instructions correctly. He just needed to call his daughter for a ride home before we began his procedure. Mr. J picked up the telephone, and I realized something was wrong as he struggled to dial. He would hit a couple of numbers then put the phone down. I immediately offered him assistance with the call. He correctly told me the numbers, but he couldn't recognize them on the phone.

After confirming his ride home, Mr. J was asked to fill out some paperwork, which consisted of a past medical history and a list of current medications. Mr. J told me he'd forgotten his glasses and couldn't fill out the forms. (Forgetting glasses is a common reason given by people who are unable to read.) It was becoming increasingly obvious that Mr. J was going to need help in dealing with the many healthcare forms he would have to complete. I assured him that I'd be happy to assist him with the paperwork. As we reviewed the forms, Mr. J was vague about what illnesses he'd had and couldn't remember what medications he was on. Knowing this information is critical in order to prevent side-effects due to allergies and/or drug-to-drug interactions. Fortunately, Mr. J's past medical and medication histories are on file in our hospital information system. I assured him I could access this information and/or call his daughter if necessary.

Once the assessment was complete, the IV was started, and I explained what was going to happen in simple terms. Even though Mr. J was here for a screening exam, there's always a possibility that something will be found that would require him to come back for further testing. I needed to instruct him in a calm, relaxed manner that was understandable and complete. I reviewed the procedure and encouraged him to ask questions. I told him that during the procedure, he would be sedated. The nurse would monitor his vital signs and alert the physician of any changes immediately. After the procedure, he would be taken to the recovery room and his vital signs would continue to be monitored and assessed as the sedative wore off. He assured me he was comfortable with the plan of care but wanted to know that I'd check up on him during the procedure.

Since a variety of clinicians interact with patients during their time on the unit, it was very important to communicate Mr. J's needs to all his caregivers. My next step was to make sure the nurses and physician involved in his care were aware of Mr. J's need to have things explained in terms that he could understand.

On that particular day, I was working in the pre-procedure area, but I made a point of keeping abreast of Mr. J's progress. As he moved from area to area, I touched base with him to let him know I was available if he needed anything, and I communicated his special needs to his nurse.

Mr. J tolerated the exam well, but unfortunately a large polyp was removed, which meant he would have to come back to the hospi-

continued on page 7

Niles recognized as 2005 YMCA black achiever

At a special awards ceremony at the Marriott Hotel in Copley Square on January 27, 2005, Ivonny Niles, RN, was recognized as one of greater Boston YMCA's 2005 black achievers. Niles, a staff nurse on White 6, was nominated by her nurse manager, Kathleen Myers, RN, who wrote of her, "I have worked with Ivonny for the past two years and seen her grow into a caring, competent professional. She is a strong patient advocate, supportive of individual differences, and an emerging leader in this organization. Ivonny provides superb physical care but also nurtures the mind and the spirit. On a daily basis, she promotes inquisitive thought and supports a team approach to patient care."

Niles is co-chair of the MGH Foreign-Born Nurses Group, an active member of the PCS Diversity Steering Committee, she is a member of the National Black Nurses Association, the National Hispanic Nurses Association, and is currently working toward her bachelor of Science degree in Nursing.

The YMCA Black Achievers Program recognizes the professional and community-based achievements of black men and women who have demonstrated a history of achievement and the potential for future development. Award recipients agree to donate 40 hours of community service to benefit minority youth.

Ivonny Niles, RN,
staff nurse, White 6

Larry Washington of MGH Police & Security was also honored this year.

For more information about the annual YMCA Black Achievers Program, contact Carlyene Prince-Erickson, director of Employee Education & Leadership Development at 6-6386.

Narrative

continued from page 6

tal in three months. Prior to discharge-teaching, I made sure Mr. J's daughter was present to hear the instructions. The recovery-room nurse reviewed the discharge plan with both of them, and Mr. J was given written documentation of his medications and medical history. Prior to leaving, Mr. J came over and thanked me for my help and patience. Through teamwork and communication, Mr. J's experience was a positive one. My greatest thanks came when Mr. J returned three months later for his follow-up appointment and asked specifically if I would help him with the paperwork. His next exam was normal.

