How do you honor a fallen hero? How do you pay tribute to a loved one who spent his life in the service of others? What gesture is big enough, meaningful enough, important enough? The family and friends of Boston firefighter, Brian McEachern, answered those questions with the creation of The Brian M. McEachern Extraordinary Care Award to recognize clinicians whose practice is characterized by extraordinary acts of compassion, advocacy, and empowerment.

On Thursday, September 22, 2005, the second annual presentation of the McEachern awards was held in the MGH Ether Dome, this year’s recipients: speech language pathologist, Tessa Goldsmith, CCC-SLP, and Medical Intensive Care Unit staff nurse, Christine McCarthy, RN.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, opened the ceremony, calling McEachern a ‘quiet hero,’ an ordi-continued on page 14

Award recipient, Christine McCarthy, RN (directly behind plaque), with members of the McEachern family, members of the award selection committee, friends and former colleagues, and senior vice president for Patient Care, Jeanette Ives Erickson, RN (second from left). Award recipient, Tessa Goldsmith, CCC-SLP, was unable to attend. Her husband, Clifford (back left), accepted on her behalf.
Quality and Safety Update

We are all acutely aware of the importance of an effective quality and safety program, and we’re all working hard to ensure that MGH meets and exceeds expectations around keeping patients safe. A number of safety initiatives are under way throughout the hospital, and I want to make sure you’re all aware of this important work.

Chris Graf, RN, director for PCS Management Systems, and her team have launched an on-line electronic dashboard to help us monitor clinical quality indicators and patient-satisfaction data. The dashboard contains quality indicators to help us prevent falls and infections and promote effective hand-hygiene. We can now compare benchmark scores with expected ranges and actual scores. Scores that fall outside expected ranges are flagged to alert managers and me to any trends we should be addressing. Dashboards are currently available on the classification system for inpatient units, the Emergency Department, the Pre-Admission Testing Area, and the IV nursing team. Indicators are specific to the patient-care activities on these units.

Next month we’ll be launching a new Nursing Quality and Patient Safety website. Joan Fitzmaurice, RN, co-director for the Office of Quality & Safety, and her team are creating a user-friendly site where hospital employees and the general public can go to see nursing quality information and metrics. The site contains general information about MGH nursing, professional achievements, links to relevant articles in the news, and a number of safety pledges, including:

- A highly skilled MGH registered nurse will be accountable for your nursing care at all times
- Your nurse will take your pain seriously

More pledges are being developed with input from staff nurses. When the site goes live, it will be accessible at: www.massgeneral.org/nursingquality.

The Massachusetts Department of Mental Health was recently here for its bi-annual site visit to ensure that our inpatient Psychiatric Unit is providing quality care in a safe environment. Reviewers met with members of the multi-disciplinary team and representatives from the Office of Patient Advocacy and Interpreter Services. The visit concluded with our Psych Unit being re-licensed for another two years.

I’m happy to report that our comprehensive Hand Hygiene Program has had a significant impact on hand-hygiene compliance rates over the past two years. The program is comprised of unit-based education, unit champions, surveillance rounds, posters, a rewards program, and active communication between unit leaders and staff. As a result, steady decreases have been achieved in MRSA, VRE, clostridium difficile, and central-line-associated bacteremias. Building on this success, higher compliance goals will be set in the coming months. We need your help to ensure our patients continue to receive the safest, highest-quality care.

Our Bar-Coded Patient Wristband Initiative is having a great impact on our ability to accurately and efficiently verify patient identification. This innovative, automated technology (currently being piloted on several units) not only facilitates accuracy in patient-identification, but will one day play a part in patient scheduling, tracking, and other patient-safety initiatives.

Thanks to a grant from the Robert Wood Johnson Foundation, a study focusing on merging palliative and critical care in the Medical Intensive Care Unit (MICU) is under way. The study seeks to integrate medical and spiritual care, increase MICU staff’s exposure to palliative-care techniques, and share best practices with other ICUs to promote patient- and family-centered care throughout the institution.

We just completed our Interim Monitoring Report for the Commission on Magnet Hospital Recognition. In it, we provided information on staff- and patient-satisfaction, nurse-sensitive quality indicators, turnover and vacancy rates, recruitment efforts, nursing educational demographics, and much more. Seeing all that information in one place, I can tell you, we have good reason to be proud.

These are only some of the many safety-related projects and initiatives under way throughout the hospital. As we continue to provide care to our community’s sickest patients, we maintain the highest standards of patient care backed by our commitment to a dynamic and robust quality and safety program.

Update

I’m happy to announce that Susan Caffrey, RN, has accepted the position of nurse manager for the Blake 14 Labor & Delivery Unit.
Fielding the Issues

Technological advancements for blind and visually impaired individuals

Question: How is it possible for blind individuals to use desktop and laptop computers?

Jeanette: In recent years technology has changed our lives in a number of dramatic ways. Think back to life before the cell phone, the blackberry, and e-mail. In a similar way, technology is responsible for many improvements in the lives of blind and visually impaired individuals. New technology has made it possible for people with little or no sight to make meaningful contributions at school, in the workplace, and in the community.

