

Caring

HEADLINES

March 3, 2005

Inside:

African American Pinning Ceremony 1

Jeanette Ives Erickson 2

- CarePages

Fielding the Issues 3

- Baby Safe Haven Act

Quality Conference 4

- Creating an Environment of Quality and Safe Practice

Collaborative Governance Celebration 6

Knight Preceptor of Distinction Award 8

- Nicola Gribbin, RN

On-Site, On-Line Nursing Education 10

Quality & Safety 12

- Safety at MGH—Behind the Scenes

IV Nurse Day 13

Professional Achievements . 14

Educational Offerings 15

NERBNA Awards 16

African American Pinning Ceremony

The tradition continues

On February 14, 2005, in O’Keeffe Auditorium this year’s honorees of the African American Pinning Ceremony were recognized by family, friends, and colleagues at what is now a familiar, but still evolving, annual event. This year’s honorees were Immacula ‘Kiki’ Benjamin, staff nurse on Ellison 18; Ron Greene, *continued on page 5*



Case manager, Ron Greene, RN, is pinned by Emergency Department nurse manager, MaryFran Hughes, RN



Staff nurse Kiki Benjamin, RN (left), was unable to attend the ceremony; she is pictured here with a colleague on Ellison 18



Human Resources generalist, Jacqueline Lynch, is pinned by PCS Human Resources manager, Steve Taranto

(Photos by Paul Batista)

MGH Patient Care Services
Working together to shape the future

CarePages

*helping patients stay in touch
with family and friends when it matters most*

Wouldn't it be great to be able to provide our patients with a quick, easy, reliable way to stay in touch with their family and friends while they're hospitalized at MGH? CarePages, a web-based, electronic communication system soon to be piloted on a number of inpatient units, does just that.

CarePages is an important new customer-service initiative sponsored by Patient Care Services. It will be free to our patients and their network of family and friends; it will be private; and it will allow individuals to post text messages and photographs on-line at a time that is convenient for them (before, during, or after their hospitalization).

We all know how stressful a hospital stay can be. Whether it's for treatment of a disease or injury or the birth of a new baby, time spent in a hospital is emotionally taxing. Add to that the need to keep loved ones informed in a timely manner, and the stress level escalates. Families want to feel connected, but all family members and loved ones can't be present at all times. And beyond the 'inner circle' of family and friends, there may be others who are concerned and want information but don't want to intrude at an inopportune time.

CarePages offers a solution to all these challenges. With CarePages, families can share information 24 hours a day, 7 days a week, at their

convenience. CarePages stay active for an initial six-month period (but there is no 'expiration date.' CarePages will stay active for as long as patients and families need them).

To use CarePages, each patient and family selects someone in their group to be the manager. That person will set up and oversee their CarePage. Set-up is easy with the help of a fill-in-the-blank template that guides them through the process. Managers then extend electronic invitations to those who should have access to the secure, password-protected CarePage; then each user will need to register to select his/her own password to gain access.

Every step of the system is user-friendly. When the manager sends an initial message to a new user, CarePages automatically includes all the basic information, such as the patient's name, the CarePage access address, and a toll-free telephone number for help or support. Once new users register, they can check or send messages any time they want, as often as they want.

Not only is this an effective vehicle for two-way communication about a patient's current medical condition, it's an excellent way for fami-



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

lies to share pictures of their loved ones before they became ill, unconscious, or incapacitated. And if a patient comes to after a long period of being unconscious, the patient herself can go to the CarePage that was created for her and review all the messages that were sent and received during that time.

CarePages will be accessible from the MGH home page and provide links to other key MGH services. CarePages will be available in English

and Spanish. Beginning later this month, the program will be piloted on a number of inpatient units before being implemented throughout the hospital. Though CarePages is a service extended to our patients and their families, demonstrations will be conducted on patient care units to ensure that staff are well informed and able to speak knowledgeably about it to our patients.

For more information about CarePages, contact Georgia Peirce, at 4-9865.

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: March 15, 2005
12:00-1:00pm**

Bulfinch 225A Conference Room

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

Your Opinion Counts!

Staff Perceptions of the Professional Practice Environment Survey – 2005

Surveys were mailed to all direct-care providers during the last week of February. If you didn't receive a survey, please call The Center for Clinical & Professional Development at 726-3111.

All individual responses are kept confidential.

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

For more information, call 726-3111

New Baby Safe Haven Act: how is MGH responding?

Question: What is the Baby Safe Haven Act?

Jeanette: The Baby Safe Haven Act was signed into law on October 29, 2004. It allows parents to voluntarily abandon a baby they feel they can't care for.

Question: Where can a baby be left?

Jeanette: The law requires all hospitals (acute care, inpatient rehabilitation, and long-term acute care) and police and fire departments to act as designated facilities where parents can leave their newborn babies.

Question: I thought that was against the law. Can a parent be prosecuted for this?

Jeanette: The intent of the law is to provide a safe alternative for parents who decide they can't take care of a newborn baby and might otherwise abandon the child in an unsafe setting. The child must be seven days old or younger. If the child meets this criterion and there are no signs of abuse or neglect, the parent can voluntarily abandon the child without fear of criminal prosecution.

Question: What should I do if I find an abandoned infant?

Jeanette: Any MGH employee who finds an abandoned newborn, or is approached by a parent or guardian who wants to relinquish their newborn under the Safe Haven Act, should bring the

infant (and parent, if willing) to the MGH Emergency Department.

If the parent is unwilling to come, the employee should thank the parent for bringing the infant to a safe place and ask if he or she is willing to provide any information that would assist in planning for the future care of the child.

Employees should try to engage the parent in conversation by asking for the name of the newborn infant and the name and address of the parent if he or she is willing to give that information.