Healthcare literacy affects 90 million people in the United States. It results in appointments being missed, preps being done incorrectly. Patients with chronic illnesses have difficulty maintaining good health. Healthcare workers need to be observant and aware. When patients struggle to perform certain tasks, it could be the result of literacy issues.

I am fortunate to be part of the Patient Education Committee and to have attended workshops on plain language. As a member of this committee, I had the opportunity to speak at Nursing Grand Rounds about Healthcare Literacy. Communicating this topic to my colleagues is a responsibility I embrace. Through my involvement and heightened awareness of this issue, I was able to identify a patient in need early on, initiate a plan of care, and successfully intervene. To me, this is the essence of nursing.

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

This narrative is a wonderful example of the power of collaborative governance and its ability to educate and inform clinicians and improve the care we give to patients and families. Experience and awareness made Mary look more closely at Mr. J. She knew it was more than lost glasses. In the most compassionate and non-judgmental way, she helped Mr. J complete all the necessary tasks, and made her colleagues aware of his special needs. Mr. J sought Mary out on his next visit to MGH because he felt so safe in her care. What better testament to her skill?

Thank-you, Mary.

The Employee Assistance Program

presents

Get the Skinny on Popular Diets

presented by Suzanne Landry, RD,
Ambulatory Nutritional Services

Come hear a nutritionist review the pros and cons of popular low-carbohydrate diets. Learn how to live a nutritious, healthy life style. Resources will be provided, and there will be time for a question-and-answer session.

March 17, 2005
12:00–1:00pm
Wellman Conference Room

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

Carbon-monoxide poisoning: know the signs

—by Trisha Flanagan, RN, clinical nurse specialist

Carbon monoxide (CO) is a potentially lethal gas that's responsible for hundreds of deaths each year (the actual death rate from CO poisoning is 5,000 per year in the United States, but the majority of those cases are suicide). Carbon monoxide is a colorless, odorless gas that is produced by the incomplete combustion of certain fuels. Homes (or cars) that are fueled by gas, oil, or wood, if not maintained properly, can accumulate dangerous levels of carbon monoxide.

During the home heating season in New England, scores of people are treated for carbon-monoxide poisoning. Exposure is most prevalent in areas with inadequate ventilation, most commonly in automobiles with snow-obstructed exhaust pipes (which traps the fumes in the car) or homes with faulty heating systems or blocked vents. Exposure can also occur when kerosene heaters are used indoors, or when a stove or oven is used to heat a home.

Carbon-monoxide poisoning is not just a winter hazard. Many cases of CO poisoning occur as a result of exposure to boat exhaust fumes. Particularly susceptible are people who sit on the rear platforms of motor boats. The number of drowning deaths related to CO poisoning is unknown. Another means of exposure is riding in the back of pick-up trucks (out in the open or enclosed).

Carbon-monoxide poisoning affects people at the cellular level. Carbon monoxide competes with oxygen to bind with hemoglobin, the red blood-cell protein that transports oxygen from the lungs to the tissue. Carbon monoxide has a greater affinity for hemoglobin (200 times greater) than oxygen. The result is that tissues become starved for oxygen. The tissues that show the most profound effects of oxygen-starvation are the brain and the heart.

Acute exposure to high concentrations of carbon monoxide produce immediate symptoms of headache, nausea, and loss of consciousness. But it's important to note that carbon-monoxide poisoning can be slow and not easily detected in cases of chronic, low-level exposure. The symptoms of low-level exposure can be confused with a number of mild illnesses from a flu-like syndrome to food poisoning.

Symptoms of carbon-monoxide poisoning include:

- headache (in 90% of cases)
- nausea, with or without vomiting
- dizziness
- weakness
- memory deficit

As CO levels rise in the blood, the signs and symptoms become more ominous:

- visual impairment
- disorientation
- loss of consciousness

A common myth is that people with CO poisoning present with 'cherry-red' skin. In reality, red skin occurs in only about 2% of cases; patients are more likely to present with pale or cyanotic skin tone.