A new, adaptive speech-output program called JAWS, can be installed on any computer to convert existing, compatible programs (such as Outlook, Word, Excel, and Power Point) to audible output. Users navigate using key strokes (there is no mouse). Just as a sighted person might type a document then go back to review what she’s written, JAWS allows users to go back and listen to what they’ve written.

Question: Are there programs specifically for individuals with limited vision?

Jeanette: An adaptive program called Zoom Text, which can be installed on any desktop or laptop computer, enlarges text to a readable size, making all compatible programs and applications accessible to people with limited vision.

Question: Have there been any non-computer-related advancements in the area of adaptive technology?

Jeanette: A number of adaptive technologies are making it possible for blind and visually impaired people to function and contribute at a much higher level than ever before. Some of those devices include:

- The Parrot: a device that provides access to personal information such as memos, phone numbers, addresses, a calculator, and an alarm clock. It is essentially a Palm Pilot with speech-output and voice-recognition capabilities.
- Voice Note: a device that allows users to take notes; send and receive e-mails; and acts as a daily planner.
- Franklin Master: a device with speech-output capability that functions as a dictionary, thesaurus, and grammar and spelling resource.
- Special watches and alarm clocks have audible prompts and many are available with large numbers and tactilely identifiable buttons.
- Closed circuit television (CCTV) offers individuals with limited sight the opportunity to read books, newspapers, and other materials on a view screen. Items placed on a special reader are enlarged on the screen, and appear with a contrasting background.
- Kurzweil is a software program that scans material to a laptop or desktop computer where it’s converted to audible language and verbally read back to the user.

Women’s Cancers Awareness Fair

Friday, October 21, 2005
10:00am–2:00pm
Under the Bulfinch Tent
Take a moment to learn about prevention, early detection, and treatment of common cancers affecting women today.

Training for Managers and Supervisors

Learn how EAPcan help with behavioral health, mental health, and substance-abuse. Topics include: time-management, stress-reduction, and staying focused on work.

Thursday, November 3, 2005
1:00–3:00pm, Haber Conference Room
To register, call 726-6976.

The Kenneth B. Schwartz Center special symposium

“Beyond the white coat and johnny: what makes for a compassionate patient-caregiver relationship?”

facilitated by veteran journalist, John Hockenberry

November 3, 2005
3:00–5:00pm
Boston Convention and Exhibition Center, South Boston

To be followed by a panel discussion Symposium is free and open to the public. RSVP to: 617-726-0512 or e-mail schwartzcenter@partners.org

The 10th annual Schwartz Center reception and dinner will follow. Visit: www.theschwartzcenter.org for more information.

Improving the health of women through research

Friday, October 21, 2005
11:30am–12:30pm
Thier Conference Room

Dr. Elizabeth Ofili, associate dean of Clinical Research, professor of Medicine and director of the Clinical Research Center and chief of Cardiology, Morehouse School of Medicine to speak on:

“Women’s health research: new discoveries and translating the science”

Sponsored by the Women’s Health Coordinating Council
Light refreshments will be served.
The inaugural Knight Visiting Professor Program

—by Laura Mylott, RN, and Ann Martin RN

On Wednesday, September 28, and Thursday, September 29, 2005, The Knight Nursing Center for Clinical & Professional Development hosted Betty Ferrell, RN, PhD, FAAN, the inaugural Knight visiting professor at MGH. The annual Knight Visiting Professor Program, supported by a generous donation from Mr. Norman Knight, is designed to support professional development, creativity, and innovation in clinical practice. Each year, a nationally recognized nurse scientist/scholar will come to MGH to share his/her knowledge and expertise through consultations, teaching, mentoring, and research.

Ferrell has practiced oncology nursing for 28 years, focusing her clinical expertise and research in the areas of pain-management, quality of life, and palliative care. Ferrell is a research scientist at City of Hope National Medical Center in East Duarte, California. She is a fellow of the American Academy of Nursing and has published more than 270 articles in peer-reviewed journals and textbooks. Ferrell received the Oncology Nursing Society Distinguished Nurse Researcher Award in 1996. She is currently the principal investigator for a study funded by the American Cancer Society on, “Palliative Surgery,” and she is the principal investigator for the End-Of-Life Nursing Education Consortium (ELNEC) project funded by the National Cancer Institute. Ferrell has authored five textbooks on cancer pain-management, pain in the elderly, suffering, and palliative care nursing.

The Visiting Professor Program began Wednesday morning when Connnie Dahlin, RN, palliative care nurse practitioner, introduced Ferrell to a multi-disciplinary audience at Palliative Care Grand Rounds in the Ether Dome. Ferrell shared some preliminary results from her current investigation into the decision-making process and outcomes of patients who choose to undergo palliative surgery.

