

Caring

January 20, 2005

HEADLINES

Duffy retires to tributes, tears, and testimonials

When they coined the phrase, "All good things must come to an end," surely they were talking about Jan Duffy's distinguished career and the countless accomplishments and contributions she made during her 23 years at MGH. On Friday, December 17, 2004, Jan Duffy, RN, officially retired, taking with her fond memories and fond farewells from the many colleagues, patients, families, and friends whose lives she touched with her skill, professionalism, kindness, and grace.

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Jan Duffy, RN



Duffy with Rosemary O'Malley, RN (top right); Rosalie Tyrrell, RN (lower left); and MGH president, Peter Slavin, MD

(Photos by Abram Bekker)

Healing and helping after the tsunami in Southeast Asia

In the aftermath of the tsunami that devastated Southeast Asia and parts of Africa, what UN secretary-general Kofi Annan called, “a natural disaster of unprecedented magnitude,” the MGH Chaplaincy and administration co-sponsored a special service of healing and reflection. Many of you were able to attend, but for those who were not, it was a wonderful opportunity to come together to grieve for this

unimaginable loss of life so far away, and to share hope and prayers for the safety and healing of survivors everywhere.

MGH president, Peter Slavin, MD, thanked the MGH community for the outpouring of concern and generosity in the form of money, supplies and needed services. There were readings and hymns; members of the Chaplaincy led the gathering in song; and part of the service was reserved for the sounding of a

gong in honor of each country affected by the tsunami.

Jeff Davis, senior vice president for Human Resources, read this short poem by Clarissa Pinkola Estes, entitled, “The Ultimate Faith.”

New seed
is faithful.
It roots deepest
in the places
that are
most empty.

Despite the fact that this tragedy happened on the other side of the world, we are all affected. I’d like to thank the Chaplaincy for their efforts in bringing us together to support and comfort one another in the wake of this horrific event.

MGH has been invited to participate in a collaborative humanitarian effort with Project HOPE to help provide



Above: Seedlings representing new life were offered as a symbol of hope.

At right: Marianne Ditomassi, RN, executive director to the office of senior vice president for Patient Care, sounds gong in honor of countries affected by the tsunami.



(Photo by Paul Batista)



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

medical support for teams already serving in the area.

There is a request for nurses and doctors to volunteer to staff operating rooms, intensive care units, and medical units on the US Mercy (a US Naval hospital ship). Susan Briggs, MD, director of the MGH International Trauma and Disaster Institute; Larry Ronan, MD, director of the MGH Durant Fellowship; Jeff Davis; Theresa Gallivan, RN, associate chief nurse; and I will co-direct the MGH response. Our participation in the relief effort is expected to last approximately three months with teams of volunteers serving 30 days at a time.

Many of you have asked how you can help. We will do our best to ensure that any MGH volunteer who wants to be involved is able to do so. (All volunteers will

need approval from their department supervisors.)

Food, medicine, money, and supplies will continue to be needed in the days and months ahead. MGH is establishing a tsunami relief fund to contribute much-needed money to help survivors. A committee has been formed to evaluate and coordinate the distribution of monies from this fund. To make a contribution to the MGH Tsunami Relief Fund, visit <http://is.partners.org/mghintra.net/tsunami/index.htm> (no spaces). Donations can be made on-line.

Flu Vaccine Update

I want to remind everyone that despite the shortage of flu vaccine earlier in the season, there is now ample supply for all MGH patients and employees. All restrictions for receiving flu vaccine have been lifted, and it’s not too

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EMAP: the Electronic Medication Administration Process

Question: Can you tell us more about the new electronic medication system I've been hearing about?

Jeanette: The Electronic Medication Administration Process (EMAP) is a new quality and safety initiative I'm sponsoring along with associate chief nurse, Jackie Somerville.

Question: What prompted this initiative?

Jeanette: We are always looking for ways to improve quality and ensure the continued safety of our patients. Recently, the Institute of Medicine (IOM) recommended the use of both computerized POE and bar-coded med-

ication-administration systems to decrease medication errors in the hospital setting. POE is designed to reduce errors in the ordering process. EMAP ensures accurate electronic medication transcription, distribution, administration, and documentation.

Question: How does EMAP work?

Jeanette: Medication orders will flow electronically from POE to the new EMAP information system, eliminating the need for OAs to manually transcribe orders onto Medication Administration Records (MARs). Nurses will be able to

use the computer to see what medications were ordered and when they need to be administered. After retrieving the medication, nurses go to the bedside with a portable computer, scan the medications, scan the patient's identification band, and scan the nurse's identification badge. If all identifiers are confirmed, the nurse may proceed in administering the medication. At this point, EMAP automatically documents the time the medication was administered and the name of the clinician who administered it.