Carbon monoxide is particularly lethal in children. Their metabolic rates put them at higher risk even at lower levels of exposure. They typically suffer more severe symptoms even with low-concentration, short-term exposure. Children may complain of nausea only and appear to have a gastrointestinal illness. In infants, CO poisoning can mimic colic.

The first step in caring for someone with CO poisoning is to remove him or her from the site of exposure. The rescuer as well as the victim should leave the contaminated area. 100% oxygen should be administered, and in more severe cases, oxygen administration in a hyperbaric chamber is recommended. Critically ill patients may require mechanical ventilation and admission to an intensive care unit.

Carbon-monoxide poisoning is always a possibility in situations such as house fires or when someone is found unconscious in an idling car. When considering whether carbon-monoxide poisoning has occurred, you should ask these key questions:

"Do your symptoms occur only at home or only at work and resolve when you go to a different location?"

"Is anyone else at your location experiencing similar symptoms?"

"Do you have a carbon-monoxide detector?"

Pulse oximetry is a frequently used, non-invasive device that determines oxygenation levels by estimating the amount of oxygen-saturated hemoglobin. Pulse oximetry is *not* reliable in determining CO poisoning because it cannot differentiate between carbon monoxide and oxygen bound to hemoglobin.

Being aware of symptoms and high-risk situations can help prevent carbon-monoxide poisoning. Community-based education should address home-heating safety, reducing the risk of exposure, and knowing when to seek medical attention. Precautions to minimize the possibility of CO poisoning include:

- annual inspection of home-heating systems by qualified technicians
- regularly checking ventilation systems to make sure ducts are free of obstructions (such as snow, leaves, or animal nests)
- proper use of kerosene heaters and charcoal grills
- never allowing a car to idle without adequate ventilation (an open garage door may not be enough to keep carbon monoxide from accumulating)
- checking motor vehicle exhaust pipes to make sure they're unobstructed and not clogged with, or buried in, snow
- never riding in the back of a pick-up truck or on the rear platform of a power boat
- installing carbon-monoxide detectors in your home, but not relying solely on the alarm to confirm the presence of carbon monoxide—some detectors are set for low levels, others for very high levels
- immediately seeking medical attention if you suspect carbon-monoxide poisoning

For more information about carbon-monoxide safety, contact Trisha Flanagan, RN, clinical nurse specialist in the ED, at 4-4932.

Hand Hygiene Program: an MGH success story

—by Judy Tarselli, RN, Infection Control Unit

The STOP (Stop the Transmission of Pathogens) Task Force has announced new expectations for hand-hygiene compliance and is making some changes in the Hand Hygiene Rewards Program for 2005.

In the healthcare setting, hand hygiene is required *before* and *after* contact with patients or their environment. Disinfection with an alcohol-based hand rub (such as Cal Stat) is the preferred method of ensuring hand hygiene because it's fast, convenient, and highly effective at killing pathogens. Hand-washing with soap and water for at least 15 seconds is also acceptable, and is required if hands are visibly soiled before eating or after using the bathroom. At MGH, routine observations are made on units to monitor compliance with hand-hygiene requirements. Results are reported to staff and managers, allowing each unit to see its own compliance rate and compare its results to those of similar units.

Perfect hand-hygiene practices would result in a rating of 100/100, meaning 100% compliance by 100% of employees both before and after contact. Compliance rates at hospitals across the country tend to be lower than 100/100. At MGH, the STOP Task Force and unit-based hand-hygiene champions have been working to improve compliance rates through education, monitoring, feedback, friendly inter-unit competition, and rewards.

Many units have achieved lasting improvement in hand-hygiene compliance rates, and we have started to see significant results. The Infection Control Unit reported an overall decline in the rate of some hospital-acquired infections in 2004, including a steady decline in MRSA (methicillin-resistant Staphylococcus aureus).