If the parent insists on leaving without going to the ED, the employee should take the infant to the ED where staff will document the information given by the parent, conduct a medical exam of the baby, and contact the Department of Social Services (DSS) to begin the process of delivering the child to their custody.

For more information about the Baby Safe Haven Act, visit: www.babysafehaven.com (no spaces). For information about how to respond to a situation at MGH, page our Child Protection Consultation Team at pager #3-2728.

Visit the new Sharps Safety website

As part of our commitment to provide a safe environment for employees and patients, a new and improved Sharps Safety website has been launched on the MGH Intranet. It provides the most current information on sharps safety products used at MGH and includes the following sections:

- Needlebox Disposal
- I've Been Stuck by a Sharp. What's Next?
- Reporting Sticks/Near Misses
- The MGH Needlestick Reduction Task Force
- Legislation
- Products
- Frequently Asked Questions (FAQs)
- Policies
- Resources

The website has been

redesigned by two nurse clinical educators from The Center for Clinical & Professional Development, Sheila Golden-Baker, RN, and Phil Waithe, RN. Rebecca Rockel from the MGH Marketing Department was the web coordinator. The team was supported by members of the Needlestick Reduction Task Force.

The Sharps Safety website can be accessed from the MGH home page, by clicking on, "Link to MGH Intranet," in the lower right portion of the page and clicking on the 6th link in the left-hand column. Or, go to: <http://is.partners.org/mghintranet/sharpsafety/index.htm> (no spaces, no hyphens).

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.

Pain Skills and Knowledge Day

You are invited to attend a Pain Skills and Knowledge Day. This drop-in, module-based continuing education opportunity is open to all disciplines. Individual 'stations' will include practice in operating a PCA pump and converting from one opioid to another, various pain therapies, and a review of MGH Pain Management Guidelines. Drop in and stay as long as you like. It will take 60-90 minutes to get through all stations. No pre-registration is required.

Tuesday March 15, 2005

Open sessions: 8:00-11:00am;

11:30am-2:30pm, and 4:00-7:00pm

Walcott Conference Room

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

Creating an Environment of Quality and Safe Practice

—by Thomas Drake, training specialist,
The Center for Clinical & Professional Development

On February 7, 2005, the PCS Quality Committee hosted a one-day conference on “The Different Faces of Quality Improvement: Creating an Environment of Quality and Safe Practice.” O’Keeffe Auditorium was filled to capacity as speakers presented on a variety of safety and performance-improvement topics.

Marianne Ditomassi, RN, executive director to the office of senior vice president for Patient Care, welcomed the interdisciplinary audience and outlined the goals of Patient Care Services for 2005, focusing on patient-centered care.

Voices of quality

(clockwise from left): Barbara Rattner, RN, research nurse manager, Hematology/Oncology; Scott Dickinson, OC, White 8 and 10; keynote speaker, Anita Tucker, assistant professor of Operations & Information Management, University of Pennsylvania; Judy Tarselli, RN, Infection Control; Sheila Golden-Baker, RN, The Center for Clinical & Professional Development; and Joan Fitzmaurice, RN, co-director, Office of Quality & Safety

Keynote speaker, Anita Tucker, DBA, assistant professor of Operations & Information Management at the Wharton School, University of Pennsylvania, presented her research on how operational failures in hospital systems affect nursing care and patient outcomes. Organizations can benefit from working with front-line providers. Why study operational failures? According to Tucker, learning about operational failures can:

- help minimize adverse events
- increase reliability
- help improve systems

- lead to organizational improvement
- keep employee satisfaction, productivity, and effectiveness at a higher rate than if failures go unaddressed

Tucker’s 239-hour study involved 26 nurses on inpatient care units at nine Magnet hospitals. Her data cited 166 instances of missing or incorrect information, supplies, equipment, waiting for a resource, or simultaneous demands. 28 errors resulted from

the 166 operational failures. Closer analysis of hospital systems can prevent errors like these from occurring and affecting the patient.

Nurses in the study responded to these failures in two ways: ‘work-arounds’ (working around the problem) and a prevention-oriented problem-solving method.

The benefit of work-arounds is that patients ultimately receive what they need. The drawback is that they don’t take advantage of opportunities to improve organizational systems. The unintended consequences of work-arounds is that they contribute to prob-

lems happening again, which can lead to more failures and hinder organizational learning.

Tucker suggested we strive for the prevention-oriented problem-solving method, which was rarely employed in her study and only when a serious failure occurred while delivering patient care. Tucker stressed that this is the desired response to operational failures. Implementing this method exposes the failure and empowers front-line clinicians to improve the system by preventing recurrence.

Tucker summarized, saying, “Learning from failures requires a deliberate process from both managers and employees.” It fosters an open environment that promotes improved patient safety and provides the highest quality care for patients.

*continued
on next
page*



Pinning Ceremony

continued from front cover

RN, case manager; and Jacqueline Lynch, Human Resources generalist.

The theme of this year's ceremony was, "Uniquely African American," focusing on the issue of maintaining self-identity in a world that doesn't look like you. Keynote speaker, Massachusetts State Representative, Byron Rushing, gave an engaging talk on black history, racism in America, and the evolution of Black History Month into an opportunity to inform and educate. Said Rushing, "Black history does not exist in isolation. White history is not separate from black history, though textbooks and history books may lead us to think so."

Images of the Revolution, a powerful video depicting scenes of the turbulent African American struggle for freedom, was shown as a rendition of *Wake Up Everybody* by Harold Melvin and the Blue-notes was played in the background.

Honorees received the traditional Black Heritage pin and African shawl. The event closed with a slide show of the honorees and was followed by a reception in the Trustees Room.