Ferrell spent time with a group of clinicians in the ambulatory cancer center. In a discussion facilitated by nurse manager, Barbara Casheddy, RN, clinicians from many disciplines consulted with Ferrell about potential research ideas. Discussion focused on the challenges of assessing a patient’s readiness to discuss end-of-life issues, how to have ‘the conversation’ with patients and families, and how to teach and support novice nurses caring for oncology patients.

Wednesday concluded with the first Knight Visiting Professor Lecture in O’Keeffe Auditorium, entitled, “Clinical Excellence in Palliative Care: Nursing Leadership to Transform Care.” Senior vice president for Patient Care and chief nurse, Jeanette Ives Erickson, RN, introduced Mr. Norman Knight and acknowledged his many contributions to MGH Nursing.

Said Knight, “Whenever I come to MGH, I feel like I’m in the presence of angels.”

Ferrell’s presentation revolved primarily around the work and outcomes of the National Consensus Project for Quality Palliative Care. The project promotes the implementation of clinical practice guidelines to ensure consistent, high-quality care and the development and support of new and existing palliative care services.

continued on next page
Visiting Professor Program

continued from previous page

Ferrell described some of the elements needed to develop an effective palliative-care program:
- good communication skills (especially around end-of-life issues)
- the ability to respond to human need in all situations
- integration of services across patient care settings
- collaboration across disciplines
- a shared understanding of what palliative care means
- effective pain-management
- caring for and valuing nurses who care for dying patients

Thursday morning, Ferrell had an opportunity to hear several nurses from the Medical Intensive Care Unit (MICU) and nurse manager, Adele Keeley, RN, discuss outcomes of the Mentoring Palliative Care Champions Program, a research project funded by the Robert Wood Johnson Foundation.

After an introduction by clinical nurse specialist, Ann Martin, RN, Ferrell described the implementation of a national pediatric palliative-care training program to a multi-disciplinary group of pediatric clinicians. They spoke about the unique challenges involved with caring for children and the importance of gaining insight into your own feelings about death and dying.

Ferrell spent time with clinicians on Phillips House 21. In a discussion facilitated by staff nurse, Theresa Cantanno, RN, staff shared the case study of a challenging patient they had cared for over the course of his lengthy illness.

Ferrell’s visit concluded with a research-focused presentation at Nursing Grand Rounds entitled, “Eliminating Barriers to the Clinical Management of Pain and Fatigue.” Ferrell talked about the goals of her current research study, which seeks to test an innovative model for reducing barriers to the management of pain and fatigue in cancer patients.

The first annual Knight Visiting Professor lecture and visit were by all accounts an enormous success. Ferrell’s knowledge, creativity, and passion for nursing were evident in every lecture, dialogue, and consult with clinical staff. This inaugural visit marks the beginning of an important new era at MGH, bringing national experts to our hospital to enrich our clinical knowledge, advance our research agenda, and keep our passion for nursing practice burning brightly.

For more information about the Knight Visiting Professor Program, call Laura Mylott at 4-7468.
Health literacy: implications and recommendations for clinicians

— by Carolyn Bartlett, RN; Elizabeth Johnson, RN; Carol Harmon Mahony, OTR/L, and Jill Taylor Pedro, RN

The Institute of Medicine’s report on Health Literacy states that about half of American adults, approximately 90 million people, have trouble reading, understanding, and implementing healthcare information. Health literacy impacts patient care on many levels, including scheduling, completing insurance forms, understanding consent forms, giving personal medical information, and following instructions.

Health literacy is defined as a person’s ability to take in and understand healthcare information in order to make informed decisions about their own care. The problem is complex and widespread. Research shows that 22% of American adults are unable to locate their birth date on their driver’s license; 48% cannot read a bus schedule. While more than 20% of adult Americans read at or below the fifth grade level, their reading levels do not necessarily correspond with the highest level of school they attended. So asking patients their highest level of education isn’t always a valid way to assess learning needs and determine the most effective teaching methods.

The impact of literacy on health management is significant. Studies show that 46%, almost half, of all Americans are functionally illiterate with respect to health care. Forty-two percent of Americans don’t understand instructions on medication bottles; 26% cannot interpret directions on an appointment slip, 60% don’t understand informed consent forms, and 86% of those who read Medicare guidelines can’t explain their rights or responsibilities.

Among adults who report they can read, more than 20% are incapable of learning new information. They don’t understand the context of what they read or hear, so they don’t know what to ask to gain vital information. Their confusion limits their ability to perform follow-up care on their own.

Caregivers’ responsibility with respect to patient knowledge requires that we increase our knowledge around health literacy issues. JCAHO mandates that patients receive, “education and training specific to the patient’s needs.” Surveyors ask nurses about patient education and how they determine a patient’s ability to learn and understand materials.

The implications of health literacy are complex. The problem is not the availability of information, it’s the ability of a significant portion of the patient population to make sense of it. Understanding varies depending on the complexity of materials and the manner in which they’re presented. Understanding can suffer even more when communication involves different languages and ethnic backgrounds.