2005 is expected to bring greater improvement in compliance rates and more opportunities for rewards. Surveyed units will no longer compete against one another. Instead, they will strive to meet a numeric goal—a pre-specified rate for hand-hygiene compliance before and after patient contact. All units that achieve their goal will receive a pizza party or similar reward.

Quarterly targets for hand-hygiene compliance in 2005 are:

- First quarter (January–March)
  50% compliance before *and*
  80% after contact (50/80)
- Second quarter (April–June)
  60% compliance before *and*
  80% after contact (60/80)
- Third quarter (July-September)
  70% compliance before *and*
  80% after contact (70/80)
- Fourth quarter (October–December)
  80% compliance before *and*
  80% after contact (80/80)

As always, the ultimate goal for hand-hygiene compliance is 100/100. Following are some tips to help us succeed in achieving our goal:

- *Every* unit to reach the quarterly goal will be rewarded, but *both* parts of the goal must be met
- Pathogens can live on objects and surfaces you touch, so hand hygiene is required before and after contact with patients' environment even if you don't touch the patient
- The greatest area for improvement in hand hygiene is before contact. Hand-washing before contact protects patients from pathogens that may have been picked up from contact with the general hospital environment
- Gloves do not provide a perfect barrier and should not be used as a substitute for hand hygiene. Cal Stat or hand-washing with soap and water is required before and after glove use
- Give each other friendly reminders so hand hygiene becomes automatic on your unit. Be sure to include all support staff and physicians in these reminders because their actions count, too

The rewards program was created to keep attention focused on the importance of improving hand hygiene. By promoting better hand hygiene, we can stop the transmission of pathogens, and our patients are the real winners.

For more information about hand hygiene or the Hand Hygiene Rewards Program, contact Judy Tarselli, RN, in the Infection Control Unit at 6-6330.

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Abbrvs. can coz cnfsn.

(Abbreviations can cause confusion)

—by Georgia Peirce, director of PCS Promotional Communications and Publicity and National Patient Safety Leadership fellow

Even under the best of circumstances, abbreviations can be misinterpreted or misunderstood. Abbreviations may have different meanings in different settings. This can result in confusion and/or harm to the patient. Every abbreviation used in medical records and documentation should be recognizable, understandable, and mean the same thing to the diverse cross-section of clinicians and employees involved in the care of the patient. All abbreviations need to make sense in the context of the medical-record entry. If you suspect that a particular abbreviation could lead to confusion, you should spell the word out. The following table guides practice at MGH:

Abbreviations and acronyms that should not be used

Unacceptable	Acceptable
Q.D. and Q.O.D.	Use 'daily' and 'every other day'
D/C for discharge or discontinued	Write 'discharge' or 'discontinued'
MS, MSO_4 and $MgSO_4$	Write 'morphine sulfate' or 'magnesium sulfate'
H.S. for half-strength or bedtime	Write out 'half-strength' or 'at bedtime'
Zero after a decimal point (1.0)	Do not use terminal zeros (1)
No zero before a decimal dose (.5mg)	Always use a zero before a decimal when the dose is less that a whole unit (0.5mg)
ss for sliding scale	Use 'sliding scale'
µg for microgram	Use microgram or 'mcg'
U for unit	Use 'unit'
IU for international unit	Use 'unit'
Apothecary symbols	Use metric system ('ml' 'mg' 'mcg')
Per os for orally	Use 'PO' 'by mouth' or 'orally'
qn as nightly or at bedtime	Use 'nightly'
BT for bedtime	Use 'bedtime'

Prohibited abbreviations apply to all hand-written and free-text electronic clinical documentation

Meanings of commonly acceptable abbreviations can be found at: http://www.pharma-lexicon.com

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, web developer, at 6-3193

The Employee Assistance Program

presents

Single Again Financial Seminar

presented by Brendon Vigorito, regional coordinator of Education Credit Counseling Services

Program focuses on credit-related decisions, financial obligations, building a credit history and other fiscal concerns for divorced or soon-to-be-divorced individuals.