For more information about the PCS African American Pinning Ceremony, Black History Month, or any activities sponsored by the PCS Diversity Committee, contact Deborah Washington, RN, at 4-7469.



At left: Ron Greene, RN, with State Representative, Byron Rushing.

Below: Director of PCS Diversity, Deborah Washington, RN (left), and Steve Taranto present bouquet of flowers to Jacqueline Lynch.



Creating an Environment of Quality and Safe Practice

continued from previous page

Joan Fitzmaurice, RN, co-director of the Office of Quality & Safety, presented, "The Role of Patient Safety Rounds in Improving Quality Care," and it was the perfect complement to Tucker's presentation. Fitzmaurice shared that MGH does a great job in reporting failures through the filing of incident reports.

Approximately 9,000 incident reports were filed in 2004. Fitzmaurice emphasized the importance of reporting near misses as well as incidents that actually occur. Near misses present a great opportunity to identify operational failures and make appropriate changes before other incidents occur. Fitzmaurice spoke about

Patient Safety Rounds, the unit-based meetings where front-line staff provide direct feedback about the quality-improvement needs of their clinical work environment.

Fitzmaurice announced the new web-based Safety Event Reporting System that will be implemented in 2005. The process will streamline the reporting of events, and management can stay informed about critical information with the click of a mouse. The

result is a faster response time and speedier resolutions.

Afternoon sessions focused on successful performance-improvement initiatives including the Plan-Do-Check-Act (PDCA) model presented by Scott Dickinson, operations coordinator for White 8 and 10. Unit-based presentations included, the Sheath Removal Program implemented on Bigelow 14 (Cheryl Codner and Greg Nuzzo-Mueller); the Ambula-

tory Infusion Unit Pump Program (Barbara Rattner, RN); and the Hand Hygiene Program, co-presented by Infection Control (Judy Tarselli, RN) and The Center for Clinical & Professional Development (Sheila Golden-Baker, RN).

For more information about quality or quality-improvement initiatives within Patient Care Services, contact Lynda Tyer-Viola, RN, coach of the Quality Committee at 4-3608.

Collaborative Governance Celebration

—by Trish Gibbons, RN, associate chief nurse

On February 9, 2005, senior vice president for Patient Care, Jeanette Ives Erickson, RN, welcomed staff to a special celebration of Collaborative Governance Grand Rounds calling it, ‘the Super-bowl’ of teamwork. A member from each of the seven committees within collaborative governance (Diversity, Ethics in Clinical Practice, Nursing Practice, Patient Education, Quality, Nursing Research, and Staff Nurse Advisory) presented highlights of their 2004 accomplishments and outlined their goals

for the coming year. Ives Erickson observed that giving voice to this work “cements legends” and contributes to a culture of safety, evidence-based practice, and improved systems of care-delivery. She thanked collaborative governance committee members, coaches, co-chairs, and countless others who come together every day on behalf of patients and families to, “stimulate, facilitate, and generate knowledge that will improve patient care and enhance the environment in which clinicians shape their practice.” (Collaborative Governance Mission State-

ment, 2001.)
Said Ives Erickson, “Collaborative governance is possible because of the resilience, focus, and commitment to excellence of so many at MGH.

Following Grand Rounds, more than 100 staff members attended a special recognition dinner at the Holiday Inn in celebration of the work of collaborative governance. Ives Erickson encouraged everyone to read the

2004 *Annual Report and Collaborative Governance in Action*. She thanked participants for a year of hard work and great accomplishments.

Citing patient safety as one of our highest strategic priorities, Ives Erickson welcomed keynote speaker, Rosemary Gibson, a well-known

spokesperson in Patient Safety and co-author of, *Wall of Silence: the Untold Story of the Medical Mistakes that Kill and Injure Millions of Americans*.

Through some of the stories in Gibson’s book, we came to know individuals and families and
continued on next page



Rosemary Gibson

(This photo by Abram Bekker)



Jeanette Ives Erickson



Lori Pugsley and Kathy Grinke

Collaborative Governance

continued from previous page

the pain and anguish they suffered as victims of medical errors. Gibson challenged health professionals to, “reclaim the reason” in our work by becoming competent in quality- and safety-improvement. Said Gibson, when mistakes happen patients and families want disclosure of the facts, a continued connection with their caregivers, and a guarantee that the same mistake won’t happen again.

In honoring and celebrating the work of col-

laborative governance, Gibson noted that this work is an example of reclaiming reason by “striving for perfection, breaking down walls, and truth-telling,” accomplishments evident in the work of every collaborative governance committee.

Gibson quoted from the poem, “A Mind Without Fear,” by Rabindranath Tagore:

Where words come out
from the depth of truth
Where tireless striving
stretches its arms toward perfection

Where the mind is without fear and the head is held high

Where the world has not been broken up into fragments by narrow domestic walls

Where the clear stream of reason has not lost its way into the dreary desert sand of dead habit

Where the mind is led forward into that heaven of freedom, let us awake

For more information about collaborative governance and how to become involved with committee work, contact The Center for Clinical & Professional Development at 6-3111.

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



Collaborative governance representatives (l-r): Meg Soriano, RN (Staff Nurse Advisory); Karen Lipshires, RN (Quality); Lori Pugsley, RN (Patient Education); Kathy Grinke, RN (Nursing Research); Edna Riley, RN (Nursing Practice); Sharon Brackett, RN (Ethics in Clinical Practice); and Lulu Sanchez (Diversity Steering Committee)

Norman Knight Preceptor of Distinction Award

The second annual Norman Knight Preceptor of Distinction Award was presented on Thursday, February 10, 2005, in O’Keeffe Auditorium. This year’s deserving recipient was Nicola Gribbin, RN, staff nurse in the Cancer Center Infusion Center.