Health literacy affects every aspect of the care-delivery spectrum:

- **Patient Safety**—If patients don’t understand instructions about their medications, treatment, or appointments, their safety risks increase dramatically
- **Treatment Efficacy**—Treatments incorrectly implemented can result in no effect, or worse, negative outcomes for patients
- **Health Status**—Studies show that the higher a person’s health literacy, the more likely he/she is to obtain health screenings such as colonoscopies and mammograms
- **Patient’s Rights and Autonomy**—Information is power. A patient who understands what is being taught is more likely to ask relevant questions and be better able to make informed decisions. A clear understanding of information results in better care and fewer conflicts and potential legal actions
- **Self Esteem**—Iliteracy can be a source of shame. Patients are often reluctant to reveal their inability to understand instructions to their health providers because of the stigma of illiteracy
- **Therapeutic Relationships**—Patients who feel their providers are communicating above their level of understanding not only miss potentially critical information but have difficulty developing trust with their providers
- **Resource Utilization and Health Care Costs**—Patients who don’t understand health care instructions have more frequent and unplanned visits to providers. They are more likely to go to emergency rooms where costs are significantly higher. There is a direct relationship between health literacy and the number and length of hospitalizations

Health literacy can be improved using a variety of approaches:

- **Improve Verbal Communication**—For the best patient outcomes, providers need to ensure that information is clear and understandable. Patients should repeat information back or in some way demonstrate understanding. Use simple, clear language. Avoid medical jargon, and speak slowly. Ask: “Do you want to go over this again?” “Would you like a family member to hear this information?”

Conclude with, “Why don’t you show me what you’re going to do at home?”

Only provide information on two or three concepts at a time then check for understanding. Be aware of cultural and linguistic differences. Men and women may use different words to describe symptoms. Use trained medical interpreters (not family members) to translate information. Review written information

- **Improve Written Materials**—Know the continued on page 9
Take a little DIP

—by Debbie Essig, LICSW; Kassie Lopez, RN; and Debbie Jameson, RN, of the Patient Education Committee

Digitized Information for Patients, or DIP, is an extensive database of (cancer) patient-education materials that can be accessed from any MGH computer. Because publishers have given special copyright permission to use current book chapters, DIP is available on the MGH Intranet but not on the Internet.

**Question:** Can you give me an example of what I can find in DIP?

**Answer:** A few examples of what you might find in DIP include:

- An easy-to-read chapter on pancreatic cancer
- An illustration of a pancreas
- A treatment fact sheet on the drug 5-FU
- Tips on how to talk to children when a parent has cancer

**Question:** I don’t work in Oncology. How can I access DIP?

**Answer:** Everyone at MGH has access to DIP. Go to the new Cancer Resource Room website at: www.massgeneral.org/cancer/crr. Scroll to the bottom of the page and click on DIP.

**Question:** If I’m too busy to get to a computer, is there any other way to get this information?

**Answer:** Yes. Call the Cancer Resource Room at 724-1822, and we can send or fax the information to you. We can fax or mail information all over the world. Remember, there are two ways to get information from DIP:

- Go to: www.massgeneral.org/cancer/crr and click on the DIP link
- Call the Cancer Resource Room at 4-1822

Take some time to see what DIP has to offer.
My name is Linda Shuman, and I am a staff nurse in the Post Anesthesia Care Unit (PACU). Mrs. K was a 70-year-old woman with a history of thyroid and laryngeal cancer who had already received a course of radiation treatment. Mrs. K had recently undergone a barium swallow test for complaints of dysphagia (inability to, or difficulty swallowing). The test had indicated esophageal strictures so her surgeon planned an esophageal dilation (an opening or clearing of the esophagus) under general anesthesia.

While in surgery, Mrs. K experienced a perforated trachea, always a risk during an esophageal dilation, but even more so when the patient has had radiation treatments, which can weaken tissue in the affected area. Thoracic surgeons were called to assist. The repair went well, and Mrs. K was assigned to my area in the PACU as a ‘regular wake-up patient.’

Typically, when patients arrive in the PACU, we receive a report from the anesthesia resident. That report along with how the patient presents are the primary cues on which we base our initial care. This was a particularly slow day, and I was informed that I’d be receiving an, ‘A-line’ in area 28. Generally, patients with arterial lines are hemodynamically unstable or have the potential to become so. Due to the increased acuity of this case and having already settled my previous patient, I reviewed the additional information on Mrs. K so I could appropriately pre-plan for her needs. I noticed she’d had an esophageal dilation and thought it odd that she’d have an arterial line. Dilations are usually simple procedures with few side effects. Arterial lines are reserved for high-risk procedures or patients with significant medical histories. Mrs. K didn’t fall into either of those categories. After consulting with my colleagues, we asked our resident to go into the OR and assess Mrs. K. When he returned, he informed us about the perforation. I asked if a PACU overnight bed had been requested. He said it hadn’t.

Thinking of all the possibilities, I approached the resource nurse and requested that she hold an ICU bed for Mrs. K until we knew definitively what her condition was. I set up my area with everything I might need: epinephrine nebulizer, Albuterol, Ambu bag, humidified oxygen, blood-gas lab slips, syringes, and of course, an airway cart.

