

# Caring

HEADLINES

March 17, 2005

## MGH, Project HOPE, bringing humanitarian aid to southeast Asia

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On December 26, 2004, a 9.0-magnitude earthquake tore a hole in the floor of the Indian Ocean off the coast of Indonesia generating a tsunami of unprecedented proportion that claimed the lives of more than 250,000 people.

On January 26, 2005, a team of MGH caregivers,

in collaboration with Project HOPE, embarked on Operation Unified Assistance, a humanitarian mission to bring aid and relief to survivors in the area. Team members were transported to the USNS Mercy, a Navy hospital ship that served as home base for relief efforts.

The team returned home last month as the second wave of MGH volunteers were deployed to continue this important work. Many team members were able to correspond with MGH colleagues from the Mercy. Their stories tell of unimaginable devastation and of the triumphant spirit of an amazing and resilient people.

*(See e-mail correspondences on pages 4-7, and Jeanette Ives Erickson's column on page 2)*



## To Mercy and back: my trip to Banda Aceh

*As many of you know, Peter Slavin and I recently had the opportunity to accompany John Howe, MD, director of Project HOPE, to southeast Asia to visit MGH caregivers stationed on the medical ship, Mercy, in the Indian Ocean. A team of 25 nurses, 14 physicians, two social workers, and a nutritionist was deployed on January 26, 2005, to care for survivors of the tsunami disaster that claimed hundreds of thousands of lives the month before. Dr. Slavin, Dr. Howe, and I left on February 11th to rendezvous with the team. Following are excerpts from the journal I kept during our trip.*

February 13, 2005

Our journey begins in earnest when we arrive in Jakarta and are met at the airport by Lucciana, an Italian immigrant who works for a relief organization. She talks about the orphaned children and the devastation in Banda Aceh.

We go to our hotel, which is about 45 minutes from Jakarta. We have dinner that evening with Don McGillis (a reporter from *The Boston Globe* who traveled with us), staff of Project HOPE, local volunteers, and Admiral William McDaniel.

Dinner conversation is fascinating as we discuss various strategies to ensure the success of this humanitarian mission. We're told how well the MGH team is doing, and we hear stories of specific patient outcomes.

One young boy, who was found adrift in the water two days after the tsunami, was critically ill with a ruptured appendix and water in his lungs. He was taken to the ship for life-saving surgery. We're told there's hope he'll be off the ventilator by the time we board the Mercy.

We talk about an exit strategy. University Hospital, the main medical facility in the area, is

expected to be up and running by March 19th. There's hope that the second team (from MGH) will be able to stay on land instead of making daily trips back and forth to the ship.

February 14, 2005

Our team meets in the hotel lobby at 5:00am and we catch the shuttle to the airport. At 9:45 in the morning it is 100 degrees. I'm drenched, it

is so hot. At 9:55 we are in the air, flying low enough to see the land below.

As we prepare to land in Banda Aceh, we see the destruction that stretches for miles from the coast inland. It looks like a line was drawn where the destruction ends and lush greenery begins.

At the airport we're met by Project HOPE staff and others. I'm happy to see Larry Ronan, MD, a

member of our team. He looks well.

As we head for the helicopter, we see signs from many countries and a wall covered with photographs of missing people—many are children.

We drive to a soccer field that's being used as a landing strip. In a little while, we hear the helicopter. It lands easily in the field. Quickly and efficiently, two pilots depart the helicopter and hand us vests to put on. I put mine on trying to mimic what others are doing. Thankfully, Admiral McDaniel offers to help (the first time you put on one of these vests, it's complicated). Next a bulky helmet and goggles. Within seconds, we jump on the helicopter. I'm seated next to the door as they want us to see the view below. In a

matter of seconds, we're in the air.

From the air, we see more devastation—homes in ruin, buildings reduced to rubble, debris floating in the water.

Soon, the Mercy comes into view. It looks grand and awe-inspiring from the air. We land easily on the deck.

Once on board, we follow crew members inside to meet Commander Llewelyn who welcomes us to the ship. We're brought to another location and I'm introduced to Jeannie Cromhill, chief nurse of the Mercy, and a Naval officer. She gives me a brief tour pointing out key landmarks so I don't get lost.

She tells me that MGH nurses are doing well. I'm anxious to see them

*continued on next page*



Preparing to board  
helicopter



but it's clear there's a schedule to follow.

We proceed to the officers' dining room for a briefing. Each ward has prepared a briefing in which MGH staff participate. Then we're able to go on rounds. It's so good to see our team. There's a lot of hugging.

Karen Holland is in charge of the Access Unit. She's doing a great job.

There is a young person in a bed. He has scabies. The discussion revolves around containment.

We tour the general care units and Pediatrics.

Social workers, Natasha and Karen, have set up a playroom. The walls are covered with children's drawings of the tsunami. One drawing depicts the three waves that destroyed this community. An-

other shows a child playing with a ball.

Outside the room, there is a mixture of hope and sadness. The Acehaens are hopeful. We are concerned.

There's a man with a massive neck tumor involving much of his jaw and neck. Because of vascular involvement, it is too late for surgery. He is with his family. They smile. I wonder what will happen to him when he's discharged. There are others with similar tumors.

There's a young girl whose lower arm was amputated because a tumor was eating through the bone. She was in a great deal of pain when admitted to the ship. She is beautiful with black hair and almond eyes. I'm told she is responsible for some of the draw-

ings. I'm glad to learn she is right-handed as it was her left hand that was amputated.

We tour the ICU. This is where the tsunami miracle child is (the boy who was found adrift after the tsunami). He is beautiful, and he is extubated. He is accompanied by two surviving uncles.

I have separated from the larger group, which gives me time to spend with patients. I ask if I can put on a gown to see the child. I note the sign, "MRSA," and feel right at home.

The boy is weak and much smaller than his 12 years would indicate. I speak with him. He takes my hand and kisses it. He steals my heart. I sit at his bedside.

It's obvious he's not out of the woods. I don't

have a stethoscope so I put my hands on his chest and feel the rales. I ask if there's a physical therapist—he needs chest PT. There is.

His breaths are short, about 25/minute. I demonstrate slow, deep breaths, and he follows my example and coughs. Kim Waugh suctioned him.

For some reason, I don't think this child will live, but I don't share my concerns as the team is in high spirits now that he is extubated.

Many of our team and Navy personnel are credited with saving his life.

The ICU is comprised entirely of isolation rooms. Two women in isolation have TB.

I'm told that worms are a common problem among many patients on board.

Karen Holland escorts me to my quarters where I give her the extra scrubs I've brought. Then I tour again, but this time with MGH doctors on their rounds.

At 6:00pm, I see more staff from MGH. I'm concerned there won't be time to visit with them as a 7:00pm meeting is planned.

At the meeting, Dr. Howe reads several letters from senators and other dignitaries. Dr. Slavin addresses the group and distributes Red Sox and Patriots hats. There's a slide show of scenes from the tsunami and afterward MGH and Project HOPE team members meet.

It's a beautiful night, but I'm tired and depart for my quarters. I sleep from 10:00pm to 2:00am.

February 15, 2005

At 5:30am, I pack my bags and go to the Access Unit.

