

# Caring

November 17, 2005

## HEADLINES

### PT Month 2005

### “Your health, our hands”

(see page 4)

#### Inside:

Celebrating Physical Therapy Month .....	1
Jeanette Ives Erickson .....	2
• Strategic Planning Retreat	
Fielding the Issues .....	3
• Universal Protocol	
Ballantine Award .....	7
Clinical Narrative .....	8
• Denise Montalto, PT	
Another Perspective .....	10
• Linda Brace, RN	
Clinical Nurse Specialists ....	12
• Kathryn Beauchamp, RN and Lois Parkier, RPh	
Hand Hygiene .....	13
Food & Nutrition Services ....	14
Educational Offerings .....	15
Reading Disabilities .....	16



Senior physical therapist, Paula Downes Vogel, PT, works with patient, Barbara Lee, on the stationary bike in the Physical Therapy gym

## Patient Care Services Strategic Planning Retreat (Part I)

Over the years, the Patient Care Services Leadership Team has held many valuable strategic planning sessions. I think I speak for the entire team when I say that the strategic planning retreat we held last month was one of the most comprehensive, productive, and informing planning sessions we've ever had.

Preparations for the retreat began months beforehand when I gave members of my leadership team a series of assignments and pre-retreat exercises to help lay the foundation for our work. I wanted us to be able to 'hit the ground running' when we finally came together at the retreat.

The first exercise came in the form of a book report. Drawing from my own library, I assigned each member of the team a book to read and summarize, and then share with the group. I wanted us to have a common understanding of some of the themes and ideas discussed in these books. Some of the titles included:

- *Managing the Unexpected*, by Weick and Sutcliffe
- *Leadership without Easy Answers*, by Heifetz

- *The Genius of Sitting Bull*, by Murphy and Snell
- *FYI: For Your Improvement*, by Lombardo and Eichinger
- *Creativity, Inc., Building an Inventive Organization*, by Mauzy and Harriman

Each book generated discussion and debate. Each book gave us a little more grist for the idea mill. And each book helped us ask provocative questions about our own organization, our own leadership, our own future vision.

The next pre-retreat exercise was a survey I constructed to help set a tone and direction. I asked each member of the team to answer these questions honestly:

- What is the one thing you are most proud of?
- What's the one thing you wish you had done?
- What one thing do you worry about?
- What one thing do you want to learn more about?
- What one thing do you plan to accomplish in the future?
- When they write the history of the last nine years of Patient Care Services, how will we be remembered?
- If you could change one thing within Patient Care Services in

the next ten years, what would it be?

- If you could make sure one thing in Patient Care Services *didn't* change in the next ten years, what would it be?

This was a valuable exercise and really helped us hone in on what's important to us as an organization.

Another exercise to help prepare for the retreat was a solicitation of original thoughts and ideas related to specific topics. For instance, I asked each team member to identify 'worthy aims' and enumerate specific action steps to help accomplish those aims. I asked them to identify worthy aims in the following categories:

- Evidence-based clinical practice and professional development
- Evidence-based administrative practice and support of administrative practice
- Performance-improvement
- Customer service and patient satisfaction
- Healthy work environments; creating a culture of quality and safety
- Community outreach
- Cultural competence
- Communication
- Reward and recognition



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

Many excellent ideas surfaced from this exercise. And it became clear early on that a lack of creativity and innovative thinking was not going to be a problem.

It also became clear that with so much going on, with so many competing priorities, this was not going to be a retreat that would easily yield a set of clear-cut strategic goals. This was going to be the beginning of a process where members of the PCS leadership team could share ideas, inform one another about issues and concerns affecting their disciplines, and brainstorm about how to prioritize the important work ahead.

As you can see, a lot of time and energy was spent before the retreat even began. When we did come together for the intensive, two-day, planning retreat, I invited select members of the team to provide overviews of some key areas, to further inform our work.

George Reardon, director of Systems Improvement, gave us an update on the status of our physical environment, building logistics, and the challenges created by limited space availability, judicious use of capital spending, accessibility, and the need to remain technologically competitive.

Joan Fitzmaurice, director of the Office of Quality & Safety, reviewed a number of safety campaigns and initiatives currently under way, and shared information about some national quality indicators including the national voluntary Consensus Standards for Nurse-Sensitive Care.

Associate chief nurse for The Knight Nursing Center for Clinical & Professional Development, Trish Gibbons, revisited the Staff Perceptions of the Professional Practice Environment Survey, noting that there was an excellent response

*continued on next page*

## Universal Protocol: a JCAHO National Patient Safety Goal

**Question:** What is the Universal Protocol Policy?

**Jeanette:** The Universal Protocol is a National Patient Safety Standard issued by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that states that prior to any invasive procedure or surgery, all patients will have a 'time out' during which clinicians verify that the correct patient is undergoing the correct procedure on

the correct procedural site.

**Question:** What procedures fall under the Universal Protocol?

**Jeanette:** All procedures that expose patients to more than minimal risk (including procedures performed in settings other than the operating room). Some examples include: peritoneal taps, lumbar punctures, chest-tube insertions, and arterial-line placement.

Procedures not included under the Universal Protocol would be procedures such as: venipuncture, peripheral line placements, PICC lines, and the insertion of NG tubes and Foley catheters.

**Question:** Where is the Universal Protocol applicable and who should conduct the 'time out'?

**Jeanette:** The Universal Protocol is used in operating rooms, procedural suites, the Emergency

Department, ambulatory clinics and some inpatient units. The physician or nurse performing the procedure should conduct the time-out.

**Question:** What happens in the case of a patient-care emergency?

**Jeanette:** In the event that a patient is in an emergent cardiac/respiratory-arrest situation, the intent of this protocol is for caregivers to meet the minimum expected requirements for patient identification and verification of the procedure to be performed (the patient's name is John

Smith and a central-line placement is going to be performed).