In the event that a discrepancy is detected,

the nurse would receive an alert indicating a mismatch. For example, if a patient was supposed to receive 40mg of Lasix, and the nurse only scanned 20mg, an alert would be triggered.

Question: How will this work on patient care units?

Jeanette: Each nurse will have a portable computer, which will allow her to use the EMAP system, access POE, CAS, and all other functions currently available on desktop computers. Respiratory therapists will use the system to administer and document the medications they administer. Nurses, physicians, therapists, and all other members of the team will be able to see which medications a patient has received (and EMAP information can be view-

ed by more than one person, in more than one location, at a time). But only one clinician is able to administer and document medications at any given time.

Question: What systems need to be integrated or updated in order to implement this program?

Jeanette: Pharmacy is installing a new computer system called Misys, which will be electronically linked to POE eliminating the need for manual transcription. The new Misys system needs to be in place before EMAP can be implemented, and that installation is expected to be complete by late 2005.

Last year, the FDA mandated that pharmaceutical companies start bar-coding medications as an added safety precaution (currently 50% of all medications are bar-coded). The MGH Pharmacy is in the process of bar-coding medications not previously bar-coded, and this work must be completed before EMAP can be implemented.

The wristband initiative, which will convert current patient ID bands to bar-coded wristbands must be implemented before EMAP; and Smart Pump technology, which is coming to MGH in the future, will also need to be integrated into the EMAP system.

Question: What is the time frame for implementation?

Jeanette: EMAP committees have been meeting for the past several months. Focus groups have been held with nurses and respiratory therapists to provide input about EMAP and our current work flow. More focus groups are planned for the future.

The next event will be a product fair where clinicians will have an opportunity to learn more about potential EMAP systems. Then a vendor will be selected and integration with POE and Misys will begin.

For more information about the EMAP initiative, contact staff specialist, Rosemary O'Malley, at 6-9663.

Jeanette Ives Erickson

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late to benefit from the protection the vaccine can provide.

This winter saw a mild start to the flu season, but in recent weeks there has been a dramatic increase in the number of cases reported. It is anticipated that flu activity will continue to increase during the months of January and February.

All MGH patients and staff are encouraged to get a flu shot. Vaccine is available from Occupational Health Services (6-2217) and on all inpatient units.

MGH patients should contact their doctors to ask about being vaccinated. Patients may also be vaccinated at the MGH Medical Walk-In Unit Mondays-Fridays, from 10:00am-3:00pm. The cost of a flu shot is \$11, but many insurance companies cover the cost.

Please help spread the word, and not the flu. Thank-you.

Updates

I'm pleased to inform you that Susan Morash, RN, has accepted the position of nurse man-

ager for the White 11 General Medicine Unit.

Chris Donahue Annese, RN, has accepted the position of staff specialist to Theresa Gallivan, RN, associate chief nurse for Medicine, Cardiac, and Emergency Nursing.

Katie Farragher has accepted the position of senior project specialist in the Office of Quality & Safety.

Keith Brinkley has accepted the position of operations coordinator for Ellison 14 and the BMT Infusion Unit.

Roche, Tufts, receive Marie C. Petrilli Oncology Nursing Award

—by Julie Goldman, RN, professional development coordinator

Nurses, Maria Roche, RN, and Lisa Tufts, RN, were recipients of the 2004 Marie C. Petrilli Oncology Nursing Award in recognition of the high-quality care, compassion, and commitment they show in their practice with oncology patients.

The Marie C. Petrilli Oncology Nursing Award was created by Al Petrilli (Marie's husband) and his brother David, who founded the Marie C. Petrilli Cancer Research and Treatment Fund to help raise money and

awareness around cancer and cancer research. Money from this fund has also supported our Social Services department in providing funds for patients in need and completing renovations on Bigelow 7.

Recipients were honored at two separate ceremonies, one at the annual Petrilli fund-raiser at the Winthrop Yacht Club on October 1, 2004, and one in the Hackett Conference Room on November 16th.

Nurses can be nominated by patients, family

members, nurse managers, colleagues, or physicians.

Roche has been a nurse for 14 years, nine as a nurse practitioner. In a letter of recommendation in support of Roche, Dr. Carolyn Krasner said, "Maria is able to develop an excellent and important rapport with her patients. During their first visit with her, patients air their deepest fears. Maria provides a calming influence as she helps them discuss their pain and treatment options. Maria is able to

guide them through the many ups and downs of cancer treatment, and support patients and families through hospice care. And she continues her involvement with bereaved families." Said Dr. Krasner, "Many young people who come to work here with an interest in medicine and/or research, leave to pursue nursing after working with Maria."