Soon, we're told we'll be going ashore to see the hospital. We're given vests and helmets, then on to the helicopter. This time, I'm in the middle seat.

We land next to the hospital. I'm glad I'm covered in Deet; flies and mosquitoes are everywhere.

University Hospital is a series of concrete buildings; it is intact and being cleaned.

This is a sad story. When the first wave of the tsunami came, it poured into the hospital. By the time the second wave came, everyone was trapped. The third wave, with its mud and debris,

*continued on page 14*



University Hospital  
in Banda Aceh

# Humanitarian Aid

## From the edge of destruction: e-mail correspondences from our team in southeast Asia

We're on the ground in Banda Aceh. This area lost more than 100,000 people. At least a third of the city was swept into the sea; another third is under water or caked with mud. Imagine a wave washing away Dorchester, the South End, North End, Back Bay, and Beacon Hill in a matter of hours. The hospital (330 beds) lost all its patients and much of its staff as the water simply swept over it and receded covering everything in mud. The hospital director lost his wife and children but was at the hospital the next day digging out bodies.

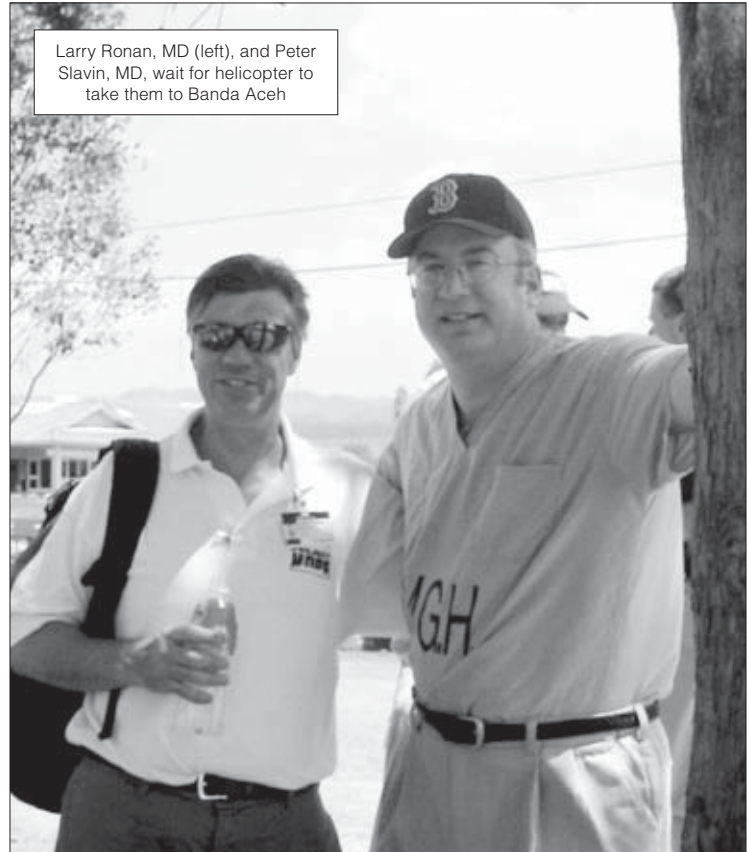
I met with the hospital director today and we talked about what we can do to leave something concrete behind. They lost their TB ward in the tsunami. I invited the pulmonary doctor here to visit us in Boston and suspect some of our faculty may want to return to continue supporting faculty here.

You should be very proud of your nurses and docs over here. The experience leads me to realize how lucky we are and how very, very grateful we should be for our families and friends and, simply, life.

—Larry Ronan, MD

When we got off the helicopter, there was a group of people (mostly children) waiting for us. I just froze. As I approached and took off my helmet, I didn't think I could do it. I felt a knot in my stomach and my eyes started to fill with tears. It was like being in a movie—too surreal to believe what was happening. I looked at another nurse who was from Pediatrics, and I knew I wasn't alone. The look on her face was a reflection of my own. We grabbed each other's hand and gave a hard squeeze. This was what we'd been waiting for.

—Renee Cloutier, RN

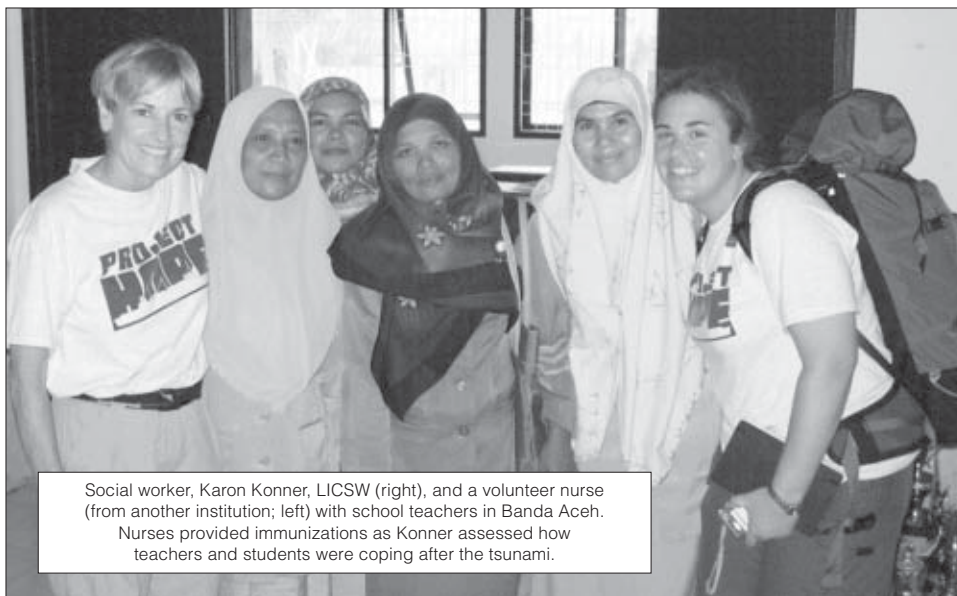


Larry Ronan, MD (left), and Peter Slavin, MD, wait for helicopter to take them to Banda Aceh

I guess the most difficult challenge is caring for the children in the ICU. The children are small here; even at 11 or 12 years old you can easily carry them in your arms. There is one beautiful little boy in the unit. He is 11 and in respiratory failure with bilateral white-out on his chest X-rays. After the tsunami, he was in the water for a long time. His whole family was killed except for an uncle who maintains a constant vigil at his bedside. When I look at this beautiful child with his half-closed eyes and long lashes lying on a stretcher on a ventilator, I am overwhelmed in a way I have never experienced in 20 years of nursing.

It's not always a good time here, and sometimes things move frustratingly slowly. But for me it has been the experience of a lifetime.

—Teresa MacDonald, RN



Social worker, Karon Konner, LICSW (right), and a volunteer nurse (from another institution; left) with school teachers in Banda Aceh. Nurses provided immunizations as Konner assessed how teachers and students were coping after the tsunami.

To make a contribution  
to the MGH Tsunami Relief Fund,  
go to: [www.massgeneral.org/  
projecthope/secondmain.htm](http://www.massgeneral.org/projecthope/secondmain.htm)



## About Banda Aceh

Banda Aceh is the provincial capital of Sumatra, an Indonesian island in the Indian Ocean west of Thailand. Prior to the tsunami that killed more than 250,000 in the region, Sumatra's population was 40 million, 4 million in the Aceh province alone. Due to long-standing internal political conditions, the Aceh province had been restricted to foreigners for many years. With the mass devastation caused by the December 26th tsunami, those restrictions were lifted to allow international relief workers access to the area hardest hit by this natural disaster.