In her opening remarks, senior vice president for Patient Care, Jeanette Ives Erickson, RN, acknowledged the kindness and generosity of award benefactor, Norman Knight, noted businessman, community leader, and philanthropist.

Said Knight in response, “I am humbled by what nurses do every day. They represent the

very best of what America is all about. I’m privileged to be ‘an honorary’ member of the MGH family.”

Ives Erickson thanked the review board for their hard work in selecting a recipient from a distinguished field of nominees. She reminded those in attendance of the criteria used to evaluate candidates. Said Ives Erickson, “A preceptor of distinction creates a safe environment in which trust and wisdom can be discovered by both the preceptor and preceptee. Through example, the preceptor encourages a journey of growth and role-models excellence in patient- and family-centered care.” A preceptor of distinction:

- is caring and non-judgmental
- possesses a spirit of inquiry
- is guided by knowledge
- is a leader
- values teamwork

Before introducing Gribbin, Ives Erickson read from a letter of recommendation written by Debbie Spaulding, RN, Gribbin’s preceptee. Spaulding wrote, “Nikki’s example of compassionate nursing care guided by knowledge and skill remains with me today and is the foundation of my practice... Transferring to the Infusion Center was the best career choice I could have made, and my success is a direct result of the caring and coaching I received from Nikki.”

Ives Erickson invited Gribbin to the podium to read the narrative she wrote and submitted as part of her application portfolio (see narrative on opposite page). The narrative was entitled, Teaching the Skills of Involvement and Presence in Clinical Practice.” Following the reading, clinical nurse specialist, Laura Mylott, RN, was asked to dialogue with Gribbin to unbundle the narrative and help identify key aspects of the preceptor role.

Said Mylott, “In the past twenty years, Nursing has come to realize that the complexity of human relationships extends beyond the existence of communication. To be in relationship, or partnership, with another human being is a caring process that involves mutual intent, the identification and shar-

ing of mutual goals, and a sharing of risk, responsibility, power, and accountability.

“Nikki role-modeled the skill of involvement as she partnered with Debbie. She implemented strategies to teach the skills of involvement so critical to the care of cancer patients.

“Nikki recognized and respected Debbie’s professional knowledge, initiative, and ability to learn, but felt she needed to learn how to become more interpersonally connected with patients so she could better understand their needs.” Gribbin tailored the precepting experience to meet the needs of the preceptee.

In closing, said Ives Erickson, “Thank-you, Nikki, for showing us what it means to be a preceptor of distinction, and Mr. Knight for supporting the important work of MGH nurses.”



Above: Norman Knight, benefactor of the Norman Knight Preceptor of Distinction Award. At right: Award recipient, Nicola Gribbin, RN (left) with Deborah Spaulding, RN, her preceptee (center), and Laura Mylott, RN, clinical nurse specialist in The Knight Center for Clinical & Professional Development.

Knight recipient shares story of exemplary precepting

(Due to length, the following is an abridged version of Nicola Gribbin's Knight Award-winning clinical narrative)

My name is Nicola Gribbin, and I am a staff nurse in the Hematology/Oncology Infusion Unit. A busy Oncology clinic, such as the Blake 2 Infusion Unit, requires nurses to have particular skills, knowledge, and reliable instincts. Recently, because of a shortage of nurses with Oncology experience, it has become necessary to hire and train nurses from other specialties.

A colleague and I were asked to precept the first nurse hired at the clinic who had no Oncology experience. We were faced with the challenge of teaching a seasoned non-Oncology clinician to be an Oncology nurse. Debbie had prior experience in Emergency, Cardiology, and Pediatric nursing, but not cancer care. I didn't realize this teaching experience would be such an endeavor; years of experience had made my work comfortable for me, but not necessarily easy to verbalize or teach.

Debbie was about to undertake a formidable task—learning a multitude of new skills, the safe administration of chemotherapy, management of central lines, blood-transfusion therapy, learning about a variety of malignant dis-

ease processes, recognizing and treating oncologic emergencies, and managing symptoms and side-effects. In addition, Debbie needed to become familiar with the systems at MGH for documentation, data-acquisition, and support services. But primarily, Debbie was going to have to learn how to be an Oncology nurse, gracefully caring for patients whose worlds had fallen out from under them.

When I first met Debbie, it was clear she was very intelligent and exceptionally passionate. She had spent a significant amount of time preparing for her new work and impressed me with her knowledge. At our initial meeting, she was able to tell me statistics about the incidence of different cancers, the chemical make-up of a variety of chemotherapeutic agents, and the side-effects of particular cell-targeted therapies. During our first few days together, Debbie

shadowed me while I cared for patients so she could learn through observation. Debbie displayed great enthusiasm, preparing the night before for the treatments we would be administering and reviewing in great detail past medical and oncologic histories of the patients we would be treating. I was impressed because she had studied hard and attained a vast amount of information in a very short time. Intellectually, Debbie displayed great talent, and I felt confident in her ability to safely treat cancer patients. She questioned lab results and drug doses if they seemed inappropriate.

But despite Debbie's ability and enthusiasm, I was concerned there was an aspect of my work that I wasn't translating appropriately to her. Debbie was learning how to treat cancer, but she wasn't acquiring the skills she needed to care for oncology patients and their families.

Mid-way through her orientation, Debbie had a day off. She called me from home to inquire about our assignment for the following day. She wanted to begin preparing for the treatment regimens we would be administering. I decided not to give this information to Debbie. Instead, I gave her a different assignment. I told her to sit and relax. It struck me that Debbie was working hard to memorize regimens, side-effects, and drugs, but not effectively using our orientation

together as an opportunity to grasp the experience of being an oncology nurse. The information she was studying was readily available in textbooks, on the Internet, and in journals, but was forever changing once learned.