Approximately 45 minutes later Mrs. K was brought into the PACU accompanied by a first-year surgical resident and a first-year anesthesia resident. As they approached her bedside, I heard audible stridor and noticed that Mrs. K was pale and diaphoretic (perspiring) with mild dyspnea (having difficulty breathing). I asked the resident and the PACU attending physician to be called for assistance with Mrs. K’s needs. We placed her on a monitor. I introduced myself, and asked her a few questions about her breathing. I asked if she had chest pains or any other symptoms. She was tachypneic (breathing faster than normal), slightly diaphoretic, and non-verbal. She was only able to shake her head in answer to my questions.

There was no obvious neck swelling or tracheal deviation, and her oxygen saturation was 99%. Her lungs sounded clear, but her upper airway was experiencing stridor. I called for a chest x-ray right away. As the anesthesia resident and attending physician approached the bedside, I gave them a brief history and explained that her dyspnea and color had worsened in the few minutes since she’d been brought in. She was now working hard to breathe, using her accessory muscles, and had become very restless. All these symptoms pointed to poor oxygen exchange in the lungs. I asked for an order for an epinephrine nebulizer. They agreed, and I promptly administered it to Mrs. K.

I asked my colleague to draw a blood gas. Mrs. K was tired, pale, and needed to be intubated. The attending asked me to prepare for intubation. The surgical resident was asked to inform his senior, who he did. Her blood gas indicated respiratory acidosis (poor oxygen exchange). I explained to Mrs. K that the swelling in her neck was making it difficult for her to breathe, and it was going to be necessary to place a tube into her lungs. She nodded as if she understood and almost welcomed the intubation. Her respiratory status was failing; she needed help to breathe. I asked one of the patient care associates to hold Mrs. K’s hand so mine would be free to assist. The intubation went smoothly. We manually ventilated her while the respiratory therapist set up the ventilator. A second blood gas indicated a great improvement in her oxygenation.

Mrs. K was lightly sedated, her color improved, she began resting comfortably, and her skin was warm and dry. As she rested, I made plans to move her to the ICU. She was going to stay intubated overnight to allow the swelling to decrease. She would have a procedure in the morning to determine if her airway edema persisted.

I spoke with Mrs. K’s family in the Gray Family Waiting Area and briefly explained her course. I told them that a volunteer would escort them to the PACU where they could speak to a physician for more detailed information. My hope was that they would be at her bedside when Mrs. K woke up. Continued on next page.
Health Literacy

continued from page 6

reading level of the materials you’re providing. Materials should be written at a sixth-to-eighth grade level. Several readability formulas are available. The Frye Readability formula is most commonly used at MGH.

- Include only essential information
- Educate Staff in Plain Language—Attend a Write Easy to Read workshop and educate staff on how to use plain language. Use common words with fewer syllables when possible
- Create a Non-Threatening Environment—Be aware of cultural and linguistic differences that can interfere with a patient’s understanding of medical information. Invite family members to hear information and help with home care and follow-up. Patients who are illiterate may feel ashamed and try to disguise these deficits. Put patients at ease
- Every clinician needs to have an awareness of health literacy. Improving patient-satisfaction, healthcare outcomes, cost-effectiveness, and reducing medical errors are directly related to health literacy. As advancements are made in information technology and as patients continue to turn to the Internet for health information, we may need to re-visit our strategies for ensuring that patients are well informed.

For more information about health literacy, call Elizabeth Johnson, RN, at 4-4118, or contact any member of the Patient Education Committee.
On Wednesday, September 14, 2005, four nurses were recognized for completing the intensive MGH-IHP New Graduate Nurse in Critical Care Program (NGCC). The addition of these professionals into the MGH critical care nursing staff raises the total number of new graduate critical care nurses to 65.

Heather Keenan, RN, Jaime Geiger, RN, Debra Sloboth, RN, and Candace Pettis, RN, received certificates for completing the program. Nurse manager, Tony DiGiovine, RN, and Laura Mylott, RN, manager and faculty for the NGCC, spoke about the rigorous and demanding challenges of the program, the resilience and determination of the participants, and the generosity of all the clinicians who volunteer to teach in the program.

Miriam Greenspan, RN, spoke briefly about the invaluable support and experience provided by preceptors and gave an example of an innovative model of precepting used in one of the ICUs.

Pettis, read a narrative she had written about the nursing care she provided to a woman who had sustained severe burns while cooking at home. Pettis’ narrative was noteworthy for how it described her ability to balance her patient’s fluctuating needs for pain- and anxiety-management. Through gentle coaching, being present, and providing reassurance, Pettis was able to give this patient and her husband the emotional and psychological support they both needed to endure the physical challenges and uncertainty of rehabilitative therapy.