Tufts came to MGH in 1996 and held a number of positions prior to her present role as staff nurse on Ellison 18. Nominated by Ellison 18 nursing colleagues and clinical nurse specialist, Mary Lou Kelleher, RN, her letter of recommend-

ation read, "Lisa always looks first at the patient as a person/child/adolescent in the context of a family and then in the context of the diagnosis. She connects instantly and sets the foundation for a strong relationship. She is a committed primary nurse but has a special fondness for pediatric oncology patients. Lisa is always amazed by the courage and resiliency of pediatric oncology patients and realizes the importance of the role of the primary nurse with patients and families."

Said nurse manager, Judy Newell, RN, "Lisa brings a 'can-do' attitude to every situation. She has the ability to keep the uniqueness of her patients and families at the center of all decisions, fostering the very best in her practice."

Other nurses nominated for the Marie C. Petrilli Oncology Nursing Award this year were:

- Jennifer Casey, RN
- Jean Kracher, RN
- Kimberly MacGregor
- Patricia McGrail, RN
- Kathleen Megan, RN
- David Miller, RN
- Connie Roche, RN
- Ann Snow, RN
- Gail Umphlett, RN

For more information about the Marie C. Petrilli Oncology Nursing Award contact, Julie Goldman, RN, professional development coordinator, at 4-2295.



(Photos by Abram Bekker)

At far left: co-founder of the award, Al Petrilli

At left: Petrilli award recipients, Lisa Tufts, RN (left), and Maria Roche, RN

Below: award recipients with Petrilli family members (l-r): Karen Cavaleri, Pamela Weeks, Paul Citro (back), Roche, Susan Neuner (back), Christine Citro, Paula Cavaleri (back), Tufts, Al Petrilli, David Petrilli, and senior vice president for Patient Care, Jeanette Ives Erickson, RN

Duffy Retires

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Among many admirers attending a reception in Duffy's honor, was MGH president, Peter Slavin, MD. Said Slavin, "Jan and I both began our careers at MGH on the Medical Service. It didn't take long for me to realize the depth of her clinical and managerial expertise. I remember to this day the ease and agility with which she oversaw day-to-day op-

erations. She was a pioneer in the area of quality and safety; it was under her watchful eye that the *Clinical Policy & Procedure Manual* grew into the interdisciplinary tool it is today. Jan's 'can-do' attitude has always been behind the scenes driving us to be the best we can be.

"Jan, on behalf of MGH, I thank you for your unwavering commitment to this hospital."

Staff nurse, Suzanne Algeri, RN, spoke about

Duffy as, "a true advocate for patients and nursing." She used words like integrity, character, disciplined, thoughtful, and reliable. Algeri recalled a time when Duffy made an observation about another well-respected colleague's retirement, saying, "Replacing her is going to be like replacing the Queen of England." Said Algeri, "I wouldn't be surprised if someone is saying the same thing about you right now."

Theresa Gallivan, RN, associate chief nurse, and the person to whom Duffy reported at the time of her retirement, gave a heartfelt tribute to her long-time friend and colleague. Said Gallivan, "Like most of us who can name colleagues, mentors, and role models who've had an enormous impact on our development as practitioners, professionals, and human beings, I was in awe of Jan Duffy. Her reputation for excellence preceded her.

"She is the consistent role model, quietly teaching, guiding, and mentoring. She's constantly raising the bar, carefully researching the issues, considering all perspectives, collaborating with and generously crediting others, getting the job done, and all the while maintaining so much energy.

"Jan, thank-you for all you've contributed, all you've taught us, and most importantly, all you've inspired us to be."

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, framed her remarks around a comparison of Duffy's exquisite career to the exquisite nursing sundial sculpture that adorns the Bulfinch lawn. The three figures in the sculpture carry a lamp, representing the past, a book, representing the importance of scientific knowledge, and a globe, representing diversity and interconnectedness. Said Ives Erickson, "Like the three figures on the sundial, Jan has 'shown us the way,' she has used evidence-based practice to guide our clinical advancement, and she has successfully brought people together to create a network of policies, programs, and an infrastructure that supports nurses today, and will continue to guide the nurses of tomorrow."

Presenting Duffy with a signed picture of the nursing sundial, Ives Erickson said, "Jan, we all wish you and your family health, happiness, and harmony as you embark on this new chapter in your life."