The lesson I wanted Debbie to learn was how to empathize with patients—people whose lives had been changed by disease—how to be present for them and their families. This is a talent that can't be learned by reading. It can't be mastered during a four-month orientation. But it can be witnessed, and a learning curve can be initiated through thoughtful observation and listening.

The next morning, I decided to employ a new approach with Debbie. It was important for her to

continued on page 11



Gribbins and Ives Erickson

Just say 'Yes' to on-site, on-line baccalaureate nursing education

—by Miriam Greenspan, RN, clinical nurse specialist,
The Center for Clinical & Professional Development

The department of Nursing has established a collaborative relationship with Northeastern University School of Nursing and St. Joseph's College of Maine to host on-site baccalaureate programs for MGH nurses interested in returning to school. Recently some of the first nurses to register shared their thoughts about the program.

Lynda Center, RN, of White 7 says, "This was an awesome opportunity to further my education."

Deborah Gorham, RN, of Pediatric Radiology, had thought about going back to school many times since completing her associate's degree, but every time, 'life' got in the way. This program was so convenient, "How could I not do it?" she says.

All participants told a similar story. They hoped to one-day work toward a baccalaureate degree but obstacles kept getting in their way. Then came the on-site RN to BSN Program. Having classes on campus Monday evenings at a reduced cost eliminated many of the barriers.

Nurse managers who offer flexible scheduling is another plus. Nurses who rotate shifts are able

to work the day or night shift on Mondays so they can go to class either before or after their shift.

Kamla Singh, RN, Ellison 19, has taken the longer route to her BSN. She began as a PCA in the Medical Intensive Care Unit. While working in the MICU she became an LPN and went on to complete her associate's degree. Her long-term goal was always to earn a bachelor's degree. Says Singh, "This is a great opportunity. School is right on your doorstep. All you need to do is focus." When she needs a place to work on assignments, Singh uses the Patient & Family Learning Center. Com-

puters, printed materials, and the quiet reading room make it the perfect place to study.

Christopher Robbins, RN, and Janet King, RN, both work on the Endoscopy Unit. They enrolled in the St. Joseph's on-line program as a team. Both have been nurses for more than 20 years and had been searching for the right opportunity to return to school. They chose the distance-learning program for the flexibility it offered and are finding it to be just the right fit.

Robbins and King study together for mutual support and to help maintain the self-discipline an independent-study program requires.

All nurses in the program have found the work interesting and manageable. The support and flexibility of faculty has contributed to a smooth re-entry into the academic world. Many

entered class with great trepidation and have been pleasantly surprised. Their unanimous advice to other nurses is: "Now is the time. Focus on your goal and take advantage of this great opportunity!"

For more information about on-site or on-line nursing education, call Miriam Greenspan at 4-3506.



Representatives from Northeastern University and St. Joseph's College speak to MGH nurses, prospective students in on-site, on-line nursing education programs.

Narrative

continued from page 9

be present and observe my interactions with patients and their families. In the past, while these interactions were occurring, Debbie would leave to get supplies or beverages or blankets. She was trying to be helpful, but wasn't using this time as a chance to discover new approaches to patient care.

When Debbie arrived that morning, I urged her not to treat any patients on her own and stay with me. I wanted her to witness my interactions with patients and families—how I talked to them, looked at them, sat with them, and listened to them. We spoke at length about the importance of assessing patients without making them feel interrogated. Debbie's prior work in Emergency, Cardiology, and Pediatrics had accustomed her to making quick assessments, but she never had an opportunity to see patients on a long-term basis and develop strong connections with them over time.

I stressed the importance of listening to patients when they answered simple question like, "What did you do this weekend?" Their answers, the manner in which they speak, their body language can tell us if they're enjoying life, coping with their disease, managing their

fatigue, feeling supported, having pain, or sleeping well. I told Debbie there was valuable information to be learned from simple, friendly conversations. And a non-threatening approach can ease paralyzing anxieties and fears, allowing patients to open up and share their experiences.

Throughout our next few days together, Debbie and I analyzed the interactions we had with patients. We de-briefed after every conversation to evaluate what we had learned. When a patient spoke about a delicious meal he had enjoyed, we knew he still had an interest in food. Patients frequently spoke of their difficulties and struggles with treatment, symptoms, or their ability to cope, leading the conversation to where we could provide support, education, and guidance.

Eventually, Debbie became more comfortable speaking with patients and displayed confidence in her interactions with them. She was able to enjoy her time with them, and patients felt more at ease during a difficult time.

Debbie started increasing her patient assignments as I remained available to offer assistance and support. At first, Debbie struggled with time-management becoming overwhelmed with caring for multiple patients. We spoke frequently about methods and techniques she could employ to work quickly without making patients

feel rushed. She listened to these suggestions and was able to make them work for her.

Debbie struggled with caring for new or particularly anxious patients who felt scared of what lay ahead. She wanted to give them the time they needed to feel comfortable, but that caused her to fall behind in her assignments.

In one instance, a woman newly diagnosed with cancer had many fears that lead her to ask a multitude of questions regarding her upcoming therapy. Understandably, Debbie sat with this woman and patiently answered her questions, giving her the information and counseling she needed. Unfortunately, this kindness and patience led to a two-hour delay in initiating her therapy and an escalation in the patient's anxiety as her fears about the upcoming treatment grew. We talked about this situation. It became clear to me that, although Debbie was doing what felt instinctively right—giving patients the time and education they needed to feel informed—the increased time it took to initiate therapy added to the patient's anxiety.