Members of the MGH team with grateful patient on the Mercy

Things are busy here. Daily flights continue to Banda Aceh where patients are seen at the hospital. Some come to the ship for testing and return to land the same day; others are admitted for surgery or treatment and return a few days later. Many patients present with aspiration of mud and flood waters,

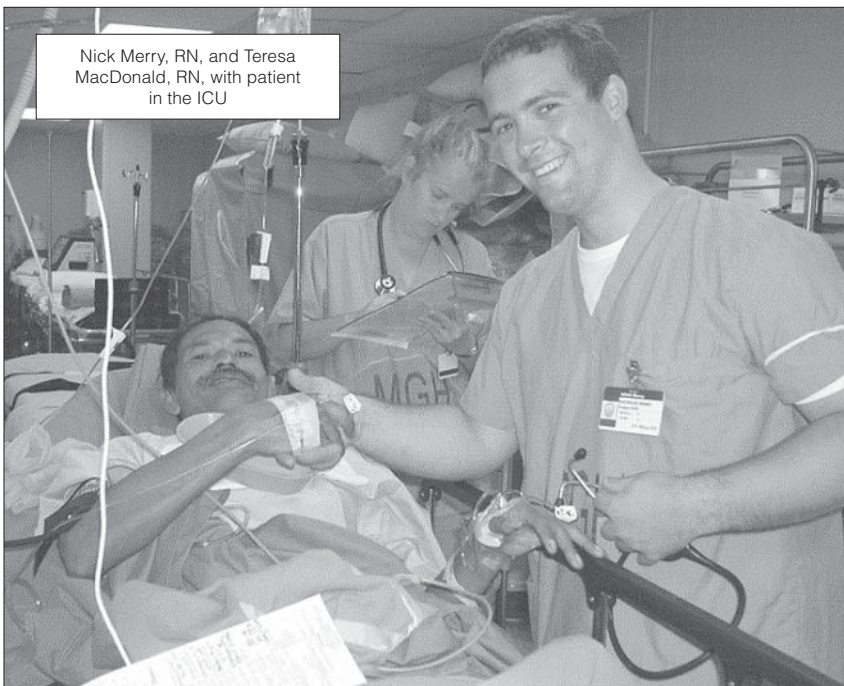
a condition that has come to be known as 'tsunami lung.' Some are near-drowning, others are less severe.

Seeing this area in person makes you realize that media coverage doesn't convey the extent of devastation or the long-term impact of this tragedy on the lives of these

warm and welcoming Indonesian people.

Yesterday, I went with Sue Tredwell to the small village of Lamno about 20 miles from Banda Aceh. This village was totally cut off after the tsunami; bridges were washed out and the entire coastline changed. We were dropped by

been. The big need was for delivery kits. Midwives had no delivery instruments since the tsunami. Sue and I examined a pregnant woman there. We went into the bedroom where there was a sleeping pad on the floor, and that became our exam table. The woman was fine, she just needed some reassurance.



Nick Merry, RN, and Teresa MacDonald, RN, with patient in the ICU

helicopter in a small field at the edge of town. Locals greeted us. As the helicopter took off, a small group of children ran onto the field to dance in the helicopter's wash. As the dancing subsided, cows resumed their grazing where the helicopter had been just moments before.

Sue and I met with 16 midwives at one of their homes. They were as open and delightful as everyone here has

We went to the Pakistani-staffed hospital, which was about 30 feet from the front door of the house. There, we were asked to examine two OB patients. One was 24 weeks along, she also had tsunami lung, and she was positive for TB (or some other lung organism). She needed a chest X-ray to get a better idea of her diagnosis and treatment plan. She had lost a child in the tsunami and was terrified of the water. We needed to get her to the ship, but the helicopter ride was a concern for her. Sue flew with her and said that when she was strapped into the helicopter, husband on one side, Sue on the other, she closed her eyes and went into a 'zone' for the entire flight. She did just fine.

—Lynda Brandt, RN

# Humanitarian Aid

## E-Mail Correspondences from our Team in Southeast Asia

*continued from previous page*

They are helicoptered over from the land by the dozens. I'm working on a ward where we're scheduled to work 12-hour shifts, seven days a week, because of how many patients there are. And they are amazing. Most are surgical patients who have broken legs, broken jaws, or broken hands from the tsunami. They've had no treatment and have been in pain all this time. Their stories are unreal. They come with a friend or family member, and often, it's the only friend or family member they have left. One patient came with his 8-year-old daughter; (her mother and 3 siblings died in the tsunami). She stared at me for awhile then started following me around putting stickers all over me. Then she put stickers on herself in the exact same spots. She

smiled. Her father smiled. Most of the locals have never seen blonde hair, so they'd come up to me and touch my hair and smile.

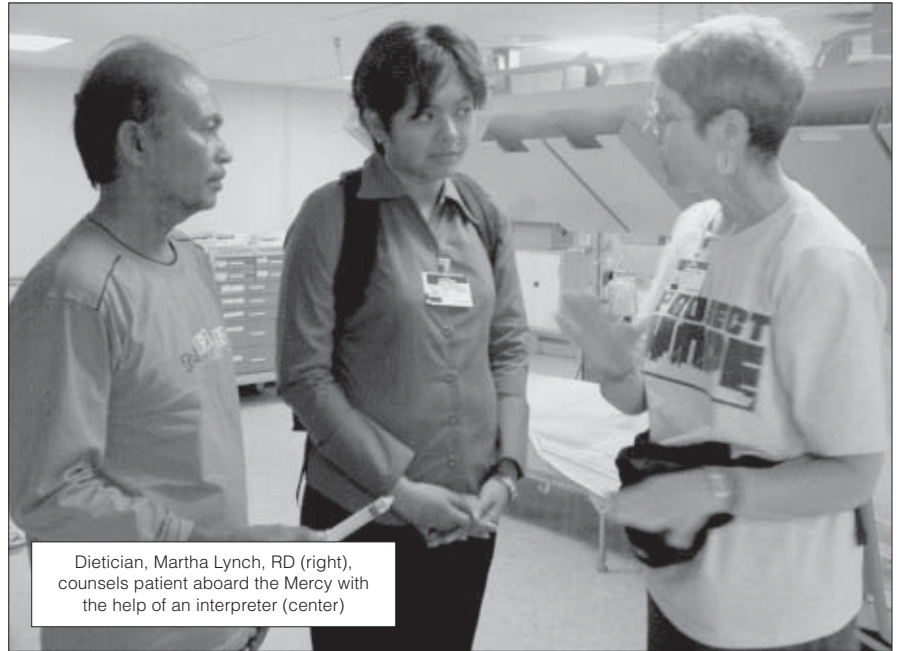
The most frustrating part is that I feel like we could stay here for a year and still not help everyone. We'd been told that Indonesians don't like to be

touched, but that was not my experience. The people I cared for definitely wanted to be touched. I don't know if it was because of the tragedy or what they'd been through, but many

of them came up and hugged me. They've been through so much, lost so much. I don't know how their lives will ever be normal again. But they smile and say, "Thank-you." It makes

you think about your life and how lucky we all are. I'll never ever forget how important a simple smile can be and how much it can make a difference to someone.