**Question:** Is there a specific form to be used for the Universal Protocol and is there a written policy?

**Jeanette:** Yes, the Universal Protocol form can be ordered from Standard Register (order #84530). The policy can be found in the Clinical Policy & Procedure Manual under Universal Protocol.

For more information about the Universal Protocol, please contact the Office of Quality & Safety at 6-9282.

### Jeanette Ives Erickson

*continued from previous page*

rate with the majority of staff reporting a high level of satisfaction with the work environment. Three areas identified as requiring more attention were: conflict management; cultural sensitivity; and the 'non-stop' pace and demand of the day-to-day work load.

Sally Millar, director of the Office of Patient Advocacy and Joan Fitzmaurice shared data and feedback related to patient- and staff-satisfaction. Feedback received by the Office of Patient Advocacy grouped concerns into four broad categories: clinical care, interpersonal relationships or communication, operations, and finances.

Sally noted that operational concerns usually revolved around communication issues or having to wait longer than expected for procedures or appointments. Joan shared data from our patient-satisfaction survey and compared MGH results with national averages.

Steve Taranto, manager, for PCS Human Resources, and Chris Graf, director of PCS Management Systems, gave an overview of vacancy rates throughout Patient Care Services and spoke about staff participation in the PCS Clinical Recognition Program.

Armed with all this information and charged with sorting out priorities for the future of Patient

Care Services, our work was just beginning.

I will continue this account of our most recent strategic planning retreat in the next issue of *Caring Headlines*. But know that your managers, associate chiefs, and directors are working hard and diligently on behalf of our patients and staff. There will be many opportunities for staff to be involved in these efforts, and I look forward to working with you as our strategic plan unfolds. Once again, I'm filled with pride by the spirit of unity and teamwork that permeates this organization.

#### Update

I'm pleased to announce that Janet Mulligan, RN, has accepted the nurse manager position for the IV Nursing Team.

## Call For Abstracts

### Nursing Research Day May 10, 2006

Submit your abstract to display a poster on Nursing Research Day 2006

Categories:

- Encore Posters (posters presented at conferences since May, 2005)
- Original Research
- Research Utilization
- Performance Improvement\*

\* Two new conditions for acceptance of Performance Improvement abstracts:

- Key personnel have been certified in the Protection of Human Subjects. (<http://www.citiprogram.org/default.asp>)
- Project has been reviewed and approved or excluded by the Partners Human Research Committee (HRC). For more information about the HRC review, contact your clinical nurse specialist; Catherine Griffith, RN, co-chair of the Nursing Research Committee; Virginia Capasso, RN, coach; or Kathleen Walsh, RN, (pager: 3-1792)

For more information, or to submit an abstract, visit the Nursing Research Committee website at:

[www.mghnursingresearchcommittee.org](http://www.mghnursingresearchcommittee.org)

Abstract deadline is March 1, 2006



## MGH celebrates Physical Therapy Month

—by Tracy Daigle, PT, physical therapist

During the month of October every year, the physical therapy profession is celebrated in hospitals and communities across the country. As

part of the PT Month celebration, the MGH Physical Therapy Department highlighted its commitment to patients and the profession with a number of educational

presentations, the annual Marjorie K. Ionta Lecture, a special community-service project, and its annual recognition luncheon. The theme of this year's national celebration was, "Your

health, our hands."

On October 19, 2005, the department offered a presentation focusing on developing, implementing, and 'staying with' a safe exercise program. The presentation highlighted the unique contributions of physical therapists through the comprehensive evaluation of a patient's physi-

cal condition and developing an individualized exercise program.

Physical therapists gave presentations at the MGH health centers and at MGH West. On October 20th at the Chelsea HealthCare Center, posture screenings were provided to health center staff. On October 24th, a

*continued on page 6*



Above left: physical therapy clinical specialist, Diane Plante, PT, is one of several featured speakers at this year's Marjorie K. Ionta Lecture.

Above: senior physical therapist, Morgan Cole, PT, updates the progress of the PT-OT community-service, fund-raising competition on the Hopkinton-to-Boston marathon board, created to monitor pledges accrued by sponsors.

At left: physical therapist, Kate Adeleti, PT, and colleagues, staff educational booth in the Main Corridor to help raise awareness about exercise-related injuries and physical therapy treatments.



Physical therapist, Badia Eskandar, PT,  
works with patient, William Anastas, at the bedside  
on the Ellison 6 Orthopaedic Unit

## Physical Therapy Month

*continued from page 4*



demonstration of workstation ergonomics was held in Revere. And on October 31st, physical therapists in Waltham hosted a forum for staff to discuss exercise and ergonomics.

The 23rd annual Marjorie K. Ionta Lecture was held on September 27th. The Ionta Lecture is jointly sponsored by the MGH Physical Therapy Department and the Physical Therapy Program at the MGH Institute for Health Professions. It honors the vision and contributions of former MGH Physical Therapy director, Marjorie Ionta. More than 165 staff members, IHP faculty, students, and alumnae attended.

A number of speakers shared their thoughts about their professional journeys in various areas

of clinical practice. Presenters included: Lucy Buckley, PT, private practitioner and owner of Better Bones in Chatham, Massachusetts; Jim Gleason, PT, associate director, The Eunice Kennedy Shriver Center for Developmental Disabilities; and Diane Plante, PT, MGH physical therapy clinical specialist.

Now a Physical Therapy Month tradition, PT and OT staff challenged each other in a high-spirited, community-service, fund-raising project. The competition was expanded this year to include faculty, staff, and students of all disciplines at the IHP. In keeping with the theme of exercise and a healthy life style, 12-member teams competed in a 'marathon challenge' to raise money for the MGH Social Services Discretionary Fund and relief efforts for Hurricane Katrina.

Team members found sponsors to support their exercise activities over a three-week period. Their progress was monitored on a rendering of the Hopkinton-to-Boston marathon route. Teams crossed the finish line with a grand total of 209 miles, which translated into \$3,395 for two very worthy causes.