I gave Debbie an analogy. I asked her to think about the anxiety a person who is afraid of flying would feel while sitting in a plane waiting to take off. We agreed that this person's fears would not go away until the plane took off and

the flight ended with the plane safely on the ground again. We spoke about how it would feel for this person waiting to take off if the flight attendants attempted to ease her anxiety by explaining the complicated mechanics of an airplane and the extensive security measures that were used. We agreed that the detailed explanations would not ease her anxiety but add to her worry and concern. We compared this scenario to that of her patient, newly diagnosed with cancer, sitting in a treatment chair, worrying about her upcoming therapy. Patients fear the unknown. For them, it's like sitting on a runway listening to explanations in a language that's beyond their comprehension when they would just prefer to take off, have a safe flight, and land safely again. Through this analogy, Debbie was able to understand the importance of caring for patients in a manner that recognized and managed their fears, but that set boundaries to prevent their anxiety from becoming all-consuming.

Debbie is learning to be an Oncology nurse. Her four-month orientation has laid the groundwork, and the ongoing work she does with patients provides more growth every day. Debbie has been working in our clinic for approximately one year. When I reflect back on the expansive amount of information she has learned

during this year, I am amazed. She started her first day nervously approaching patients diagnosed with cancer. She was fearful of their fears and unsure how to provide support and guidance. A year later, as Debbie gains more and more experience, she is acquiring the skills needed to relate to patients and help them manage their lives as they learn to live with their disease. Her patients and her colleagues have confidence in Debbie, and trust her.

What surprised me was what this mentoring experience showed me about my own development as an Oncology nurse. It has helped me formulate what it is I do on a daily basis to care for patients with cancer. It has forced me to recognize what makes me an Oncology nurse. Generally, my days are busy and I do what I do without much self-analysis. But watching Debbie has caused me to realize and reflect on my own progress over the past ten years. Like Debbie, I used to be overwhelmed easily, cry at the sadness I faced, and be afraid to get close to patients I might eventually lose. Now, I am able to recognize that what I do is to give strength and control back to our patients at a time when they feel hopeless. Likewise, they give strength to me. By guiding Debbie through this process, I have gained confidence in myself as an Oncology nurse.

Safety at MGH—behind the scenes

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

Every person who works at MGH is a care provider. Some provide one-on-one care to patients in clinics or at the bedside—nurses, USAs, therapists, social workers. Others provide complementary or indirect care or services behind the scenes—employees in Nutrition & Food Services, Materials Management, Buildings and Grounds, Information Systems, Police & Security. Regardless of role, every one of us is responsible for helping MGH deliver the safest, highest-quality patient care possible.

In an ideal world, or ‘system,’ those providing direct care and those supporting them behind-the-scenes work together closely toward the common goal of seamless patient safety. In examining this relationship, some patient safety models describe the healthcare delivery system as having a sharp end and a blunt end. The sharp end refers to the point of patient contact or care; the blunt end refers to behind-the-scenes people and programs that guide and support front-line care providers.

We know from human-factors research that any process that involves human interaction inherently contains the potential for human error—much of which occurs in

a predictable way. If we are to be successful in creating a safe environment of care, we need to focus our efforts on the consistent root cause of problems: system errors in design and implementation. These efforts help front-line clinicians—those at the sharp end—to perform at their best both individually and collectively, making it difficult for errors to occur.

Currently at MGH, there are a number of behind-the-

scenes efforts designed to enhance the safe delivery of patient care. Others are expected to reach the front lines of our delivery system in the coming months and years.

In the spring, we will be introducing a new patient wristband designed for ease of reading and legibility. This seemingly simple change will lay the important foundation from which a variety of patient-safety initiatives can be launched. Every wristband will be bar-coded for electronic recognition and eventually used to embed vital medical and health information such as blood types and allergies. Bar-coding could

lead to a system of electronically ensuring that the right medication is matched to the right patient. The possibilities are endless. MGH is working with Partners to develop an on-line safety reporting system. By moving the incident reporting process from paper to an electronic medium, data can be collected and stored more accurately and efficiently. Analyzing data in aggregate gives us the ability to identify and

observe patient-safety trends. For example, hand-hygiene practices on one unit might result in a reduction of certain types of hospital-acquired infections. Knowing what works best in one area allows us to share those best practices throughout the institution.

Certain changes, such as the introduction of new equipment, may be an instance where areas of concern begin to emerge. A problem so rare it might only occur once or twice on any given unit could be prevented entirely by looking at hospitalwide data, identifying the problem, and solving it on those units before it has a chance to harm patients.

MGH is embarking on an electronic medication administration process (eMAP) initiative. The goal is to improve the efficiency, accuracy, and safety of medication administration, a highly complex process. Studies show that medication administration involves between 80 to 200 steps per single dose administered in a hospital setting. The potential for systems failures within these steps is very real. Once up and running, eMAP would facilitate the electronic flow of an order to a new pharmacy system and then to a new electronic medication record. Nurses would use a bedside scanner to ensure that patients receive the right drug, the right dose, the right route, at the right time. The ability to interface with a bar-coded patient wristband will be key, and a robust safety reporting system will be vital to ensuring that the system works as intended.

Whether we are at the bedside or working behind the scenes, we are all responsible for ensuring that our institution provides the safest, highest-quality care possible. By closely weaving together work at the front line and efforts to support that work from all roles and all areas, we can create a tightly knit, highly-effective safety net for patients and providers alike.

Every person who works at MGH is a care provider... Regardless of role, every one of us is responsible for helping MGH deliver the safest, highest-quality patient care possible.