—Emily Schnapp, RN



Dietician, Martha Lynch, RD (right), counsels patient aboard the Mercy with the help of an interpreter (center)



Drawings done by Indonesian children adorn the walls; many depict the 'three waves' that destroyed their homes

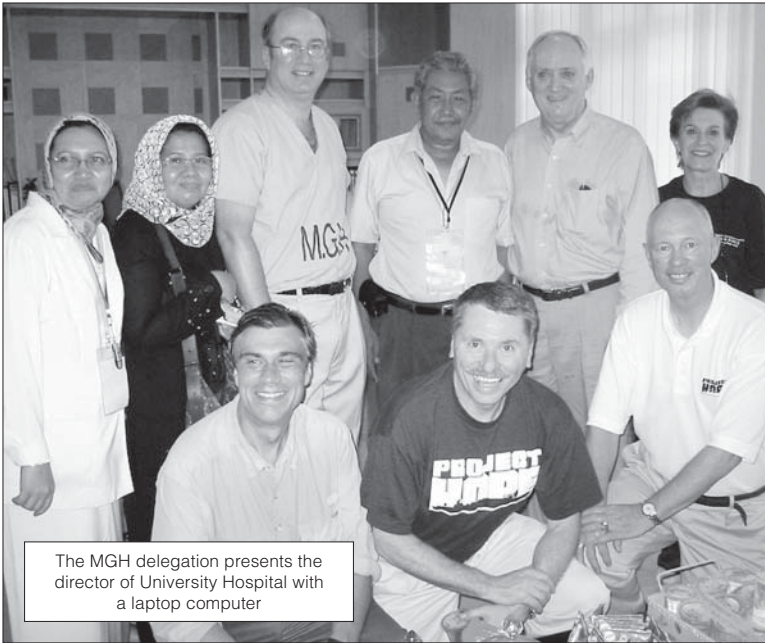
The number of patients on the ship is limited by the number of caregivers. Right now, we're at maximum capacity for the number of caregivers we have. The nurses with us are amazing. Their work is so hard. It's bedlam in the wards.

We've set up a playroom with mattresses on the floor. Children have drawn pictures and they're taped to the wall. Another room is set up to be a prayer room. Whenever I talk to a patient, other patients and family members drift over and join in the discussion. These wards have turned into little villages.

We have translators from Jakarta. Just as in Iran, they are the busiest of all. They have volunteered their services and I think it's really hard for them. It occurs to me that they probably experience just as much post-traumatic stress as the rest of us, seeing all the sadness.

—A. K. Goodman, MD





The MGH delegation presents the director of University Hospital with a laptop computer

Our unit arrived as strong, assertive, individual professionals, and quickly joined forces to create a close-knit, world-class ICU/PACU team. The local culture manifests itself in the people caring so much for one another. It's as if they're all members of a huge extended family. Maybe if you survive a tsunami, you *are* all one family, and you *must* help care for each other.

We cared for a man yesterday who had a mass removed from the side of his neck. He stayed overnight and I talked with his wife through an interpreter. She had a family photo with her. She lost two daughters in the tsunami. One of them had gotten married a month before the tsunami and had just returned home after her honeymoon. She and her husband had been clinging to one another when a huge piece of wood hit them and they were separated. The daughter was lost. I don't know how they go on. The people are incredible. We take so much for granted in our healthcare system. We have the best of everything whether we can afford it or not. We are truly blessed to be Americans.

The people here are remarkable. They take such pride in their appearance. The women have the most beautiful head coverings with what looks like Belgian lace at the bottom. We can learn from their tenacity, their love for each other, and their love of life. In the ICU, visitors come to see each patient and talk with them and their families. If a visitor leaves for a little while, another patient's family member comes and sits with the patient. Sometimes it's hard to remember who belongs with whom. They take care of each other with so much love and dignity. They are appreciative of everything and smile when we do the smallest things for them. They sit on a metal stool in the ICU for hours waiting for their loved one to come out of surgery; they make no demands and are grateful just to have a stool.

I hope I have made a difference in someone's life here. Because they have changed me for the better.

—Jane Kimbrough, RN

After arriving off the coast of Banda Aceh, it was decided that doctors and nurses in small groups would assist on land in areas where the need was greatest. This turned out to be the Emergency Room at University Hospital, and a number of other clinics and camps. When I went ashore, I saw the devastation these people had experienced. One lovely doctor acted as our interpreter as we evaluated the needs of an overwhelmed clinic. The main clinic had been badly damaged and she, along with the rest of her staff, had moved to other locations to provide desperately needed services. She later accompanied us on a tour of the waterfront where we saw the most horrific scenes. Boats and barges had been transported miles inland, crushing houses, wiping away everything in their path.

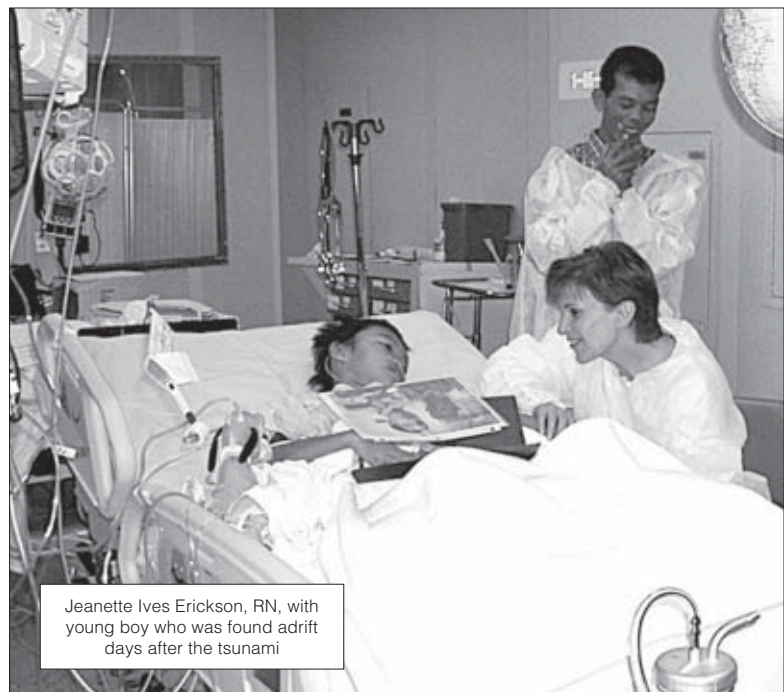
The doctor described her own experience the day the tsuna-

mi hit. She lived two miles from the coast and she survived by standing on her window sill and holding onto the frame to keep her head above water. When we got to the shore, I asked about her family, and she broke down in tears. She couldn't speak. Later she told me the most difficult part for her was that they couldn't find the bodies.

Incredible faith is what sustains these people through this unbelievable loss. They will forever be in my thoughts and prayers. Indonesians are a warm, gracious, spiritual people. They smiled in gratitude at what little we were able to offer.