Physical Therapy Month activities concluded with the annual recognition luncheon on October 27th. Speakers, Ned Cassem, MD, department of Psychiatry;

Leslie Portney, PT, director of Physical Therapy Programs at the IHP; and Mary Knab, PT, director of Clinical Education at the IHP, described the contributions of MGH physical therapists to the care of patients, the education of students, and the Physical Therapy profession at large. Jacqueline Mulgrew, PT, clinical specialist, shared some of her thoughts about the evolution of her professional practice over the course of her career.

At the luncheon, the

Physical Therapy Annual Report was shared with staff. The report spotlights the many contributions of individuals and groups within the department.

Physical Therapy Month is an opportunity to celebrate the unique contributions of physical therapists to the care of patients and the communities we serve. Physical Therapy Month was rich with activities and events that represent the collaborative work of so many who share a vision and commitment to their professional journeys.



Photos on this page show physical therapist, Janet Callahan, PT, performing the Hallpike-Dix test with patient, Vincent Giordano.

The test is a diagnostic tool for detecting benign paroxysmal positional vertigo (BPPV).

Callahan is assisted in the exercise by physical therapy co-op student, Molly Krumpelbeck.





## Patel receives Janet Ballantine Oncology Volunteer Award

**O**n October 24, 2005, three years to the day after the passing of Janet Ballantine, friends, family members,

and others in the MGH community came together in the Satter Conference Room to pay tribute to a loved one with the presentation of the an-

nual Janet Ballantine Oncology Volunteer Award. This year's recipient was Raj Patel, a volunteer in the Yawkey 8 Infusion Unit.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, reminded guests of Ballantine's own contributions as a committed MGH volunteer. Said Ives Erickson, "During her illness, Janet and a fellow breast-cancer pa-

tient co-founded the Friends of Hope organization, which has raised more than \$100,000 to support breast-cancer research at MGH and the Dana Farber Cancer Institute."

Ballantine's family created the Janet Ballantine Oncology Volunteer Award in her honor to recognize volunteers who demonstrate a commitment to compassion, caring, and the important contributions of the volunteer role.

Patel, this year's recipient, was nominated by two nurses in the Yawkey 8 Infusion Unit, Laura Ryan, RN, and Kate Costello, RN. In her letter of recommendation, Ryan wrote, "Raj has a wonderful way of interacting with staff and patients. He immediately makes patients feel like dear friends. He has the uncanny ability to speak on many subjects and topics, instantly putting patients at ease."

Said Costello, "Raj is a caring and compassionate volunteer. His personality is so engaging, that often a conversation with one patient will escalate into a group discussion with many patients and family members."

Patel thanked the Ballantine family and his co-workers, saying, "It is an honor to receive this award for something I love to do. I will continue to do my best for patients at MGH."



Award recipient, Raj Patel (center), with members of the Ballantine family and Jeanette Ives Erickson, RN, senior vice president for Patient Care (left), director of Volunteer Services, Pat Rowell (right), and professional development coordinator, Julie Goldman, RN (second from right).

### Burn Safety and Smoking Cessation

**(Burns, the other reason to stop smoking)**

The Prevention Committee of Sumner Redstone Burn Center will present an information booth in conjunction with the MGH Quit Smoking Service.

**November 17, 2005  
Main Corridor**

In 2002, tobacco products caused an estimated 14,450 residential fires, 520 deaths, 1,330 injuries, and \$371 million in residential property loss.

### Training for Managers and Supervisors

This session will help you learn how to use the Employee Assistance Program as a management and employee resource. Consultation with EAP can help you with behavioral health, mental health, and substance-abuse concerns. Session will include a didactic presentation, case studies, and discussion.

**Tuesday, January 31, 2006  
9:00-11:00am  
Haberman Conference Room**

To register, call the Employee Assistance Program at 726-6976.

## Physical therapist relies on valuable past experiences in treating spinal-cord injury patient

*Denise Montalto is an advanced clinician in the PCS Clinical Recognition Program*

**M**y name is Denise Montalto, and I am a senior physical therapist at MGH. It was another tragic story of a teenager's life altered forever. I entered the Pediatric Intensive Care Unit (PICU) to consult on a young man who had been in a car accident. Most likely, his mother had told him to wear his seat belt, but he didn't. And the law says, "Don't speed," but he did. And then there was the question of substance abuse. Now, he was here with a spinal cord injury, and his friend had died in the accident.

Every year there are approximately 11,000 new cases of spinal cord injury (SCI) in the United States; 80% of them are sustained by males, and 50% are due to motor vehicle accidents. At 17, Joe was younger than the average SCI victim (38). There are stories of recovery after spinal cord injury; recovery can depend on the amount of damage to the spinal cord, the fracture or amount of dislocation of the vertebrae, how quickly medical care was initiated, even the size and shape of the spinal canal.

After reviewing Joe's chart and looking at all the CT, MRI, and opera-

tive reports, it was clear that Joe's spinal cord was severely injured. He had sustained an unstable fracture at the 8th, 9th, and 10th thoracic vertebrae with a burst at T9 causing severe narrowing of the spinal canal. He had had his spine surgically stabilized with rods and screws from T6 to T12 and been given solumedrol to reduce the swelling in his spinal cord. Joe had associated injuries—rib fractures from 2 to 9 and pulmonary contusions. At the 9th thoracic level, I would expect him to be able to achieve independence with bed mobility, transfers, and activities of daily living. He would be able to propel a manual wheelchair, drive an adapted car, and play sports if he desired. He might be able to stand with bracing, but his primary mode of transportation would be a wheelchair.

I have taken great care in developing my approach to patients with trauma and their families, because I know the initial encounter can be difficult with the uncertainty of recovery and the possibility of permanent disability. It has taken practice and a lot of reflection to learn how to answer questions about possible functional outcomes and rec-

ognize both what to say and when to say it.