MGH celebrates IV Nurse Day

—by Debra Guthrie, RN, IV nurse

In celebration of National IV Nurse Day the MGH IV nurse team presented an information booth in the Main Corridor on Wednesday, January 26, 2005, to help raise awareness about IV therapy. The team displayed various intravenous devices (including short peripheral IVs, PICCs, Hickman catheters, and implantable ports), diagrams of possible IV site locations, information on IV therapy complications, IV equipment and pediatric IV therapy.

The role of IV nurse at MGH is best described as a vascular access specialist primarily involved with the insertion of short peripheral IVs, PICCs, and midlines. IV nurses perform daily maintenance and dressing changes of all PICCs and mid-

lines, troubleshoot issues and concerns with venous access devices, administer blood transfusions, and provide support and consults on phlebotomy and accessing implanted ports for patients who have difficult access.

Members of the IV nurse team participate in collaborative governance. Many of the IV nurses belong to specialty associations such as the INS (Infusion Nurses Society) and the AVA (Association for Vascular Access) and have attained the credentialing designation of CRNI.

For more information about the IV nurse team or IV therapy at MGH, contact the IV resource nurse at 6-3631.



IV nurses, Mary Anne Killackey, RN (above); Peg Munson, RN (below, left); and Deb Guthrie, RN, staff educational booth in Main Corridor in celebration of IV Nurse Day.

Published by:

Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital.

Publisher

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

Managing Editor

Susan Sabia

Editorial Advisory Board

- Chaplaincy
Reverend Marcia Marino, DMin
- Development & Public Affairs Liaison
Victoria Brady
- Editorial Support
Marianne Ditomassi, RN, MSN, MBA
Mary Ellen Smith, RN, MS
- Materials Management
Edward Raeke
- Nutrition & Food Services
Martha Lynch, MS, RD, CNSD
- Office of Patient Advocacy
Sally Millar, RN, MBA
- Orthotics & Prosthetics
Mark Tlumacki
- Patient Care Services, Diversity
Deborah Washington, RN, MSN
- Physical Therapy
Occupational Therapy
Michael G. Sullivan, PT, MBA
- Police & Security
Joe Crowley
- Reading Language Disorders
Carolyn Horn, MEd
- Respiratory Care
Ed Burns, RRT
- Social Services
Ellen Forman, LICSW
- Speech-Language Pathology
Carmen Vega-Barachowitz, MS, SLP
- Volunteer, Medical Interpreter, Ambassador and LVC Retail Services
Pat Rowell

Distribution

Please contact Ursula Hoehl at 726-9057 for all issues related to distribution

Submission of Articles

Written contributions should be submitted directly to Susan Sabia **as far in advance as possible.**

Caring Headlines cannot guarantee the inclusion of any article.

Articles/ideas should be submitted in writing by fax: 617-726-8594 or e-mail: ssabia@partners.org

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

Next Publication Date:

March 17, 2005



Carroll, Hamilton, Rankin receive poster of distinction honor

Diane L. Carroll, RN, PhD, FAHA, clinical nurse specialist and chair of the Human Research Committee, Panel B, and co-authors, Sally H. Rankin, RN, PhD, FAAN, and Glenys A. Hamilton, RN, DNSc, will display their poster on February 16, 2005, as part of the MGH Scientific Advisory Committee (SAC) meeting. The poster, "Peer Advisors Improve Physical Health Outcomes in Elders" has been designated a poster of distinction. Of the 172 posters displayed, 12 were designated posters of distinction.

Peterson named to Mass Pain Initiative Council

Gayle, Peterson, RN, staff nurse on Phillips House 20, has been appointed to the Legislative Issues and Access to Care Council of the Massachusetts Pain Initiative Council for a two year term beginning January, 2005. The Council identifies legislative and regulatory barriers to effective pain-management. The Council is part of the American Society for Pain Management Nursing, Massachusetts Chapter. Peterson also serves as secretary of the American Society for Pain Management Nursing, Massachusetts Chapter.

Jampel appointed to APTA Advisory Panel

Ann Jampel, PT, MS, physical therapist, was appointed to the Advisory Panel on Education for the American Physical Therapy Association (APTA) Summit, on January 21-24, 2005, in Washington, DC.

Capasso, Empoliti, Gallagher and Martin present at Primary Care Conference

Virginia Capasso, PhD, APRN, BC, Joanne, Empoliti, MSN, APRN, BC, Joan Gallagher, EdD, APRN, BC, and Ann Martin, MSN, APRN, BC, presented, "Wound Care: All You Need to Know," at the National Primary Care Conference in Boston on December 4, 2004.

Burke, Dighe, Rao, and Gomez present poster at Institute for Healthcare Improvement conference

Debra Burke, RN, MSN, MBA, associate chief nurse; Anand Dighe, MD, PhD, associate director, Clinical Pathology; Arjun C. Rao, MBBS, MBA, senior project specialist, Decision Support and Quality Management Unit; and Maximo Gomez, MPH, administrative fellow, presented their poster "Enhancing patient identification using bar-coded wristbands: an MGH Clinical Performance Management initiative," at the Institute for Healthcare Improvement conference on December 14, 2004, in Orlando, Florida

Briggs, Forgione, Owens, publish in *Journal of Emergency Nursing*

Patricia J. Owens, RN, BSN, CNOR, trauma team leader in the Main Operating Room; Anthony Forgione, Jr., LPN, and Susan Briggs, MD, MPH, published, "Challenges of International Disaster Relief: the Use of a Deployable Rapid Assembly Shelter/Surgical Hospital (DRASH)," in the Disaster Medical Response section of the January–March 2005, *Journal of Emergency Nursing*. The article describes their humanitarian trip to Iran following the devastating earthquake in late 2003.