It was hard for many of us to leave knowing how much help our country and our hospital have to offer. Hopefully, we have made a difference and good things will come of this experience.

—Maryalyce Romano, RN



Jeanette Ives Erickson, RN, with young boy who was found adrift days after the tsunami

## Colleague to colleague: finding the right NICHE

### *A difficult situation*

My name is Alison Squadrito. I am a physical therapist and board-certified geriatric clinical specialist. Though I have advanced knowledge about the care of older adults, I recently found myself struggling to make the best decision in a situation involving my own grandmother, who has Alzheimer's disease. I was getting married and, while I was sure I wanted my grandmother to be an important part of my wedding day, I wasn't sure how to manage this.

Grandma has fairly advanced Alzheimer's disease. She is unable to walk, but she can transfer into a wheelchair and sit up for several hours at a time. She understands a great deal of what is going on around her, but her cognitive processing is slowed and she rarely talks. Her smile and her eyes are her best means of communication.

I had always imagined my grandmother at my wedding, celebrating the day with me, and it was hard to give up this plan. I knew, however, that having her attend the ceremony and the reception was simply unrealistic. My parents and I considered several options. We thought perhaps Grandma could come to the house before the ceremony and visit

with me as I got ready. Maybe she could come to the church for the ceremony and then return to the nursing home. Or, the best idea might be for Jim, my new husband, and I to go to the nursing home in our wedding clothes after the reception.

I carefully weighed the options. I knew my grandmother would be able to transfer into and out of a car with help. That wouldn't be a problem. But because she can't walk, she wouldn't be able to climb the stairs to enter my parents' house. If the weath-

er was good, Grandma and I could visit outside on the lawn, but if it rained, that would be more challenging. I knew we could get the wheelchair up the steps, but the stairway is narrow and it wouldn't be easy. I assumed I'd be a nervous wreck, so I wasn't sure I'd even be able to relax enough to have a good conversation with my grandmother before the wedding.

It seemed important that my grandmother witness the actual ceremony. The church would be easier to enter than my parents' home, but

once inside the small building, there wouldn't be any place for the wheelchair except in the middle of the aisle. The church is down the street from my grandmother's former home; she had walked there for mass every Sunday. In fact, mass is one of the few activities in which my grandmother still actively participates. Celebrating mass in her own church would be a familiar event, which made that option appealing. But I was still concerned she'd be overwhelmed, and I resigned myself that perhaps the best option was to have her stay in the nursing home. I quickly realized I couldn't make this deci-

sion alone. I didn't have the knowledge to understand all the variables that affect an elderly woman with Alzheimer's disease. Through my work on the hospital's NICHE committee (Networking to Improve the Care of Health System Elders), I knew I had many resources at MGH to help me. I felt a psychiatric clinical nurse specialist would have the insight I was missing, so I called Barbara Guire and asked her for guidance.

### *Expert advice*

My name is Barbara Guire. I'm a clinical nurse specialist on the Blake 11 Psychiatry Unit. When Alison approached me to *continued on next page*



Squadrito and grandmother



## Clinical Narrative

*continued from previous page*

think through the options available for having her grandmother present during her wedding, I tried to help her sort through her hopes rather than the realities of her grandmother's disease. Dealing with the emotion of an impending wedding can be both joyous and stressful. Marriage has many layers of hope and tradition for the bride, the groom, and the parents. One of the hardest things for families to cope with is the loss of these traditions when a loved one has Alzheimer's disease. Our goal was to maintain Alison's grandmother's dignity while ensuring the fulfillment of Alison's hopes for her wedding celebration.

Thinking through options can add a layer of complexity to an already complex situation. We looked at the realities of where Alison's grandmother was functionally and cognitively. As any family who has dealt with a loved one with dementia knows, plans frequently have to be adjusted to meet the most current functional state of their loved one. In an attempt to keep the plans as fluid and flexible as possible, we reviewed all the options without coming to any final conclusions.

I knew the general approaches to caring for people with dementia

that have proven helpful, such as establishing and maintaining a regular schedule; providing a consistent daily-care routine of bathing, dressing, and eating; having care provided by the same people in a simple, quiet environment; using calm, soothing words and touch to decrease

anxiety; presenting a pleasant, smiling face to lead emotional responses; and utilizing scheduled rest periods to decrease anxiety and confusion.

Together, we explored the potential impact that certain situations would have on Alison's grandmother, such as leaving the safety of her room, being exposed to a large number of people, increased activity and noise, and having family members present who might be hurried and anxious. We considered options for including her grandmother in wedding-day activities and realized that each option

could fulfill Alison's hopes and dreams, but could also increase her grandmother's anxiety and confusion.

If Alison's grandmother attended the wedding ceremony, her morning routine could be maintained for as long as possible. Her grandmother could sleep later if possible. There would be limited discussion about the wedding beforehand to cut down on anticipa-

tory anxiety. Alison could ask someone to transport her grandmother to the church and stay close to her throughout the ceremony. Alison's father was in the difficult position of being the primary caretaker for his mother and also planning to walk his daughter down the aisle. He couldn't be available for both his mother and his daughter at the same time. To avoid confusing conversations with so many family members and friends, the grandmother could be brought into church in a wheelchair after the guests were seated. Seating her at the front of the church

would cut down on the number of people and amount of activity she would see to help minimize her anxiety and confusion. Once the vows were exchanged, Alison's grandmother could be taken back home. We know that a change in schedule and environment and an increase in activity can increase confusion. A rest period immediately following the ceremony in her familiar, calm environment could be planned.

If they chose to go to Alison's home on the morning of the wedding (instead of the church), the same approach could be followed. Because the time leading up to a wedding is filled with joy and happiness, but also anxiety, this option had the added concern that Alison could transmit her nervousness to her grandmother.

The third option, having Alison's grandmother remain in her own safe, established environment with a visit from the bride and groom after the wedding, was discussed. We considered the possibility of bringing a videotape of the ceremony to the nursing home and watching it with her. This would allow her grandmother to be involved in the day but would keep her activity and anxiety to a minimum.

Alison was trying to be thoughtful about what she wanted as the bride, what her parents needed

as primary caregivers for her grandmother, and what her grandmother could tolerate functionally and cognitively. I may have raised more questions than I answered, but I felt Alison had the information she needed to make a good decision.

### *The decision*

I was extremely appreciative of Barbara's kindness and expertise. When I returned home the week before my wedding and discussed the options with my parents, we felt able to make a well-thought-out decision. I had believed that having my grandmother witness the ceremony was essential, but I came to realize that I just wanted a meaningful visit with her during this important day, either at the church or somewhere else. I also realized that the manner in which we would have to bring my grandmother to the church would make it a frustrating experience for all involved. Grandma would only be there for a short time, so Jim and I really wouldn't have an opportunity to have a calm, unhurried, and meaningful visit with her. Because she'd have to be brought up the aisle and out of the church with all the guests watching, we didn't feel that would be respecting her wishes. My grandmother had always been independent, vibrant, and stylish, and she hated the prospect of living

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**I didn't have the knowledge to understand all the variables that affect an elderly woman with Alzheimer's. Through my work on the hospital's NICHE committee (Networking to Improve the Care of Health System Elders), I knew I had many resources at MGH to help me.**

## Making a change: implementing evidence-based practices in critical care

—by Mary C. Lavieri, RN, and Barbara Brien, RN

Critical care units are highly specialized areas where staff are trained to care for specific patient populations. Critical care nurses continually adapt to new technology and equipment, including diagnostic testing, electronic devices, and therapeutic options. In order to provide optimal care to all patients, nursing research and study-based data must be incorporated into daily clinical practice on critical care units. And that's not always easy.