Joe was alone, resting. He was using a PCA (a patient-controlled analgesia or self-controlled pain-medication) and was a bit drowsy but able to respond to my questions. I introduced myself and explained my role in his care. I asked him about himself, his family, his activities and school. I knew I'd need to re-address this when he was more alert, but it was important to establish a rapport and relationship before starting to examine him. As we talked and I began evaluating his movement and sensation, it was apparent that he was having more difficulty breathing, and his cough was congested and ineffective. I decided it was more important to address his pulmonary system and assess his ventilation.

His spinal cord injury was at the 9th thoracic vertebra, which caused him to have weakness of his lower intercostal and abdominal muscles due to a lack of innervation. Although he's only 17 years old, Joe smokes. This can cause an increase in pulmonary secretions and poor mobilization due to damage to the mucociliary tree. He also had many rib fractures that can cause



Denise Montalto, PT  
senior physical therapist

pain with coughing. All these factors contributed to the problem he was having clearing his secretions.

Joe's oxygen saturation was adequate at 98% but he required ten liters of supplemental oxygen by face mask. With retained secretions, he was at risk for deterioration of ventilation. He complained of pain as I rolled him onto his side, likely due to the rib fractures and his spine surgery. I encouraged him to use his PCA. He reported some relief but became drowsier and participated less with deep breathing as I performed manual airway-clearance techniques with his respirations.

We tried an assisted cough. I supported Joe's upper abdomen while he coughed, trying to clear the secretions, but it wasn't effective enough and I felt it would make him tire quickly. Speaking with Joe's nurse and the medical fellow in the ICU, we discussed his

tenuous respiratory status and the need to clear his secretions with blind endotracheal suction. I anticipated that this might be necessary for a few days until his cough improved, his secretions decreased, and his pain improved allowing him to breathe more deeply. We all agreed.

I explained the procedure to Joe and he consented. We performed manual airway-clearance techniques on each side to mobilize the secretions so that suctioning would be maximally effective. As I gathered the equipment I needed, I reviewed the steps of the procedure in my mind. Even though I had done this successfully many times, I knew it was an uncomfortable treatment and I wanted it to go smoothly.

Afterward, he felt better, but smiled and said, "I can't believe you do that to people!" I could see that he used humor to get through difficult situations. He was tired, so

*continued on next page*



## Clinical Narrative

*continued from previous page*

we agree to continue his examination the next day. The nurse and I positioned him comfortably on his side and discussed a plan for the next few days.

That afternoon, I returned to check on his respiratory status. I introduced myself to his parents and explained my role in their son's care. I asked them to tell me about Joe. They told me he was very athletic, he enjoyed wrestling and weight-lifting, and more recently, he'd become interested in webpage design. I asked about their home and they immediately began telling me how they were going to change the three-step entrance to a ramp; they had a room downstairs for Joe. He was fortunate to have a supportive, creative family. Joe's mother spoke with tears in her eyes, and his father stood with his hand on Joe's arm, but they were looking forward. We discussed Joe's rehabilitation needs and goals and briefly touched on his eventual level of function.

Over the next few days, Joe's ventilatory function took priority. We focused treatment on secretion-clearance and bed-mobility. I completed his motor and sensory examination. He had no movement or sensation below the level of his injury. In his chart, his

neurologist had noted that Joe had no anal tone. It was still too early to be certain about his prognosis for recovery but these were not good signs.

Joe's body jacket (or brace) arrived three days after our initial meeting so we could begin to try to mobilize. Joe was nervous about the pain but still had access to the PCA. I assured him I would wait until he was comfortable enough to move, and his nurse was prepared to give him extra pain medication if needed. His nurse assisted me in putting on his body jacket. We moved Joe onto his side and into a sitting position for the first time in about a week. He reported feeling dizzy, but I monitored his vital signs. He showed an appropriate hemodynamic response with slightly increased heart and respiratory rates and a slight drop in blood pressure. He sat up for ten minutes and was pleased. He was tired but told me he was looking forward to tomorrow.

Five days after our first encounter, Joe asked the question I'd been anticipating: "Will I be able to walk again?"

The medical staff had discussed his injury with him, and I knew he was aware of the severity of his condition. I told him his spinal cord was severely damaged and it was unlikely he would

walk again. But he was getting the best possible treatment and we could never say, 'Never.' There was ongoing research and advances were always being made. I told him we needed to start from where we were right now, and that was with no movement or sensation in his legs. We discussed what that meant in terms of his mobility and independence. He would need a wheelchair but might be able to stand with bracing for exercise and weight-bearing. We discussed the connection between his physical and occupational therapy programs; how his upper-body strength, sitting balance, and lower-body flexibility would help him with bathing, dressing and transfers. He asked me if I knew anyone with spinal cord injuries like his. I told him about my friend from the gym who is paraplegic, who works out, is married, and has a child. Joe looked more hopeful. I wanted him to have hope for the future.

It was just a few days before Joe was transferred to an excellent rehabilitation facility that specializes in patients with SCI. He e-mailed me some pictures of himself wearing a Boston Red Sox T-shirt; he was up in his wheelchair enjoying the outdoors. Later, I received an e-mail from his physical therapist saying that Joe was always the one to greet new patients and show

them around, offering support and encouragement.

I have treated many patients with spinal cord injuries in my years as a physical therapist. Earlier in my career, I could perform the skills necessary to gather information, construct a plan for treatment, provide good care, and assess discharge needs. But I'm sure I didn't consider so carefully the psychosocial impact of such a life-altering injury. As a therapist, my role was to help people learn to compensate for their disability and I was ardently going to 'do my job.' About 15 years ago, a gentleman I was treating refused to let me treat him again after I brought a wheelchair for him to use. This was a turning point for me—learning to appreciate what a patient is ready to hear. But perhaps the most important milestone was about five years ago when I received a consult for a 13-year-old boy with a cervical spinal cord injury. I expected that his parents would want information about their son's future. That was the day I began preparing words that realistically spoke about a patient's chances for recovery; words that gave enough information to allow the patient to stay in the moment, but words that could minimize the magnitude of their grief without providing false hope.