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

SDSU nurses certified

The following nurses in the Same Day Surgical Unit passed the Certified Ambulatory Peri-Anesthesia Nurse (CAPA) exam in November, 2004:
Ruth Bryan, RN, MSN, CAPA
Maureen Daley, RN, CAPA
Kathy Farrell Alexander, RN, CAPA
Kelley Grealish, RN, BSN, CAPA
Margaret Hogan Poisson, RN, ADN, CAPA
Cheryl Ryan, RN, BSN, CAPA

Endoscopy nurses certified

The following nurses in the Endoscopy Unit passed the national certification exam by the Certifying Board of the Gastroenterology Nurses and Associates:
Maureen Byrne, RN, GCRN
Cecilia Catone, RN, GCRN
Deborah Palmer, RN, GCRN

Tyer-Viola receives PhD

Lynda A. Tyer-Viola, RN, PhD, completed her doctorate in Nursing at Boston College in December, 2004. Her dissertation was entitled, "Obstetrical Nurses' Attitudes and Care Intentions Toward HIV Positive Pregnant Women."

Guanci announces creation of greater Boston chapter of Neuroscience Nurses

Mary McKenna Guanci, RN, MSN, CNRN, clinical nurse specialist, Blake 12, Neuroscience Intensive Care, announced the formation of the greater Boston Chapter of Neuroscience Nurses. Guanci is president of the new chapter, and John Murphy, RN, MS, nurse manager of Blake 12 is treasurer.

Lonergan returns from Kuwait

Daniel Lonergan, RN, BSN, staff nurse on Blake 11, who serves as a captain in the Air Force, returned to MGH, following a four-month mission in Kuwait providing nursing care as part of the Air Force reserve team.

Educational Offerings

March 3, 2005

| When/Where | Description | Contact Hours |
|---|--|---------------|
| March 14 8:00am–4:30pm | Intermediate Respiratory Care Wellman Conference Room | TBA |
| March 15 8:00am–2:00pm | BLS Certification for Healthcare Providers VBK601 | --- |
| March 16 4:00–5:30pm | Natural Medicines: Helpful or Harmful? Founders 626 | 1.8 |
| March 17 7:30–11:00am/12:00–3:30pm | CPR—American Heart Association BLS Re-Certification VBK 401 | --- |
| March 18 8:00am–4:30pm | Patients of Size Holiday Inn | TBA |
| March 23 8:00am–4:30pm | Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other Training Department, Charles River Plaza | 7.2 |
| March 23 4:00–5:00pm | More than Just a Journal Club Welman Conference Room | --- |
| March 21 8:00am–4:30pm | The Surgical Patient: Challenges in the First 24 Hours O’Keeffe Auditorium | --- |
| March 22 7:30am–4:00pm | Greater Boston ICU Consortium “Current Issues in Diabetes.” Newton Wellsley Hospital | TBA |
| March 24 1:30–2:30pm | Nursing Grand Rounds “Anti-Coagulation Update.” O’Keeffe Auditorium | 1.2 |
| March 24 7:00–11:30am and 12:00–4:30pm | Congenital Heart Disease Haber Conference Room | 4.5 |
| March 25 8:00am–4:30pm | Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza | 8.1 |
| March 25 12:00–4:00pm | Basic Respiratory Nursing Care Ellison 19 Conference Room (1919) | --- |
| March 28 and 29 8:00am–4:30pm | BLS Instructor Program VBK601 | --- |
| March 31 1:30–2:30pm | Nursing Grand Rounds “Surgical Inpatients’ Perceptions of Communication.” O’Keeffe Auditorium | 1.2 |
| April 1 9:00am–3:00pm | ENCARE—Emergency Nurses Care O’Keeffe Auditorium | --- |
| April 5 8:00am–2:00pm | BLS Certification for Healthcare Providers VBK601 | --- |
| April 6 8:00–11:30am | Intermediate Arrhythmias Haber Conference Room | 3.9 |
| April 6 12:15–4:30pm | Pacing Concepts Haber Conference Room | 4.5 |
| April 7 7:30–11:00am/12:00–3:30pm | CPR—American Heart Association BLS Re-Certification VBK 401 | --- |
| April 8 8:00am–4:30pm | MGH School of Nursing Alumni Program O’Keeffe Auditorium | --- |

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>.

NERBNA honors three MGH nurses

—by Ron Greene, RN, case manager

The New England Regional Black Nurses Association (NERBNA) celebrated Black Nurses Day, February 10, 2005, at the Sonesta Hotel in Cambridge with the annual presentation of its Excellence in Nursing Awards. NERBNA's Excellence in Nursing Awards are given to nurses who have been nominated by their peers and chosen by a selection committee comprised of NERBNA members.

This year, three MGH nurses were among the recipients: Alecia Laing-Dell, RN, from the department of Case Management; Jen-

nifer Dubose, LPN, from Blood Transfusion Services; and Ivonny Niles, RN, from White 6, Patient Care Services.

Recognition is based on each candidate's impact on his/her unit or department, professional aspirations, personal qualities and characteristics, and a proclivity for charitable work and community service. Margaret Brown, NERBNA president, and Sebra Barcuis, member, presented the awards.

Each recipient had an opportunity to say a few words to an enthusiastic crowd of nurses from various hospitals and medical institutions, professors and students from the Institute of Health Professions, colleagues,



Dubose



Niles



Laing-Dell

friends, and family members. Each recipient made a personal statement, but the common theme among all who spoke was how much they loved being a nurse.

For more information about the New England Regional Black Nurses Association, contact Ron Greene, RN, at 4-8252, or visit nerbna@yahoo.org.

Caring

HEADLINES

Send returns only to Bigelow 10
Nursing Office, MGH
55 Fruit Street
Boston, MA 02114-2696

First Class
US Postage Paid
Permit #57416
Boston MA