### *Agents for change*

Many levels of practice exist within specific professional cultures, such as critical care units. Certain practices that have remained the same for years are strongly embedded in the unit. These routines can be extremely difficult to change despite overwhelming evidence in the literature that they should. Less-embedded practices may be changed more easily, but still require a dedicated change-agent, time, and patience.

The first goal in the process of incorporating evidence-based change on a critical care unit is to raise awareness about the need for change. Once

this is done, a commitment to change among a critical mass of supporters on the unit needs to take hold. Still, it may take months or years before the change is embedded into the culture of the unit.

Typically, there are three types of responses that change-agents encounter from staff. Some will adapt easily and embrace the change. Some will be pragmatic and need proof that the change is beneficial. Others will resist change entirely and work to prevent it. Obviously, this group will require the most support throughout the process of change as evidence-based practices are integrated into the culture of the unit.

### *Facilitating change*

How do we facilitate change and integrate nursing research into practice at the bedside? First, information about the proposed change must be made available to staff. Second, but perhaps most important, the relevance of the change must be understood by staff in order to limit resistance.

Once the team agrees that the change is relevant, a clear majority must be confident the change will benefit staff and patients alike. Every

staff member must have the opportunity to be actively involved in the process in order to engender commitment and eventually embed the change into unit practice. Communication must be open between leadership and staff as the change is introduced and adopted.

Over the past three years, the Medical Intensive Care Unit (MICU) has introduced several changes in nursing practice. One of the first changes was to develop unit-based standards of nursing care. To accomplish this, staff nurses met weekly to discuss their practice and develop standards of care. All nurses were involved either by active participation at meetings or by review of weekly drafts distributed via e-mail.

As the clinical nurse specialist on the MICU, I am responsible for the education and training of staff, as well as guiding unit-based nursing research. My role in developing unit-based nursing standards was that of facilitator. This required benchmarking information from other ICUs at MGH and in the greater Boston area. Data from nursing research and articles were used to develop unit-based nursing standards, which took about four months to complete.



Clinical nurse specialist, Mary C. Lavieri, RN (left), and staff nurse, Barbara Brien, RN

### *Instituting no-waste blood sampling*

One of the most striking examples of change in the MICU was an effort to reduce the amount of blood wasted when obtaining samples from arterial lines. The usual waste amount averaged about 3cc per draw. Most patients had blood drawn three times daily, for an average of 100-120cc per week, with about 60-80cc wasted in the process.

We wanted to implement a no-waste method in which blood is drawn back through the arterial line then re-infused rather than discarded. This method was demonstrated to staff and we discussed the evidence supporting this change in practice. Most staff embraced the no-waste method so we decided to trial the evidence-based practice for one month. All arterial lines were set up to utilize the no-waste system.

Proponents of this method spent a lot of

time teaching, coaching, and negotiating with their peers. Implementing the change was easier for newer staff who had not yet embedded the 'old' method into their practice. For senior staff, it was much more difficult since the old method was deeply embedded in their practice. Despite the fact that everyone agreed that wasting less blood was better for patients, the longer nurses had used the old method, the harder it was for them to remember to use the new method.

Evaluation and feedback were provided by staff throughout the trial period, with about 70% favoring permanent adoption of the new blood-sampling method. The new method was trialed for a second month after which it was officially adopted.

Two years later, the no-waste method of blood sampling is performed with all arterial lines and many CVP and PA lines on the MICU.



## Educational resources to support non-invasive mechanical ventilation

—by Purris Williams, RRT, respiratory therapist

Increasingly at MGH, clinicians are turning to non-invasive mechanical ventilation as an alternative to conventional mechanical ventilation to support patients in acute respiratory failure (and patients with other breathing problems). Evidence suggests that non-invasive mechanical ventilation can reduce the need for endotracheal intubation and decrease the rate of hospital-acquired pneumonia in certain patient populations. However, caring for patients on non-invasive mechanical ventilation presents a special challenge for nurses,

respiratory therapists, and other caregivers. Recognizing that successful and safe treatment requires an understanding of the indications, benefits, and risks associated with non-invasive ventilation, a group of MGH nurses and respiratory therapists recently developed three educational resources intended for nurses in all adult, inpatient, general-care areas. They are:

- *Care of the Patient Receiving Continuous Positive Airway Pressure (CPAP) or Non-invasive Positive Pressure Ventilation (NPPV)*, a self-learning packet that will be available starting March 21,

2005. Ten packets will be distributed to each unit via the Bigelow 10 Nursing Office. To obtain more copies, contact Lin-Ti Chang, RN, in The Center for Clinical & Professional Development.

- *CPAP/NPPV Precautions*, laminated reference sheets, were developed to serve as a quick bedside reference for nurses. These sheets should be posted in patients' rooms when they're on non-invasive ventilation. The Adult Noninvasive Ventilator Alarm Algorithm will be kept in patients' rooms in the Respiratory Care Flow Book.

## Clinical Nurse Specialists

*continued from previous page*

### *Putting VAP prevention into practice*

Another example of a change in nursing practice in the MICU was the recent introduction of new guidelines for the prevention of ventilator-associated pneumonia (VAP).

Evidence supporting these changes was discussed in staff meetings and with the CNS. It was decided to trial soft-suction toothbrushes and mouth-care kits that staff had learned about at the

American Association of Critical-Care Nurses National Teaching Institute. Soon, physicians started ordering anti-bacterial oral rinses for intubated patients. At the same time, MICU staff reviewed literature that indicated that elevating the head of a patient's bed by greater than 30 degrees prevented aspiration of oral secretions. So we began to change that element of nursing practice on the unit. Positive reinforcement from management and

administration proved especially helpful in securing the support of staff to make these changes in nursing practice. For example, many mornings staff nurses and house staff were greeted with an announcement from the CNS saying, "Congratulations to MICU nurses for 100% compliance to head-of-the-bed elevation in the fight against ventilator-associated pneumonia."

This enthusiastic support not only raised awareness about VAP, but helped make embedding the change on the unit a reality.

*Worth the effort*  
Implementing a change in nursing practice on most ICUs continues to be a challenge. There is a constant need for information and education about new evidence-based practices. In most cases, the opportunity to

participate in the implementation of change helps staff feel valued and involved. Though barriers to change sometimes seem insurmountable, the benefits are well worth it to patients and to the profession of Nursing.

## 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.

- A specific procedure policy outlining the care of these patients will be added to the Universal Respiratory Care Procedure Manual, a multi-disciplinary resource that can be found on every inpatient unit.

For more information about non-invasive mechanical ventilation or any of these educational resources, contact the Respiratory Care Office, at 4-4480.

## Holy Week Services

Holy Week Services will be held in the MGH Chapel beginning on Saturday, March 19, 2005.

For specific dates and times contact the MGH Chaplaincy Office at 6-2220.