The greater skill I learned, though, was

listening. Without listening, you don't know what patients and families are ready to hear. It won't always go as smoothly as it did with Joe. There will be patients and families who are too overwhelmed by the injury and cling to the hope of a miracle; those who take longer to grieve for the loss of one future before they can embrace a new one.

I'm trying to be more prepared each time. I know I'll always need to be flexible and adjust my approach to meet the patients' and families' needs.

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

Denise's compassion and empathy, as well as her exceptional clinical skills, come into play in this narrative. Having cared for many patients with spinal cord injury, Denise knew what Joe was in for. She knew how difficult it would be for Joe and his family to come to terms with the injury. Understanding where the patient is and what he's ready to hear is a skill you can only acquire with time and experience. Denise's comprehensive assessment of this patient encompassed far more than his physical abilities and limitations.

There are lessons here for every clinician: listen, learn, adjust.

Thank-you, Denise.

## To thine own self be true *one nurse's story is cautionary tale for all clinicians*

—by Linda Bracey, RN, operating room nurse

Nursing is a profession that attracts compassionate, caring, selfless individuals who put the needs of others ahead of their own. Nurses thrive on improving the lives of their patients. Whatever problem a patient may encounter, a nurse will exhaust all options to ensure the most favorable outcome. But when it comes to taking care of themselves, nurses often put their needs on the back burner. I am a classic example of how nurses put their own problems on hold while caring for others.

Being an operating room nurse for 33 years has allowed me to acquire many skills. Beyond being able to scrub and circulate on most operative procedures, I have expanded my abilities in other areas of the OR. For example, I'm a CPR instructor, and I help with the re-certification of OR staff. Sometimes, I wear the hat of nurse liaison, which enables me to interact with patients and their families to alleviate any fears connected with their surgery. I'm also a resource nurse in the OR. The resource nurse, along with staff from Anesthesia, runs the daily operation surgical schedule.

This can be a very trying role, but I get a lot of help from clinical nurse specialists, team leaders, our nurse manager, and the OR education staff. Together as a team we try to run a smooth ship. It was while working in this role a little over a year ago that I suffered a stroke.

At the time, the only symptom I exhibited was a slight slurring of my speech. While interacting with my peers, I realized I couldn't pronounce words beginning with the letters 'K' or 'L.' My tongue felt heavy on the right side, and my slurring was intermittent. My thought processes were intact. No other symptoms were evident—no weakness in my extremities, no paralysis, no visual changes. Even though the possibility of a stroke was in the back of my mind, I really thought I was having an allergic reaction to something. Thinking back, my speech and voice reminded me of how a deaf person would sound. But since the symptoms were inconsistent, I dismissed them. I continued to do my work. After giving report to the incoming charge nurse, I stayed for a few hours to help out. The problems with my speech didn't subside,

but they didn't get worse.

Later, when my husband picked me up to go home, I told him what had happened that afternoon. We went home and had dinner, and I went to bed early that night. I thought rest and relaxation would do the trick. In the morning, I woke up to find my speech the same, and I noticed a slight drooping of the right side of my mouth. This is when the reality of a stroke hit me.

On the way to work, I talked with my husband about making an appointment with my doctor. Once again, even with my symptoms, I thought my mind was okay and my thought processes were intact. Overall, I felt well enough to go to work and resume my duties as resource nurse.

While taking report from the night charge nurse, I mentioned what had happened the day before and how I felt that morning. As we

were talking, I became very emotional. She insisted I go straight to the Emergency Department. She spoke with two of our clinical nurse specialists who contacted the ED and the neuro-surgical team. We all met in the ED, and I was admitted immediately to trauma bay one. (Since we didn't know how long it would take to find out what was wrong with me, the OR called another nurse to replace me for the day.)

I was escorted to the CAT scan and MRI area. Within an hour, my fears

were confirmed. I had had a lacunar infarct. The CAT scan showed that a pea-sized clot had lodged in the lacunar area behind my left eye. The doctor told me the prognosis was good and said I should make a full recovery. But tests needed to be performed in order to find the cause.

Here I was, a 53-year-old woman with no apparent health problems. Why did this happen? Would I be able to resume my duties in the OR? What were the chances I'd have another

*continued on next page*



OR nurse, Linda Bracey, RN, prepares to leave work for the day.

## To Thine Own Self be True

*continued from previous page*

stroke? So many thoughts went through my head. My children were grown. This was supposed to be my time with my husband. Why did this happen now?

Lying on the stretcher, I came face to face with the realization that my health was in jeopardy. I tried to convince myself not to borrow trouble until all the facts were in. It was also a bitter pill to swallow (no pun intended) that I was not in control. Someone else would be the caregiver, not me. But I felt blessed that I was in the right place at the right time.

During the 36 hours I spent as a patient at MGH, I came to realize that this is a wonderful place to be ill. I saw first-hand how caring and hard-working the nursing staff is. From the 12 hours in the ED to my overnight stay on White 12, I was treated with the utmost respect and kindness. My physical and emotional needs were met with compassion and genuine concern.

Being a surgical nurse with a medical problem, this gave me a chance to meet the other half of the MGH family. Staff in CAT Scan, MRI, and Ultrasound, neurology residents, staff, and medical students—everyone was professional, caring,

and concerned.

As I went through the battery of neurological tests, the look on most doctors' faces was amazement. Even though the CAT scan showed a lacunar infarct, other than my speech, everything else was fine. It was hard for my family and friends to believe I'd had a stroke. I looked okay, but if I got nervous or tired my speech would start to slur.

Throughout my hospitalization I came in contact with caregivers from a number of disciplines: neurologists, hematologists, speech path-

ologists. When all the tests were completed, it was determined that my stroke had not been caused by stress but by polycythemia and thrombocytosis. In layperson's terms: too many red blood cells and platelets. Doctors surmised that I had a bone-marrow defect that had caused an increase in the production of red blood cells and platelets.