In a packed Walcott Conference Room, in her trademark, soft-spoken manner, Duffy thanked everyone for coming and for the privilege of being part of the MGH community for 23 years.

Said one teary-eyed colleague, "It's not every day that a 'Jan Duffy' walks through your front door."

You'll be missed, Jan.



Above: Jan Duffy with senior vice president for Patient Care, Jeanette Ives Erickson, RN.

At right: Duffy with associate chief nurse, Theresa Gallivan, RN, and husband, John, at special reception in her honor. Duffy was a 23-year veteran of MGH.



Diffusing a difficult situation with confidence, caring, and a positive attitude

My name is Laurie Miller, and I am a staff nurse on White 12. I was working the 3-11 shift as charge nurse one evening when I received a new admission. The patient was a 73-year-old man who was coming in from a community hospital with severe back pain. During a phone conversation with the referring nurse, she told me, "The patient is fine. The family is another story." According to the nurse, the family had been very demanding both physically and emotionally, and staff was glad that a transfer was in progress.

I was also told that the patient had a history of lung cancer. In the work-up at the other hospital, lesions had been discovered on his kidney, liver, and thoracic spine. From what the nurse told me, I knew that pain was going to be a primary concern, not only for the patient but also for his family.

I've dealt with many difficult patient and family situations in my 17 years as a nurse on White 12. Experience has taught me that these situations need to be approached with openness. As I began to plan for this man's admission, I thought how stressful it must be for him and his

family. Not only were they coping with the hospitalization of their father and husband, they were also facing the possibility that this could be a metastatic process with a poor outcome. I imagined myself in their situation and began to think how we might be able to help them holistically.

A short time later, Mr. D arrived by ambulance. He was thin and fragile in appearance and seemed frightened. I settled him into his bed and his wife and three daughters arrived a short time later. Their stress level was obvious. The daughters all had medical backgrounds, one had been a nurse years ago at MGH.

They asked to see the physician and charge nurse immediately. I knew that the first step in diffusing a potentially difficult situation was to be prompt and confident. It became evident during this meeting with the family that they were under a great deal of stress. They were acutely aware that this could be a metastatic process, and their primary concern was maintaining Mr. D's comfort. They told me they had not yet shared the prognosis with him, and they were considering a number of ideas as to how best to do that. It became clear that Mr. D

had been a very active, independent, and stoic man. The level of pain he was experiencing frightened him as well as his family. They were all concerned that his pain had not been adequately addressed at the other hospital. In consideration of this, the family asked that we touch him as little as possible and avoid providing any physical care without first pre-medicating Mr. D.

I realized that Mr. D's family was going to require a lot of emotional support. I knew it was going to be crucial to develop a trusting relationship with all of them. I reassured them that Mr. D's pain would be addressed and managed. I had to accomplish a lot in a short period of time. Fortunately, it was the beginning of a 12-hour shift for me, giving me the time I needed.

The family and I discussed a number of methods of short- and long-term pain-control and the various team members who would be involved in the process. Since this was clearly a priority, I began by asking the admitting physician for a pain consult. The pain team agreed to see him urgently, and shortly thereafter Mr. D was started on a PCA to control his short-term pain. This seemed to give Mr. D and his family a sense



Laurie Miller, RN
staff nurse, White 12

of control. It reassured them that we were able to manage his pain regardless of how quickly it came on. Next, we discussed and initiated MS Contin for longer-acting control. Mr. D's family was relieved by this, knowing we were addressing both his short- and long-term needs.

I established a plan that included non-medical treatment modes for Mr. D's pain. This included taking him to testing areas in his bed rather than transferring him to a stretcher. Tasks such as bathing and other ADLs were coordinated around medication times to maximize his ability to perform them while minimizing pain.

I still needed to deal with the family's anxiety. With their medical knowledge, they knew there was a high probability their father had metastatic cancer and were familiar with the regimen of chemotherapy, radiation, surgery, or palliative care that would follow. I placed a call to our

social worker who began regular visits with the family every day.

Another measure I employed to minimize their anxiety was to limit the number of caregivers involved in Mr. D's care to foster continuity and trust. This was accomplished by the charge nurse who ensured that Mr. D was assigned the same group of nurses and PCAs on every shift. I was able to secure a cot for the family in Mr. D's room, providing them with unlimited visiting hours, and allowing them ongoing involvement with Mr. D's care.

Each morning when the pain team rounded, the attending physician was usually present. The nurse, social worker, and physicians would meet at the nurses' station to review any issues or concerns. This added to the continuity of care, as all members of the team would be knowledgeable about the plan when meeting with Mr. D or his family.