The Jewish holiday of Purim will be celebrated on Friday, March 25, 2005, from 10:00–11:00am in the MGH Chapel.

## Doucette receives 2005 Orren Carrere Fox Award

—by Mary Ellin Smith, RN, professional development coordinator, The Knight Center for Clinical & Professional Development

On Thursday February 24, 2005, when Orren Carrere Fox and his family came to the Newborn Intensive Care Unit at MGH, they were visiting a place Orren doesn't remember, but his family will never forget. Orren was a patient in the NICU as a newborn, and his parents, Elizabeth and Orren, established the Orren Carrere Fox Award for NICU Caregivers in recognition of the compassionate care he received from all members of the NICU team during his hospitalization.

This year's recipient of the Orren Carrere Fox Award was senior respiratory therapist, Danielle Doucette, RRT. Doucette, a graduate of Quinnipiac College, has been a respiratory therapist at MGH for nine years. She is highly regarded for her knowledge, skill, advocacy, and ability to be present to patients and families at the most difficult times. Doucette helps parents create normalcy in a high-tech, medical setting by encouraging them to hold their child, sing a song, or change a diaper.

Doucette is an advanced clinician and a recipient of the 2004 Stephanie Macaluso Excellence in Clinical Practice Award. NICU nurse manager, Peggy Settle, RN, and assistant director of Respiratory Care Services, Daniel Chipman, RRT, presented the award to Doucette at a small reception in the NICU Conference Room on February 24th. For more information about the award, contact Mary Ellin Smith, RN, at 4-5801.

**Below:** Danielle Doucette, RRT, senior respiratory therapist (right), accepts Orren Carrere Fox Award from NICU nurse manager, Peggy Settle, RN; and assistant director of Respiratory Care Services, Daniel Chipman, RRT.

**Bottom:** Doucette, Settle, and Chipman are pictured with the Carrere Fox family





## Clinical Narrative

*continued from page 9*

with any sort of disability or reliance on others. She would not want to be the center of attention in her current condition.

I loved Barbara's idea of watching a videotape of the ceremony with Grandma in her own home. This would allow her to watch us get married (repeatedly, which might be helpful for her) in a calm environment with us close to her. But the nursing home was almost an hour away, so by the time we got there, it would be fairly late. Grandma no longer had the stamina to stay up in the evening or attend to people and stimuli at the end of the day.

I had been extremely hesitant to have my grandmother come to the house before the wedding. I assumed I'd be very nervous, which would affect both my grandmother's emotions and my ability to relax and enjoy my time with her. But once I got to my parents' home the week before the wedding, I was surprisingly calm and happy. I quickly realized that my

resistance to this option was unnecessary, and that it was by far our best option. The weather report was good, we had a close friend who could bring her to the house, and we were all comfortable with this decision. I got up early to get ready and had plenty of time to sit alone with my grandmother and talk. She doesn't say much, but she told me how much she loved me. I was delighted we were able to have our time together and felt content and ready to go to the church to get married.

A lot of thought and planning went into this decision. Though I've always known that respectful, high-quality care of older adults requires strong interdisciplinary teamwork, this personal experience made that fact even clearer to me. The collaboration of caregivers with different areas of expertise undoubtedly resulted in the best outcome for my grandmother.

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

This narrative, written jointly by Alison and Barbara, beautifully demonstrates how the

NICHE program (Networking to Improve the Care of Health System Elders) can enhance our care of elders by building a community of clinical experts in geriatric care. Sharing knowledge among disciplines allows all members of the healthcare team to contribute to a safe and respectful environment for elders.

When Alison realized she was troubling over this important decision, she knew there were expert resources at MGH who could help her make an informed decision. Barbara was an insightful sounding board, helping Alison identify options and weigh their pros and cons. Always putting Alison's grandmother's safety and comfort first, they explored alternatives that would allow her to share in the joy of Alison's wedding without putting her at risk.

Truly, a picture is worth a thousand words! (See page 8.)

Thank-you, Alison and Barbara. For more information about the NICHE program at MGH, contact Mel Heike, RN, staff specialist, at 4-8044.

### The Employee Assistance Program

presents

### Elder Care Monthly Discussion Groups

facilitated by Barbara Moscovitz, 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: April 12, 2005  
12:00-1:00pm  
Bulfinch 225A Conference Room**

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

### MGH Perioperative Nursing Education and Orientation Program

#### Are you interested in becoming an OR nurse?

If you are currently an experienced nurse and have an interest in working in the Operating Room, the Perioperative Nursing Education and Orientation Program may be for you. The program begins June 6, 2005. You must be a registered nurse with experience in an acute-care setting.

For more information, contact Michele Andrews at 617-724-6052

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#### Publisher

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

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Susan Sabia

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#### 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.

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For more information, call: 617-724-1746.

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## Jeanette Ives Erickson

*continued from page 3*

created a death chamber for staff and patients inside.

The walkways are filled with damaged beds and equipment. People are working everywhere.

We go to the children's ward where there are many children in need of care. One child has rheumatic heart disease. Another has shriveled arms and a swollen abdomen. They think he may have leukemia. Another child has an oxygen mask and is being monitored. He's tachycardic, pale, and short of breath. Many children lie in their mother's arms, debilitated.

Dialysis machines are outside, too damaged to be used.

We meet with the director of the hospital. In stark contrast to the rest of the buildings, his office was untouched because it's on the second

level. He thanks us for coming. We talk about his needs. We offer condolences for the loss of his family and staff. He tells us his new purpose in life is to rebuild his hospital.

Dr. Slavin presents him with a laptop computer.

We tour the hospital, then have lunch in a fly-infested room. There's not enough water, so we share a bottle.

Two vans arrive to take us on a tour of the area. Words cannot describe what we see—homes completely demolished, homes with no windows, foundations where homes used to be. The Indonesian flag is visible in many locations. It marks where dead bodies have been found. The mosque in the center of town is untouched.

We see writing scribbled on many walls. We're

told the words say, "I am alive; do not take my belongings." The date, December 26, 2004, is everywhere.

Surely, the most dramatic evidence of the power of the tsunami is seen when we drive down a sandy road and come to a huge barge blocking the road. It lies on top of several crushed cars and houses. People are taking pictures of it. At first, I don't understand. Then someone explains. We are 3 kilometers from the nearest water. The sheer force it took to transport this enormous barge 3 kilometers inland is staggering to think about.

We drive to the ocean. Nothing is standing. Nothing remains except a single concrete obelisk that looks like it might have been a beacon. It stands tall but there is no sign of its light.

I don't know what a nuclear bomb site looks like, but this is how I imagine it would look. There's nothing left.

We return to University Hospital. Dr. Howe, Dr. Slavin, and I say goodbye to our hosts.

On the plane ride home, there is time to reflect on the events of the past two days. I am filled with emotion at the power of caring I have witnessed. I saw extraordinary loss and sadness... but I also saw healing and hope. I feel such pride in my colleagues both here and at home who have sacrificed much and contributed even more to help the people of southeast Asia. I feel a sense of optimism and peace.

### *Racing Against the Clock* offers inspiration for the ages

The Stoeckle Center and the MGH department of Psychiatry are co-hosting a special screening of the film, *Racing Against the Clock*, an inspirational look at the lives of five extraordinary women over the age of 50.