Pettis’ practice developed under the expert precepting of Brooke Holmes, RN, and Frank Ireland, RN. Ireland, who has precepted several new graduate nurses over the past three years, reflected on his experiences teaching and coaching new nurses. He emphasized the importance of helping to socialize new nurses into the profession and into the unit culture. Ireland encourages new nurses to develop their own, individualized style of practice while ensuring that they master the necessary standards of clinical nursing.

The New Graduate Nurse in Critical Care Program is guided by a group of critical care nurse managers and clinical nurse specialists who meet regularly under Mylott’s leadership to address opportunities for program development.

For more information about the New Graduate Nurse in Critical Care Program, contact the nurse manager or clinical nurse specialist in any ICU, or call Laura Mylott at 4-7468. For application information, call Sarah Welch in Human Resources at 6-5593.
The Open Galley Project: coming soon to a galley near you!

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

Patient Food Services is excited to announce plans to open pantry kitchens in seven additional patient care areas this fall. The Open Galley Project, aimed at increasing patient- and nursing-satisfaction, was initiated this past winter on six patient care units.

Traditionally, the small kitchens, or ‘galleys’, on patient care units are kept locked when patient food service personnel are not on the unit. The pilot program looked at:

- the feasibility of ‘opening’ galley 24 hours a day, 7 days a week, by giving staff on units a key to the galley
- what provisions are necessary to meet JCAHO requirements
- what needs to be stocked in galley for nurses to access
- what impact open galley will have on staff-satisfaction

The Open Galley Pilot Project was well received, and feedback from nursing has been very positive. Patient Food Services continued to provide delay trays and hot food requests, but nurses were able to access the galley any time it was necessary. By all accounts, the Open Galley Pilot Program was an enormous success.

This fall, galleyes will be opening on seven more patient care units (galleyes remain locked to patients and visitors but unit staff have a key). We look forward to opening galleyes throughout the hospital and will continue to do so as budgetary considerations make it possible. Our goal is to complete the Open Galley Project by the end of fiscal year ’06.

For more information about the Open Galley Project, contact Susan Doyle, RD, senior manager of Patient Food Services, at 6-2579.

Nutrition service coordinator, Marie Senatus, in galley on Ellison 16

STOP Task Force: Stop the Transmission of Pathogens
Infection Control Unit
Clinics 131; 726-2036

MGH is committed to improving hand hygiene

Glove Safety:

When should gloves be worn?

Gloves are used to protect healthcare workers and patients, and reduce cross-contamination between patients, workers, and the environment.

Standard precautions: used for all patients

Glove use is recommended when contact is anticipated with non-intact skin, mucous membranes, bodily fluids, or items contaminated with bodily fluids or excretions.

Is there a correct way to put gloves on and take them off?

Yes. If you’re unsure of the proper technique, contact your nurse manager or the Infection Control Unit for a demonstration.

Special precautions: for patients on airborne, contact, droplet, neutropenic, or other precautions

Gloves may be required for all contact with patients on the above-mentioned precautions (including intact skin) and/or contact with items in the patients’ environment.

See posted signs or the Infection Control Manual for further information on the specific precaution requirements for your patient.
Among many other things, the Pre-Admission Testing Area (PATA) provides patients and families with information necessary to safely prepare for surgery. PATA plays a pivotal role in the pre-assessment process for patients and families. It’s important for patients and clinicians to understand the PATA process so they are well informed and have clear expectations about what’s necessary to prepare for a PATA visit and for the day of surgery.

In the winter of 2003, PATA created the PATA Patient Booklet as a first step toward improving and enhancing the consistency of information conveyed to patients. PATA nursing staff designed and created the patient-centered booklet to provide clear and concise information to help patients and families prepare for the PATA experience. Distribution of the booklet significantly improved compliance, but PATA staff felt there was still more that could be done.

The next step was to create a bridge between written materials and an on-line website. The goal was to create a website that was easily accessible to patients and clinicians and provided concise, standardized information to better prepare patients for their PATA visit and the day of surgery. In the winter of 2005, the journey began to design, create, and implement a PATA website. The work group included staff from PATA and the Same Day Surgical Unit; web coordinator, Kristen Joyce; medical director, Jean Kwo; and nurse manager, Bessie Manley, RN.

After six months of development, the team feels confident that the final product reflects the mission and vision of PATA staff. The site provides accurate, consistent information and helps prevent misunderstandings and false expectations.

The website is divided into easy-to-access sections:

- **General Information**
  This section provides a step-by-step description of the PATA visit and the day of surgery, including clear instructions and expectations
- **Anesthesia**
  This section provides information on the anesthesia plan, options, and risks
- **Nursing**
  This section links directly to the Patient Care Services website providing a brief overview of the unit, staff, and patient care delivery model
- **Resources**
  This section allows patients to link to various sites that will help them become active participants in their care. Some links include the newly revised, Preparing for Your Surgery: Information for Patients; the American Society of Anesthesiologists; discharge information; health care proxies; hotel accommodations; the MGH Cancer Center; the Treadwell Library, and much more
- **FAQs**
  This section addresses questions and concerns patients may have about PATA, the day of surgery, and anesthesia
- **Directions**
  This section provides directions to the hospital via public transportation and driving; and access to maps and parking information
- **Contacts**
  This section provides specific unit information and an e-mail address that allows patients and clinicians to contact a staff person in PATA with any questions, concerns, or feedback.