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Clinical Narrative

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Within a few days, the family's anxiety level had significantly decreased, and they had developed a trusting relationship with staff. Mr. D's pain significantly improved, and he began getting out of bed to actively participate in Physical Therapy.

At the time of discharge, Mr. D was able to ambulate in the hallways with supervision and the use of a walker. His family had stopped staying overnight but took very active roles in his physical care, assisting him when necessary, but helping to foster his independence.

This patient-family interaction clearly demonstrates the importance of developing a trusting relationship early in the course of a patient's hospitalization. It also illustrates the need for caring

for a patient and family from a social, emotional, psychological, and physical perspective. Pain-relief was the prime concern for Mr. D and his family, and I made it a priority from the moment they arrived on White 12.

The family's concerns about sharing Mr. D's diagnosis with him were effectively managed by involving the social worker from the beginning. Emotional support was provided to Mr. D and his family throughout his hospitalization and through the process of dealing with their inevitable loss.

Years of experience helped me quickly identify and assess the needs of this patient and his family, establish a plan that met their physical and psychological needs, and follow through with

a plan that included consistency among members of the healthcare team. I believe my early interventions on the first day of Mr. D's hospitalization contributed to a positive outcome for him, his family, and for staff.

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

"Difficult" is in the eye of the beholder. When Laurie received report on Mr. D she could have let another caregiver's impressions carry over into her own perceptions of Mr. D and his family. But she did not. Laurie suspended judgment, put herself in their place, and quickly assessed what

she could do to ease their suffering. Knowing that it was a priority for the family, she took immediate steps to address Mr. D's pain. She allayed their fears by inviting family members to stay overnight. And she promoted continuity by en-

suring Mr. D had a consistent team of caregivers.

With honesty and openness, Laurie turned what could have been a contentious interaction into a powerful, united working relationship.

Thank-you, Laurie.

Hand Hygiene Champion of Champions Award

Nominations are now being accepted for the 2004 Hand Hygiene Champion of Champions Awards to recognize hand hygiene champion(s) from patient care units. The award honors champions who have worked creatively and diligently to promote awareness around hand hygiene.

Applications are available in the Bigelow 10 and Founders 108 Nursing offices.

Deadline for nominations is January 31, 2005.

For more information, call Rosemary O'Malley at 6-9662 or send e-mail.

Call for Abstracts Nursing Research Day May 4, 2005

The Nursing Research Committee is calling for poster abstracts for Nursing Research Day 2005.

This is an opportunity to share nursing research, evidence-based practice models, and creative approaches used to improve the nursing care of patients and their families

To submit an abstract, go to the Nursing Research Committee website at: www.mghnursingresearchcommittee.org (no spaces), select "Abstract Submission" and follow the submission guidelines.

For more information contact: www.mghnursingresearchcommittee.org

Submissions are due by January 31, 2005

Call for Proposals The Yvonne L. Munn, RN, Nursing Research Awards

Staff are invited to submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Week in May of 2005.

Proposals are due by March 1, 2005. Guidelines to assist in developing proposals are available at: http://pcs.mgh.harvard.edu/CCPD/cpd_award_munn.asp (no spaces)

For more information, contact Virginia Capasso, RN, at 726-3836 or by e-mail at vcapasso@partners.org

Nurse Week 2005 will be celebrated at MGH May 1-6, 2005

Spanish for healthcare providers

Register now for winter classes. Five levels of classes offered from beginner to advanced. Classes start the week of February 1, 2005.

\$75 for MGH employees;
\$150 for non-MGH employees.
Payment must be made at time of registration. Register in person at MGH Training, 100 Charles River Plaza from 8:00am-5:00pm. Classes are held once a week for 16 weeks

For more information call 4-3241; call Natalia Cepeda at HablEspana, (617) 426-4868 ex.201; or e-mail mghtraining@partners.org

Registration ends Tuesday, January 25th

Ethics and practice: an overview of advance directives

—by Theresa Cantanno-Evans, RN, and Joanne Empoliti, RN

Advance directive is a general term used to define two categories of legal documents—treatment directives and proxy directives. A treatment directive provides specific instructions about future medical care for an individual, while a proxy appoints another individual to make health decisions when the appointor is incapable of making decisions independently.

Confusion sometimes arises when deciding which directive is more suitable in a given state.

Each state has unique guidelines for advance-directive planning. In Massachusetts, for example, a healthcare proxy has been the preferred form of advance directive for many years.