February 22, 2005
12:00–1:00pm
Anesthesia Conference Room

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

The Employee Assistance Program

presents

Elder Care Monthly Discussion Groups

facilitated by Barbara Moscowitz, LICSW, geriatric social worker

Caring for an aging loved one can be challenging. Join us for monthly meetings to discuss legal, medical, coping and other issues.

Next meeting: March 15, 2005
12:00–1:00pm
Bulfinch 225A Conference Room

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

When/Where	Description	Contact Hours
February 25 8:00am–4:30pm	**Preceptor Development Program** Training Department, Charles River Plaza	7
February 25 12:00–4:000pm	**Basic Respiratory Nursing Care** Ellison 19 Conference Room (1919)	- - -
February 28 8:00am–4:00pm	**Advanced Cardiac Life Support—Instructor Training Course** O'Keeffe Auditorium. Current ACLS certification required. Fee: $160 for Partners employees; $200 for all others. For more information, call Barbara Wagner at 726-3905.	- - -
March 3 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
March 3 8:00am–12pm	**Congenital Heart Disease** Haber Conference Room	4.5
March 4 and March 21 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
March 7 8:00–11:00am	**Advance Directives: Hard Facts, Humor and How To's** O'Keeffe Auditorium	3.3
March 8 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	**CPR—Age-Specific Mannequin Demonstration of BLS Skills** VBK 401 (No BLS card given)	- - -
March 9 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
March 9 11:00am–12:00pm	**Nursing Grand Rounds** "Methadone: an Important Analgesic." Sweet Conference Room GRB 432	1.2
March 9 and 10 8:00–5:00pm	**End-of-Life Nursing Education Program** TBA	TBA
March 10 1:30–2:30pm	**OA/PCA/USA Connections** "Professional Interactions in a Diverse Hospital Setting." Bigelow 4 Amphitheater	- - -
March 14 8:00am–4:30pm	**Intermediate Respiratory Care** Wellman Conference Room	TBA
March 15 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
March 16 4:00–5:30pm	**Natural Medicines: Helpful or Harmful?** Founders 626	1.8
March 17 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK 401	- - -
March 23 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
March 23 4:00–5:00pm	**More than Just a Journal Club** Welman Conference Room	- - -
March 21 8:00am–4:30pm	**The Surgical Patient: Challenges in the First 24 Hours** O'Keeffe Auditorium	- - -
March 24 1:30–2:30pm	**Nursing Grand Rounds** "Anti-Coagulation Update." O'Keeffe Auditorium	1.2
March 24 7:00–11:30am and 12:00–4:30pm	**Congenital Heart Disease** Haber Conference Room	4.5

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.

Senior HealthWISE lecture focuses on cardiovascular health

On Tuesday, February 8, 2005, in the Walcott Conference Room, Dorothy Noyes, RN, nurse practitioner for the MGH Heart Failure Disease Management Program, spoke as part of the MGH Senior HealthWISE lecture series. Her topic was, "Cardiovascular Health."

Noyes spoke about the risk factors associated with cardiovascular disease: high blood pressure (or a history of high blood pressure), high cholesterol, obesity, a family history of heart disease, or any combination of these factors (more than one risk factor increases your overall risk for heart disease). She stressed that heart disease, while typically associated with men, affects women, too, though women tend to experience heart attacks differently (reporting symptoms of nausea, fatigue, and heavy limbs).

In terms of preventing heart disease, Noyes recommended:

- a diet of fresh fruits, vegetables, and fiber
- limiting your intake of saturated fats
- limiting your intake of prepared food (which can be high in sodium)
- exercise more (walking is still the best exercise for good heart health)
- control high blood pressure by limiting your intake of alcohol, nicotine, and sodium; and keep stress to a minimum

Noyes closed by reminding elders that keeping fit is one of the best things you can do for yourself. For more information about the Senior HealthWISE program, call 4-6756.

Dorothy Noyes, RN, nurse practitioner for the MGH Heart Failure Disease Management Program

Caring HEADLINES

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