When I was discharged, I was told to take some time off to recover and get my systems in order. In the three months I took off, I met often with my doctor, speech pathologist, neurologist, and hematologist, who were all very supportive. Today, I'm taking a few medications to help keep

everything on an even keel. Occasionally, I have to have blood drawn to help control the production of red blood cells and platelets.

It's been a year since my stroke. In my time off, I came to an important realization. If I don't take care of myself, how can I take care of anyone else.

Words can never express my gratitude to my colleagues at work. Their cards, phone calls, and visits helped me through a very tough time.

I returned to work full time last January 2nd, and was able to resume all my duties. Coincidentally, on the anniversary of my stroke, I read a poem at a dear friend's

memorial service. I was apprehensive because of the problems with my speech, but I relied on what my speech pathologist had taught me. Take your time, enunciate, and everything will be fine. It went off without a hitch.

And last but not least, my husband and children were given the scare of their lives. Even though we all think we're indispensable in some way, I felt blessed and extremely lucky to have my family by my side. They took wonderful care of me while I recuperated, and made it easy for me to return to work.

I just want to say one thing to all nurses. Be true to your patients after you're true to yourself.

## Safety Net


the new Partners patient-safety newsletter

The first issue of *Safety Net*, the new Partners patient-safety newsletter was released this month in hard-copy and on-line. The quarterly publication features tips, stories, and updates on programs and initiatives aimed at keeping our patients safe.

*Safety Net* is the product of the Partners Office of Patient Safety. The editorial board is comprised of patient-safety leaders from throughout the Partners network including Joan Fitzmaurice, RN, and Cy Hopkins, MD, directors of the MGH Office of Quality & Safety.

*Safety Net* can be found at: <http://intranet.partners.org/ClinicalAffairs/content/Newsletter/Current.pdf>. For more information, call 726-5255.

Volume 1, Issue 1  
Fall 2003



### SAFETY NET

READ THIS NEWSLETTER TO HELP KEEP PATIENTS SAFE

---

**JCAHO's National Patient Safety Goals**

JCAHO's National Patient Safety Goals are those efforts to prevent errors with consequences in patient safety. National Patient Safety Goals are general goals to be achieved by all hospitals. They are designed to be measurable and to be achieved by all hospitals. They are designed to be measurable and to be achieved by all hospitals.

- Accuracy of Patient ID
- Effective Communication
- Safety of Using Medications
- Safety of Using Infusion Pumps
- Reduce Risk of Healthcare Associated Infection
- Accuracy and Completeness of Medication Administration
- Reduce the Risk of Patient Harm Resulting from Falls

---

**"Mistakes are a fact of life. It's the response to the error that counts."**  
— Nikki Giovanni (American Poet, 1943 - )

Welcome to *Safety Net*, a new quarterly publication from the Partners Patient Safety Leaders, Partners Office of Patient Safety and Significant Initiatives, which hopes to increase Partners-wide sharing of important information that can help keep our patients safe. This publication is founded on the premise that by sharing brief stories of close calls along with practical advice about how to prevent the situation from recurring, our "Safety Net" will strengthen. Most of the articles will be contributed by PPS colleagues recounting what happened, why it happened, and what can be done to prevent it from happening again. In addition, we will feature information on important external initiatives, such as J. 1117 patient safety goals and government regulations, which will impact our approach to safety. We encourage you to contribute to *Safety Net* by contacting your institution's Patient Safety Leader or the Partners Patient Safety Office, 781-455-8335.

---

**"Good Catch" Case: WON'T ANYONE LISTEN?**

The long-awaited improvement to the Operating Room was ready for use. It was a new light system that would allow the surgeon to see the patient's face more clearly. The new light system was installed in the Operating Room. The new light system was installed in the Operating Room. The new light system was installed in the Operating Room.

It is not easy to speak up and question experts about their work. Many people might have reacted with the advice to "not worry about it," but this technician was willing to risk reputation for patient safety. Rather than acquiesce, this technician was successful in getting to the bottom of the problem, finally engaging experts who confirmed and addressed the issue, thus ensuring patient safety in the Operating Room. These are the behaviors that we hope to encourage with this newsletter.

---

**WEB-BASED SAFETY REPORTING SYSTEM**

Turning concerns into solutions, across our Partners hospitals, an implementing a computerized safety reporting system, allowing employees to electronically submit reports of actual or potential lapses in safety. Experience is also indicating, however, that the more safety reports submitted, the more opportunities to learn and develop innovative solutions to enhance safety. The safety reporting system will help to characterize these events and further follow-up and resolution of the safety issue identified. With each issue of *Safety Net*, we will be reporting on the status of implementation of the system.

	QW	MGH	PH	U.C.	PHS	MSMC
Contract Signed						
System Installed Planned Q2003						
System Installed In Progress						
Fully Implemented						



## Pediatric Medication Administration Process

—by Kathryn A. Beauchamp, RN, PICU clinical nurse specialist  
and Lois F. Parker, RPh, senior attending pharmacist

The Pediatric Service, along with the departments of Pharmacy and Biomedical Engineering, has undertaken a collaborative approach to medication safety. The effort involves eliminating the 'Rule of Six,' and implementing standard concentrations for vasoactive medications and continuous infusions.

Medication administration for pediatric patients differs greatly from that of adult patients because of the need for weight-based dosing that requires individual dose calculations. Pediatric patients are at greater risk for medication errors due to the math and individual mixing required for each infusion. Based on a 2001 study conducted at MGH and Children's Hospital, 13% of medication errors occur in the administration phase.