In 1983, advance directives were introduced to assist the public in addressing end-of-life issues. However, it wasn't until 1990 when the Patient Self Determination Act was created that the measure really took hold. The Patient Self Determination Act came in response to Cruzan vs. the Missouri Department

of Health, a landmark end-of-life-care legal decision. The government felt it was time to create clearer guidelines to clarify states' roles in these situations. Senators Danforth (of Missouri) and Moynihan (of New York) introduced the bill to Congress with support from Representative Levin (of Michigan) in October of 1989.

The Patient Self Determination Act was enacted in 1990 and implemented in 1991. Part of the Omnibus Budget Reconciliation Act, it required that all facilities, hospitals, home-health agencies, skilled nursing facilities, HMOs, and hospice organizations receiving Medicare and Medicaid funds provide patients with information regarding advance directives and inform them of their right to complete one. Additional support has come in the form of JCAHO standards and requirements.

Three key provisions of the Patient Self Determination Act speak directly to advance-directive planning. Healthcare facilities are to provide written information to patients about their decision-making rights while ensuring compliance with state law. Facilities are to maintain policies and procedures for advance-directive planning



clinical nurse specialists, Joanne Empoliti, RN (left), and Theresa Cantanno-Evans, RN

and document whether a patient has completed a directive. And facilities are to educate staff and the community about advance-directive planning. The Patient Self Determination Act did not create new rights for patients, just affirmed the rights guaranteed under the Fourteenth Amendment.

At MGH, all patients capable of making decisions should be asked if they have completed an advance directive. If they have, a copy should be placed in the designated section of the medical record. The original should remain with the patient (and it's suggested that agents, primary physicians, and family members receive copies). The admitting nurse should document that a copy has been obtained, and the physician should discuss the directive with the patient.

If a patient has not completed an advance directive, information should be provided about

the Massachusetts Health Care Proxy. Assistance in completing the form should be offered at this time and, if necessary, in follow-up visits. A current understanding of the patient's wishes by the assigned agent is critical to the success of advance directives. Communication between all involved parties should be encouraged.

Resources at MGH that might be helpful to patients include Social Services, ethics committees, Chaplaincy, the Blum Patient & Family Learning Center (for access to advance directives in other languages), and *The Clinical Practice & Procedure Manual*. Advance care planning is a work in progress and continues to be the collaborative focus of many at MGH.

For more information about advance directives, contact Theresa Cantanno-Evans, RN, at 4-6010, or Joanne Empoliti at 6-3254.

Healthcare proxy vs. durable power of attorney for health care

Some of the terminology surrounding advance directives can be confusing. For instance, a *health care proxy* in one state is virtually the same thing as a *durable power of attorney for health care* in another state, which is the same as *medical power of attorney* in others (see: www.partnershipforcaring.org for more information). The phrase, 'power of attorney,' can be misleading because in other situations it carries legal implications. Many people believe, like estate planning, they need a lawyer to create an advance directive. That is not the case in Massachusetts. When an individual appoints a *power of attorney for health care*, it shouldn't be confused with a power of attorney for other matters, such as finances. The latter requires notarization and is completely separate from healthcare planning. For this reason, Massachusetts uses the term *health care proxy* to avoid confusion. Any healthcare advance directive can and should be prepared with the help of a healthcare provider.

On-site/On-line RN to BSN degrees in Nursing

MGH nurses seeking a baccalaureate (BSN) in Nursing, come learn more about opportunities to earn degrees through on-site and on-line programs.

On-site program offered by Northeastern University

On-line (distance learning) program offered by St. Joseph's College of Maine

Information Session
Monday, February 7, 2005
6:30am-8:00pm
Main Corridor

For more information, contact
Miriam Greenspan, RN,
on-site/on-line education coordinator in
The Center for Clinical & Professional
Development at: 4-3506
pager: 3-0724
or by e-mail.
(Next class session in late March)

The Different Faces of Quality Improvement: Creating an Environment of Quality and Safe Practice

All members of the MGH community are invited to attend this educational offering to learn how to create and maintain the safest possible environment for patients, families, visitors, and employees. Topics will include:

Strategic Planning
Patient Safety Goals for 2005
The Role of Patient Safety Rounds
Planning a Project Improvement Initiative
Hand Hygiene

Keynote speaker, Anita Tucker, DBA, will speak on,
"The Impact of Operational Failures on Nurses and their Patients"

Monday, February 7, 2005
8:00am-4:30pm
O'Keeffe Auditorium

CEUs available
For more information, call 6-3111

Women's health research database

The Women's Health Coordinating Council has launched a new website to help clinicians find clinical research related to the care of women at MGH. The site features a database of clinical studies that include women; relate to health issues experienced by women; or address specific health concerns of women.