**March 25, 2005  
7:30–9:00am  
O'Keeffe Auditorium**

The film was directed by local filmmaker, Bill Haney, who will receive the MGH-Harvard Medical School Humanitarian Award.

Copies of the movie are available for off-site screenings. For more information, call Pat Gavin at 617-726-1218 or e-mail Helen Riess, MD, at [hriess@partners.org](mailto:hriess@partners.org)

## Visit the Electronic Medication Administration Vendor Fair

Manufacturers of various electronic medication administration systems will be showcasing their products at a vendors' fair this month. MGH is currently screening electronic medication administration systems to find the one that best meets our requirements. Clinicians are welcome to come to the vendors' fair to review systems under consideration. Drop in any time and stay as long as you like. It will take 45 minutes to see the entire selection. No pre-registration required.

**Monday March 21, 2005  
9:00am–5:00pm  
Walcott Conference Rooms**

For more information, contact Rosemary O'Malley, RN, at 6-9663

### Clinical Recognition Program

**Clinicians recognized  
December, 2004–February, 2005**

Advanced Clinician

- Jeff Chambers, RN, Emergency Department
- Laurie Miller, RN, Neurology
- Laura J. Ryan, RN, Infusion Unit
- Maureen Bonanno, RN, Surgical Unit
- Stephanie Walsh, RN, Infusion Unit
- Jean Stewart, RN, Orthopaedics
- Sheila Brown, RN, Radiation Oncology
- Cheryl Ryan, RN, Same Day Surgical Unit
- Timothy Sowicz, RN, Medical Unit
- Joan Tafe, RN, Surgical Unit

Clinical Scholar

- Michele Lucas, LICSW, Social Work
- Diane Lyon, RN, Newborn Unit
- Michelle Bell, RN, IV Therapy
- Kathleen Reilly Lopez, RN, Surgical Unit
- Mary Wyszynski, RN, Newborn Intensive Care Unit
- Mary Ann Pastore, RN, Newborn Unit
- Linda Roth, RN, OB Unit
- Marilyn Wise, LICSW, Social Work



# Educational Offerings

March 17, 2005

When/Where	Description	Contact Hours
March 24 7:00–11:30am and 12:00–4:30pm	<b>Congenital Heart Disease</b> Haber Conference Room	4.5
March 25 8:00am–4:30pm	<b>Psychological Type &amp; Personal Style: Maximizing Your Effectiveness</b> Training Department, Charles River Plaza	8.1
March 25 12:00–4:00pm	<b>Basic Respiratory Nursing Care</b> Ellison 19 Conference Room (1919)	---
March 28 and 29 8:00am–4:30pm	<b>BLS Instructor Program</b> VBK601	---
March 31 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Surgical Inpatients’ Perceptions of Communication.” O’Keeffe Auditorium	1.2
April 1 9:00am–3:00pm	<b>ENCARE–Emergency Nurses Care</b> O’Keeffe Auditorium	---
April 5 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
April 6 8:00–11:30am	<b>Intermediate Arrhythmias</b> Haber Conference Room	3.9
April 6 12:15–4:30pm	<b>Pacing Concepts</b> Haber Conference Room	4.5
April 7 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---
April 8 8:00am–4:30pm	<b>MGH School of Nursing Alumni Program</b> O’Keeffe Auditorium	---
April 12 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK 401 (No BLS card given)	---
April 12 4:00–5:30pm	<b>Natural Medicines: Helpful or Harmful?</b> Founders 626	1.8
April 13 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
April 13 7:00am–12:00pm	<b>CVVH Core Program</b> VBK 601	6.3
April 13 1:30–2:30pm	<b>OA/PCA/USA Connections</b> “The World of Materials Management.” Bigelow 4 Amphitheater	---
April 13 11:00am–12:00pm	<b>Nursing Grand Rounds</b> “Child Abuse and Neglect.” Sweet Conference Room GRB 432	1.2
April 15 8:00–11:00am	<b>On-Line Clinical Resources for Nurses</b> Founders 626	---
April 21 and 22 7:30am–4:30pm	<b>Pain-Relief Champion Workshops</b> Wellman Conference Room	TBA
April 25 and 26 7:30am–4:30pm	<b>Intra-Aortic Balloon Pump Workshop</b> Day 1: VABHCS; Day 2: VBK601	14.4 for completing both days
April 26 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK 401	---

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>.

## Video interpreting comes to MGH

*This spring, MGH Medical Interpreter Services will introduce a video interpreting pilot for patients and clinicians in the ambulatory OB practice on Yawkey 4.*

**Question:** What is video interpreting?

**Jeanette:** Video interpreting uses video conferencing technology to visually connect non-English and limited-English speaking patients with medical interpreters via the Internet to facilitate communication between patients and their providers at the point of care. Over the past 40 years, video conferencing technology has evolved from a crude, expensive, frequently unreliable process to the affordable, refined system it is today. From classrooms to operating rooms this technology shortens the virtual distance between two or more individuals and assists in the transfer of knowledge and information.

**Question:** How does this represent a service enhancement for Interpreter Services?

**Jeanette:** Currently, Interpreter Services provides a spectrum of services ranging from pre-scheduled face-to-face interactions to medical interpreting provided by an outside phone service. Though more accessible in instances of emergent need, medical interpreting via the telephone scores lower on patient-satisfaction surveys when compared to face-to-face interactions. However, recent studies indicate that interpreter services provided via video conferencing elicit the same high level of patient satisfaction, and in some cases a greater level, when compared to face-to-face interactions. Patients report an increased sense of privacy with video con-

ferencing (the screen image can be confined to the patient's face), and a greater sense of connection and understanding than can be achieved over the phone.

**Question:** What other benefits does video interpreting offer?

**Jeanette:** In high-volume areas throughout the hospital, video interpreting effectively eliminates many of the coordination issues associated with pre-scheduled requests. And in instances of emergent need, interpreters can be available in 'real time' as needed, effectively eliminating the logistical difficulties associated with unscheduled requests.

Every year the demand for medical interpreting in the MGH community grows. Implementation of video conferencing technology will

help medical interpreters meet this increased demand. Video conferencing also provides a cost-effective and equally satisfying service for patients with the speed and convenience of a phone call.

**Question:** How will the pilot program work?

**Jeanette:** Beginning this spring, video conferencing

hardware will be located in the MGH Interpreters Office and on the OB unit on Yawkey 4. Clinicians and patients will manage their interpreting needs using this equipment. After the pilot, the process will be evaluated, improved, and offered to a wider population. Video interpreting will be a valuable resource as the main campus expands.

### 2nd Annual Spring Seminar Series on Mental Health and Wellness: Common Challenges and Practical Solutions

Sponsored by the  
MGH Mood & Anxiety Disorders Institute  
Resource Center and Schizophrenia Program

**Thursday evenings  
March 17–May 5, 2005  
6:30–8:30pm  
O'Keefe Auditorium**

Seminars are intended to help participants become more knowledgeable consumers of mental health services and more effective advocates for their own and their loved ones' mental health care

Space is limited, so register early

Seminars are free and open to the public

For more information, contact the Mood & Anxiety Disorders Institute Resource Center  
at: 617-724-8318

# Caring

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