Because the majority of medications are delivered via continuous infusion in the Newborn and Pediatric Intensive Care Units (NICU and PICU), the Rule of Six method has been utilized for many years. The Rule of Six was originally designed to enable caregivers to easily prepare

and titrate admixtures of vasoactive medications. The concentrations are based on the patient's weight, so that 1mcg/kg/minute always equals 1mL per hour. However, utilizing this formula for patients whose weights range from less than 1kg to more than 40kg resulted in an unlimited number of drug concentrations. Since Pharmacy could not provide support for such a wide variety of concentrations, nurses were involved in preparation at the unit level.

Prior to 2004, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) included minimizing the number of available concentrations of a given medication in its National Patient Safety Goals. The JCAHO specifically included eliminating the Rule of Six as part of this goal, with an implementation deadline of December 31, 2008.

As part of a larger focus on patient safety, a multi-disciplinary task force was formed to address this issue. The task force included representation from Nursing, Pharmacy, Smart Infusion Pump Learning Lab (sponsored by the Sims

Lab) and Biomedical Engineering. Goals included:

- eliminating the Rule of Six
- establishing standard concentrations for continuous infusions
- implementing smart infusion pumps with MGH-approved drug libraries.

There are many benefits to using smart infusion pumps.

- Drug libraries can be tailored to the patient population by weight categories
- Soft minimums (recommendation can be overridden) and maximum dosing for each drug provides guidance to clinicians to prevent under-dosing or over-dosing
- Hard minimums and maximum dosing (recommendations are a fail safe and cannot be overridden) to prevent over-dosing of electrolyte solutions
- Bar-coding capabilities

As a first step, team members visited the Albany Medical Center to review their medication delivery system, especially the weight-based standard drug concentrations and administration guidelines.



Kathryn Beauchamp, RN (left), and Lois Parker, RPh

Considering the fact that we would be providing standard drug concentrations to patients weighing less than 1kg, and children who were fluid-restricted, the group recommended that the patient's weight no longer drive mixing calculations. Rather, standardized mixes would be used based on safe flow rates. As a result, weight profiles were identified for the pediatric drug library to guide the dosing parameters needed for smart infusion pumps.

Since pump flow rates of at least 0.3mL/hour provide optimal titration, standard drug concentrations were developed, using patient weights ranging from 0.5kg to more than 40kg. The Pediatric Medication Administration Process Manual for Syringe Infusion Pumps was developed, which includes mixing guidelines and flow rates. The manual contains:

- the pediatric drug library

- mixing guidelines and flow rates for each drug and concentration
- IV administration guidelines for each drug, starting dose, bolus, or loading dose, and continuous dose by drug
- usual and maximum dosing by drug
- pump flow rates by drug concentration, dose rate, and patient weight

Color zones, based on traffic lights (red, yellow, and green) were developed to assist clinicians in choosing the concentration associated with optimal flow rates. This method of pediatric medication administration is so progressive that the manual has been copyrighted and affiliates are expressing a great deal of interest in implementing this new program.

Team members completed the initial project goals in the summer of 2005. Standard drug concentrations and smart infusion pumps using the

*continued on next page*

## Infection Control Week focuses on hand hygiene

National Infection Control Week was observed October 17–21, 2005, and the MGH Infection Control Unit sponsored a number of activities and events to mark the occasion. With an educational display in the Main Corridor, the Infection Control Unit focused primarily on raising awareness about hand hygiene.

In addition to disseminating information, raffling off prizes, and giving away colorful 'hand-shaped' pins, organizers offered employees an opportunity to sign a 2x3-foot poster signifying their support for good hand hygiene. More than 500 employees signed the poster; others had an opportunity to sign smaller versions of the poster on their units.

During National Infection Control Week, healthcare organizations around the country plan activities designed to heighten public awareness and professional commitment to preventing infections in healthcare settings. Healthcare workers, patients, and visitors can help prevent the spread of infection by using infection-control measures such as good hand-washing practices.

For more information about hand hygiene or infection control, call the Infection Control Unit at 6-6330.



(L-r): associate chief nurse, Jackie Somerville, RN; and from the Infection Control Unit, staff nurse, Judy Tarselli, RN; Hazel Audet, RN; and David Hooper MD, chief, collect signatures for the Hand Hygiene Campaign

## Pediatric Medication Administration

MGH pediatric drug library were introduced in the NICU and PICU in September, 2005, and the Cardiac OR in October, 2005.

Future goals include expanding the use of smart pumps and

the pediatric drug library to all inpatient areas that care for pediatric patients, including the ED, operating rooms, and the Cardiac Cath Lab and evaluating outcomes.

We would like to thank the

members of our task force for their hard work and commitment during the past two years: co-chairs, Brenda Miller, RN; and Ray Mitrano, MS; project manager, Gayle Fishman, RN; pediatric pharmacist, Lisa R. Morlitz; Mary Wyszynski, RN; Ellen Kinnealey, RN; and Nat Sims, MD.

### 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 (interim)  
Marianne Ditomassi, RN, MSN, MBA  
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  
Susan Doyle, MS, RD, LDN  
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 by e-mail: [ssabia@partners.org](mailto:ssabia@partners.org)  
For more information, call: 617-724-1746.

### Next Publication Date:

December 1, 2005



## We hear you loud and clear!

—by Susan Doyle, RD, senior manager, Patient Food Services

As our alliance with Nursing continues to develop, Nutrition & Food Services has received an enormous amount of positive feedback. We have been meeting with staff on units where pilot programs have been implemented to provide service-improvement updates and explore opportunities for future improvement. The spirit of collaboration and our mutual commitment to patient-centered care has been so important during this journey.

Our goal is to give patients what they want. We've learned that while specific menu items might be important to some patients, other patients are more concerned with the timeliness of meal delivery. Overnight

admissions and diet-advances have become common, and our turn-around-time for breakfast delivery hasn't met the needs of all patients.

In an effort to better respond to the varied needs and requests of our patients, we're piloting an 'Express Breakfast Menu.' We're researching breakfast items that can be stocked on units and offered to patients in a more timely fashion.