The next step is to make patients and clinicians aware of the website and encourage them to use it. We have linked the PATA website to the sites of all departments that use PATA services (surgical departments, Patient Care Services, procedural areas, and the Blum Patient & Family Learning Center). The site is listed on the MGH intranet and in our printed materials, which are distributed to patients prior to their PATA visits.

We’re proud to be able to launch this website and provide our patients and colleagues with the opportunity to access vital information. Our goal is to empower patients with the knowledge they need to safely prepare for surgery.

For more information, visit our website at: www.massgeneral.org/pata.
Danforth publishes
Suzanne Danforth, CCC-SLP, speech pathologist, wrote, “Speech and Swallowing Management of the Patient with ALS,” in a chapter entitled, “Rehabilitation,” in Amyotrophic Lateral Sclerosis published this summer. Other contributors to the chapter are: Lisa S. Krivickas, MD; Vanina Dal Bello-Haas, MEd; and Gregory T. Carter, MD.

Ojimba leads convention
Reverend Felix Ojimba, planned and led the bi-annual convention of the Uli Development Foundation in Buffalo, New York, July 15–17, 2005. He was unanimously re-elected president for another four-year term. The Uli Development Foundation is a New York-based, not-for-profit charitable organization geared toward providing Nigerian immigrant families opportunities for social interaction and cultural adaptation. The Foundation addresses hunger, poverty and illiteracy in rural Nigeria.

Prater and Getzoyan publish

Krupnick presents

Peirce elected to board
Georgia Peirce, director of PCS promotional communication and publicity, was elected to the Health Research & Educational Trust (HRET) Fellowship’s Board of Advisors for a two-year term.

Whitney publishes


Nunn presents

Training for Managers and Supervisors
Topics include: time-management, stress-reduction, and staying focused.
Thursday, November 3, 2005
1:00–3:00pm, Haber Conference Room
To register, call 726-6976.

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Monday, Tuesday, Friday
8:30am–3:00pm
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http://pcs.mgh.harvard.edu/
For assistance in searching back issues Of Caring, contact Jess Beaham, at 6-3193

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Articles/ideas should be submitted by e-mail: ssabia@partners.org
For more information, call: 617-724-1746.

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October 20, 2005
McEachern Awards
continued from front cover

nary man who performed extraordinary deeds during the course of his 31-year career as a firefighter. Said Ives Erickson, “We are privileged with this award to welcome Brian McEachern and his sisters, Geri and Diane, as part of the MGH family and part of our legacy.”

Family friend and former colleague, Paul Christian, commissioner and chief of the Boston Fire Department, shared some personal memories of McEachern. He noted that Brian’s years of service at a time when adequate breathing apparatus was not yet available contributed to his death. He called his friend a man of great dignity and strength and thanked the McEachern family and MGH for keeping his memory alive.

Mary Manning, RN, another family friend, said McEachern had two families—one at home and one at the firehouse—both helped sustain him during his long illness and the great uncertainty that came with it. Said Manning, “Brian received extraordinary care at MGH. It’s that care and the leadership that made it possible, that helped shape this award.”

Both of McEachern’s sisters, Geri and Diane, commented on how honored they were to be part of the award selection committee and to read all the stories of extraordinary care throughout the hospital. They thanked all who were nominated and all who helped make the award possible.

Award recipient, Tessa Goldsmith, was unable to attend the ceremony; her husband, Clifford, accepted on her behalf. Ives Erickson quoted Goldsmith as saying, “My clinical challenge is to understand the pathology of speech and swallowing so well that I can break it down to its smallest components to make the abnormal functional.”

In a letter of support, director of Speech, Language & Swallowing Disorders, Carmen Vega-Barachowitz, CCC-SLP, wrote, “Tessa is recognized as an expert and a mentor. She is well known for her compassion, dedication, and commitment to helping patients retain their dignity.”

In introducing Christine McCarthy, Ives Erickson read from a letter of support submitted by nurse manager, Adele Keeley, RN, who wrote, “Christine is well known in the MICU as a caring advocate for her patients—no matter what it takes. She provides exquisite care to every patient and family member. Christine is a role model to others as she cares for patients and families in crisis. She guides and advocates for them as they address the many challenges that arise.”

The ceremony ended with the unveiling of the Brian M. McEachern Extraordinary Care Award plaque, a beautiful avonite slab etched with gold and affixed with the names of the recipients and the image of a firefighter superimposed over a fireman’s shield. The plaque will find a home, fittingly, in a prominent location in the halls of MGH.

Ives Erickson closed by thanking all clinicians who honor the memory of Brian McEachern with the extraordinary care they provide.