For more information, visit: <http://is.partners.org/mghintranet/whcc/index.htm>

Nursing Career Expo

Patient Care Services Human Resources will be hosting a Nursing Career Expo. Please invite your friends and colleagues to attend and learn more about positions as staff nurses (new grad and experienced), clinical nurse specialists, nurse managers, and project managers.

Sunday, January 23, 2005
12:00-3:00pm
North and East Garden Dining Rooms

For more information, contact
Sarah Welch (shwelch@partners.org)
at 617-726-5593

Backup Childcare Center

February Vacation Club

The MGH Backup Childcare Center announces February Vacation Club, from February 22-25. The cost for the program is \$220 for the 4-day week; individual days can be reserved for \$60 per child.

The program is available for children age 6-12, and will include:

- * a visit from "Bugworks" (Tuesday)
- * a trip to the Omni Theater (Wednesday)
- * a skating party on the Frog Pond (Wednesday)
- * a Pizza Party at the center (Friday)

For more information or to make a reservations, call Patty at 724-7100

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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:

February 3, 2005



Say ‘Cheese!’

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

Whether you realize it or not, Swiss cheese and health-care safety go hand in hand. That is, at least, according to one of the better known models used in by healthcare experts.

In 1990, James Reason, noted British psychologist, published the landmark book, *Human Error*, today considered the Bible of error theory. In it, Reason suggests Swiss cheese as a model for understanding human error. He proposes that errors are principally caused by the conditions in which people work—the root cause being the system, not the people. Put another way: good people can work within flawed systems or under flawed conditions.

To shield patients from potential harm, we must incorporate barriers, or layers of defenses, into our systems of care. Reason compares these layers of defenses to slices of Swiss cheese. Examples of institutional defenses might include Provider Order Entry (POE), pop-up warnings on clinicians’ computer screens, alarms for IV pumps, bar-coding, etc. While these measures don’t completely elimi-

nate the possibility that an error will occur, they are designed to reduce the probability that errors will have any impact on patients. In practice, these defenses consistently catch or prevent nearly all potential errors, keeping harm from coming to patients.

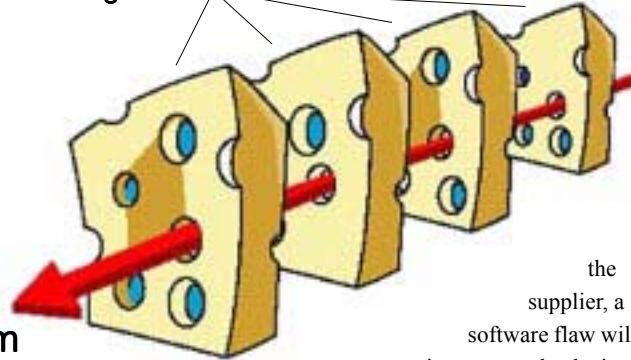
In the case of POE, for

into play) the defenses themselves can contain undetectable holes or flaws. For example, what if a new IV pump needs to be programmed using a specific, multi-step process in a specific, unalterable sequence. Programming current pumps doesn’t require such an exact sequencing process. Unbeknownst to the caregiver or

Reason recognizes that, “Unlike Swiss cheese, the holes [in our defenses] are continually opening, shutting, and shifting their location.” We work in a dynamic environment with new technologies introduced all the time; patient volume and acuity fluctuating on a daily, if not hourly, basis; multiple caregivers contributing to the care of every patient; and countless other variables that impact care-delivery every day. With so many moving parts and changing conditions, the potential for error is an unavoidable reality in our environment. While we can never completely eliminate the possibility of errors occurring, we can greatly minimize the probability that errors will affect our patients.

Safety in health care will always be an ongoing challenge. Each of us plays an important role in protecting the quality of our systems and the safety of our patients. Be vigilant in looking for the holes in the Swiss cheese. Be vigilant in preventing that line-up of circumstances that could lead to potential errors. Be proactive in fixing problems as they arise, or finding someone who can.

Defenses, barriers, and safeguards



Harm

Hazards

example, if a physician ordered a potentially harmful dose of a specific medication, prior to filling the medication order, a pharmacist would review the order (this would happen 24 hours a day, 7 days a week). The pharmacist would recognize the problem, call the physician immediately, and determine the appropriate course of action. This built-in defense works, and the patient is protected from harm.

However, (this is where the Swiss-cheese analogy comes

the supplier, a software flaw will mis-program the device if certain steps are performed out of order, incorrectly delivering the entire contents of the IV solution to the patient. While the chances of this happening are rare, even remote, the results of an unforeseen error of this kind could be disastrous.