We will continue to offer alternative breakfast choices with the understanding that they may take a little longer to prepare and deliver. This gives patients a choice based on their own needs and preferences.

We know that storage of used trays continues to be a problem, particularly in the evening. Our

efforts in this area are not limited to pilot units. With the help of Buildings & Grounds, we're installing cabinets in patient care areas. These cabinets provide an unobtrusive place to store used trays until they can be collected and returned to Food & Nutrition Services. We are restructuring job flow to allow more frequent pick-ups of used trays. And we're moving to an upgraded paper service for all 4-Food deliveries after 8:00pm. It is our hope that these changes

will help alleviate our problems with used trays.

If a back-up of used trays should occur, call 4-Food (4-3663) to arrange for a pick-up. Any time you notice an unusual amount of used trays, call 4-Food. This helps keep the collection of used-trays moving

smoothly, and it helps us help you.

As winter approaches, we'll be rolling out service-improvement initiatives to more areas. As our work continues, please let us know how we can serve you better? Call 6-2579, or e-mail comments or suggestions to: [sjdoyle@partners.org](mailto:sjdoyle@partners.org).



Manager of Patient Food Services, Sara Estabrook, RD (left) and senior manager of Patient Food Services, Susan Doyle, RD

### Call for Proposals

#### The Yvonne L. Munn, RN, Nursing Research Awards

Staff are invited to submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Recognition Week, May 7–12, 2006.

Proposals are due January 15, 2006. Guidelines for developing proposals are available at: [www.mghnursingresearchcommittee.org](http://www.mghnursingresearchcommittee.org) under "Funding Sources"

For more information, contact Virginia Capasso, PhD, at 617-726-3836, or by e-mail at [vcapasso@partners.org](mailto:vcapasso@partners.org)

The Knight Nursing Center for Clinical & Professional Development presents

### Inaugural Visiting Professor in Wound Healing

Courtney H. Lyder, ND, GNP, FAAN, professor of Nursing, professor of Internal Medicine and Geriatrics, University of Virginia

**Thursday, December 15, 2005**

"Pressure Ulcers: Avoidable or Unavoidable?"

A dialogue with critical care nurses

**11:00am–12:00pm, Blake 8 Conference Room**

All are welcome, contact hours will be awarded

"Building an Infra-Structure for Wound Care in Acute Care"

A dialogue with the CNS Wound Care Task Force

**12:00–1:15pm, Blake 8 Conference Room**

Open to members of CNS Wound Care Task Force

"Shifting the Paradigm: Implications of Deep Tissue Injury and F-Tag 314 on Care of Pressure Ulcers"

Nursing Grand Rounds

**1:30–2:30pm, O'Keeffe Auditorium**

All are welcome, contact hours will be awarded

"Pitfalls of Pressure Ulcers: Avoiding a Malpractice Suit"

**2:30–3:30pm, Blake 8 Conference Room**

All are welcome, contact hours will be awarded



# Educational Offerings

November 17, 2005

When/Where	Description	Contact Hours
November 28 8:00am–4:30pm	<b>Special Procedures/Diagnostic Tests: What You Need to Know</b> O’Keeffe Auditorium	TBA
December 1 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK401	---
December 1 7:00am–12:00pm	<b>CVVH Core Program</b> Yawkey 2220	6.3
December 2 8:00am–2:30pm	<b>Pre-ACLS Course</b> O’Keeffe Auditorium \$100. (to register e-mail: ccatt@partners.org)	---
December 5 8:00am–4:30pm	<b>Coronary Syndrome</b> O’Keeffe Auditorium	TBA
December 6 and 9 8:00am–4:00pm	<b>Oncology Nursing Society Chemotherapy-Biotherapy Course</b> Yawkey 2220	16.8 for completing both days
December 7 8:00am–4:30pm	<b>Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other</b> Training Department, Charles River Plaza	7.2
December 7 8:00–11:45am	<b>Intermediate Arrhythmias</b> Haber Conference Room	3.9
December 7 12:15–4:30pm	<b>Pacing Concepts</b> Haber Conference Room	4.5
December 7 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
December 12 8:00am–4:30pm	<b>Intermediate Respiratory Care</b> Respiratory Care Conference Room, Ellison 401	TBA
December 14 11:00am–12:00pm	<b>Nursing Grand Rounds</b> “Pulmonary Hypertension.” Sweet Conference Room GRB 432	1.2
December 15 8:00am–4:30pm	<b>Workforce Dynamics: Skills for Success</b> Training Department, Charles River Plaza	TBA
December 15 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
December 15 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Deep Tissue Injury.” O’Keeffe Auditorium	1.2
December 16 12:00–1:00pm	<b>Schwartz Center Rounds</b> Walcott Conference Room	---
December 16 8:00–11:00am	<b>On-Line Clinical Resources for Nurses</b> FND626	3.3
December 19 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK401 (No BLS card given)	---
December 20 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK401	---
December 21 8:00am–2:30pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
December 22 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Care of the Stroke Patient.” O’Keeffe Auditorium	1.2
February 16 and 23 8:00am–4:00pm	<b>Oncology Nursing Society Chemotherapy-Biotherapy Course</b> Yawkey 2220	16.8 for completing both days

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111.  
For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.



*Gala benefit  
to help bring reading  
to children*



To promote awareness about dyslexia and support the theme, "Help Us Bring Reading to Children," Phyllis Meisel, director of Reading Disabilities and her staff sponsored the first annual, "Opening Doors to Literacy," gala event and benefit auction, Thursday, October 20, 2005, at Long's Jewelers in Boston. Music, mingling, and enthusiastic bidding made for an exciting evening as the winner of a \$1,000 shopping spree (at Long's) was revealed in a raffle drawing. The evening was a great success, raising money and awareness for an important cause.

Many thanks to Eileen Faggiano, chair of the planning committee, and her enthusiastic team for coordinating the event.



(Photos by Abram Bekker)

## 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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_