For more information about the Brian M. McEachern Extraordinary Care Award, contact Julie Goldman, RN, at 4-2295.
### Educational Offerings

**For detailed information about educational offerings, visit our web calendar at [http://pcs.mgh.harvard.edu](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](http://www.hrm.harvard.edu).

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<tr>
<th>When/Where</th>
<th>Description</th>
<th>Contact Hours</th>
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| October 14 and 24 8:00am–5:00pm | Advanced Cardiac Life Support (ACLS)—Provider Course  
Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room | 16.8 for completing both days |
| October 14 8:00–11:00am | On-Line Clinical Resources for Nurses  
FND626 | 3.3 |
| October 19 8:00am–4:30pm | Preceptor Development  
Training Department, Charles River Plaza | - - - |
| October 20 1:30–2:30pm | Nursing Grand Rounds  
“Kidney Care.” O’Keeffe Auditorium | 1.2 |
| October 20 and 21 8:00am–4:00pm | Oncology Nursing Society Chemotherapy-Biotherapy Course  
Yawkey 2220 | 16.8 for completing both days |
| October 21 and 28 7:30am–4:00pm | Pediatric Advanced Life Support (PALS) Certification Program  
Thier Conference Room | - - - |
| October 24 8:00am–12:00pm | BLS Certification–Heartsaver  
VBK601 | - - - |
| October 24 and 25 7:30am–4:30pm | Intra-Aortic Balloon Pump Workshop  
Day 1: MAH; Day 2: VBK601 | 14.4 for completing both days |
| October 25 7:30–11:00am/12:00–3:30pm | CPR—American Heart Association BLS Re-Certification  
VBK401 | - - - |
| October 26 8:00am–2:30pm | New Graduate Nurse Development Seminar II  
Training Department, Charles River Plaza | 5.4 (for mentors only) |
| October 27 1:30–2:30pm | Nursing Grand Rounds  
“Case Management.” O’Keeffe Auditorium | 1.2 |
| October 28 12:00–1:00pm | Schwartz Center Rounds  
Walcott Conference Room | - - - |
| November 1 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric) | CPR—Age-Specific Mannequin Demonstration of BLS Skills  
VBK401 (No BLS card given) | - - - |
| November 2 7:30am–12:00pm | Congenital Heart Disease  
Haber Conference Room | 4.5 |
| November 3 7:30–11:00am/12:00–3:30pm | CPR—American Heart Association BLS Re-Certification  
VBK401 | - - - |
| November 3 1:30–2:30pm | Nursing Grand Rounds  
“Preventing Medication Errors.” O’Keeffe Auditorium | 1.2 |
| November 4 and 14 8:00am–4:00pm | Advanced Cardiac Life Support (ACLS)—Provider Course  
Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room | 16.8 for completing both days |
| November 4 8:00am–12:30pm | Pediatric Advanced Life Support (PALS) Re-Certification Program  
Training Department, Charles River Plaza | - - - |
| November 9 8:00am–2:30pm | Mentor/New Graduate RN Development Seminar I  
Training Department, Charles River Plaza | 6.0 (mentors only) |
| November 9 1:30–2:30pm | OA/PCA/USA Connections  
“Materials Management.” Bigelow 4 Amphitheater | - - - |
| November 9 11:00am–12:00pm | Nursing Grand Rounds  
Sweet Conference Room GRB 432 | 1.2 |
| November 10 8:00am–2:00pm | BLS Certification for Healthcare Providers  
VBK601 | - - - |
Patricia Benner presents at Nursing Grand Rounds

—by Mary Ellin Smith, RN, professional development coordinator

Patient Care Services welcomed world-renowned author and lecturer, Patricia Benner, RN, PhD, FAAN, September 8, 2005. Benner is a professor in the department of Physiological Nursing at the University of California, San Francisco, and a leading expert on skill-acquisition and clinical judgment. Benner’s work was the theoretical foundation for Patient Care Services’ Clinical Recognition Program.

During her visit, Benner presented at Nursing Grand Rounds where she had an opportunity to dialogue with staff about their clinical narratives. Suzanne Curley, OTR/L, advanced clinician in Occupational Therapy; Donna Lawson, RN, advanced clinician on the Bigelow 11 Medical unit; and Kimberly Stewart, SLP, advanced clinician in Speech Language & Swallowing Disorders, shared their narratives.

Benner spoke about the knowledge shared by different disciplines and the need for interdisciplinary discussions about patients, practice, and the environment of care.

Benner met with the Clinical Recognition Review Board to discuss their observations about the program three years post-implementation. She spoke about the opportunity the board has to identify best practices and areas for improvement by reading portfolios submitted during the application process.

Benner met with associate chiefs and directors to discuss the role of leadership in creating an environment for reflective practice and promoting the Clinical Recognition Program. She provided insight into the challenges of ensuring competent skills and helping clinicians grow professionally. She spoke about clinicians becoming disengaged from practice and how leaders can help prevent this during the first years of a clinician’s practice.

Said Benner, “By making the attributes of excellent practice clear and visible, a recognition program brings with it a change in organizational culture.”