Generally, a problem like this will be caught before ever reaching the patient; the safety defenses work. But on rare occasions, those tiny holes in the lines of defense line up—if only for a moment—and let harm through, leading to catastrophic consequences.

Educational Offerings

January 20, 2005

When/Where	Description	Contact Hours
January 28 12:00–4:00pm	Basic Respiratory Nursing Care Ellison 19 Conference Room (1919)	---
January 28 9:30–11:30am	CINAHL: Cumulative Index to Nursing and Allied Health FND626	1.2
January 31 8:00am–4:00pm	Special Procedures/Diagnostic Tests: What You Need to Know O’Keeffe Auditorium	TBA
February 1 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
February 3 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
February 7 8:00am–4:30pm	Different Faces of Quality Improvement: Creating an Environment of Quality and Safety Practice O’Keeffe Auditorium	TBA
February 8 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
February 9 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
February 9 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
February 9 12:15–4:30pm	Pacing: Concepts Haber Conference Room	4.5
February 9 11:00am–12:00pm	Nursing Grand Rounds “Continuous Opoid Infusions.” Sweet Conference Room GRB 432	1.2
February 9 1:30–2:30pm	OA/PCA/USA Connections “Breaking down myths about psychiatric illness.” Bigelow 4 Amphitheater	---
February 15 1:30–2:30pm	On-Line Clinical Resources for Nurses FND626	---
February 23 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
February 24 1:30–2:30pm	Nursing Grand Rounds “Electronic Medication Records.” O’Keeffe Auditorium	1.2
February 25 8:00am–4:30pm	Preceptor Development Program Training Department, Charles River Plaza	7
February 25 12:00–4:00pm	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 and 12–4:00pm	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

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>.

Perry has paper published

Donna Perry, RN, professional development coordinator in The Center for Clinical & Professional Development, published the paper, "Transcendent pluralism and the influence of nursing testimony on environmental justice legislation," in the February, 2005, *Policy, Politics & Nursing Practice*

Hughes co-authors article in *Journal of Emergency Nursing*

Maryfran Hughes, RN, nurse manager for the Emergency Department, co-authored the article, "Recognizing Excellence in Nursing Service: a First-Hand Report from an ED Manager at a Magnet Hospital in Boston," in the December, 2004, issue of *Journal of Emergency Nursing*.

The Employee Assistance Program

presents

Elder Care Monthly Discussion Groups

presented by Barbara Moscovitz, LICSW, geriatric social worker

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

**Next meeting: February 15, 2005
12:00-1:00pm**

Bulfinch 225A Conference Room

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

Dahlin, Billings serve on Palliative Care Steering Committee

Connie Dahlin, RN, and Andrew Billings, MD, of the MGH Palliative Care Service, were selected by their peers to serve on a national Steering Committee to establish voluntary *Clinical Practice Guidelines for Quality Palliative Care*.

Anderson, Kelly, and Michaelidis certified

Bridget Anderson, RN, of Ellison 12; Nancy Kelly, RN, of Ellison 12; and Anastasia Michaelidis, RN, of White 12 recently passed the Neuroscience certification exam to become CNRRNs.

Fitzmaurice, Mian and Warchal present in San Diego

Joan Fitzmaurice, RN, Patricia Mian, RN, and Susan Warchal, RN, presented the research paper, "Impact of Multi-Faceted Interventions on Nurse and Physician Behavior Attitudes and Behaviors Toward Family Presence During Resuscitation," at the Emergency Nurses Convention in San Diego, California, on October 1, 2004.

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

For assistance, contact Jess Beaham, web developer, at 6-3193

Coughlin, Galley-Reilley certified

Eleanor Coughlin, RN, staff nurse on Blake 6, and Jayne Galley-Reilley, RN, transplant coordinator for the Abdominal Transplant Program, recently passed the Certified Clinical Transplant Nurse exam given by the International Transplant Nurses Society.

Millar serves on AONE Education Committee

Sally Millar, RN, director of the Office of Patient Advocacy and PCS Information Systems, will serve on the AONE Education Committee for a one-year term in 2005. The committee advises AONE in the planning and implementing of educational programs.

The Employee Assistance Program

presents

Domestic Violence Support Group

Announcing a confidential, 10-week education and support group for women employees who have been affected by domestic violence.

Weekly discussions will help promote strength and healing. Meetings are free and confidential.

**Starts January 20, 2005
4:30-6:00pm
Location TBA**

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

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