August 17, 2006

Caring HEADLINES

Inside:

Providing quality health care half-way around the world

(See page 6)

Bigelow 11 staff nurse and Durant Refugee Medicine fellow, Chanda Plong, RN, with some of her young patients aboard the USNS Mercy, currently deployed in southeast Asia

(Photo provided by staff)

MGH Patient Care Services

Working together to shape the future

Citizens of the world: a shift to global thinking

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

These are difficult times. Several personal interactions recently have reminded me how closely connected we are to international events.

I was having dinner with friends one evening, friends whose company I value and enjoy. Our time together is usually carefree and relaxed; but on this occasion, something was different. There was an uneasiness in the air.

"Is your family safe?" I asked.

My friends are of Lebanese decent and have family living in Lebanon.

Earlier in the day, I had sent an e-mail to another friend with a similar inquiry. "Have you heard from your family in Israel?"

These are difficult times. We are members of an international community. Our interests and relationships transcend physical borders. And as healthcare providers, we're committed to caring for and about people from all cultures and backgrounds.

I feel blessed to work at MGH with people who share my passion for patient care and my desire to be part of a diverse and compassionate community. Our definition of community has changed as the world has become more interdependent and our thinking more global. Our 'community' is no longer that little neighborhood along the Charles; our community is the world. And MGH is a microcosm of that world with patients, visitors, and employees from states and countries around the globe.

I'm proud that MGH is a leader in providing humanitarian aid to troubled nations. I'm proud that MGH is a leader in global health, education, and research. I'm proud that so many of our employees feel empowered to look beyond our walls and share our resources with those who have such great need.

> "Responsibility does not only lie with the leaders of our countries or with those who have been appointed or elected to do a particular job. It lies with each of us individually. Peace, for example, starts within each one of us."
>
> —the Dalai Lama

As I write this, two of our nurses are bringing their knowledge and skill to struggling countries in Africa and southeast Asia. Thomas Durant Refugee Medicine fellow, Lucinda Langencamp, RN, is working in rural Rwanda delivering primary care and HIV treatment. Chanda Plong, RN, is aboard the USNS Mercy in Cambodia and Indonesia bringing much-needed care in the aftermath of catastrophic natural disasters (see story on page 6).

Karen Holland, RN, and Joy Williams, RN, are also aboard the Mercy for three-month internships under the auspices of the Durant Fellowship Program.

Karen and physician colleague, Larry Ronan, MD, have been named recipients of this year's *Boston Business Journal's* Champions in Health Care Awards. They will be honored along with other local recipients at a special breakfast reception in September.

Perhaps one of the most important initiatives on which we're embarking is the launching of the new MGH Center for Global Health and Disaster Response. The mission of this new center is to, "improve the health of the world's most vulnerable and crisis-affected populations through care-delivery, education, and research." Our goals include:

- serving as a resource for MGH constituents working in the field of humanitarian aid
- serving as a resource for governmental and non-governmental agencies
- studying the impact of natural disasters and war on healthcare systems and populations
- planning for and creating an operational infrastructure for rapid-response teams
- extending MGH expertise in improving the health of the world's vulnerable and crisis-conflicted populations

This is exciting work. With the creation of a formal Center for Global Health and Disaster Response we will truly be able to, 'Extend MGH to the World,' by:

- establishing rapidly deployable, multi-disciplinary teams to respond to humanitarian emergencies
- designing standards of care-delivery and educational programs for populations in need
- designing strategies to educate all disciplines around global-health issues and disaster preparedness
- offering multi-disciplinary consultation on establishing infrastructures for providing global-health services and disaster response
- studying the impact and outcomes of global-health and disaster-response initiatives

We're in the process of recruiting a director for the Center for Global Health and Disaster Response and securing physical space to house staff. I'll keep you informed as we move forward with this important initiative.

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An update on some service-improvement initiatives at MGH

Question: We've had problems with out-dated morgue stretchers? Is there any way to get new ones?

Jeanette: Yes. I'm pleased to report that new morgue stretchers have been ordered. After reviewing several different models, a task force unanimously selected a new stretcher, which will improve the transporting process and provide ergonomic relief to staff nurses and pathologists. The new stretchers should arrive in October.

Question: At a recent Staff Nurse Advisory Committee meeting, we heard a presentation on replacement PCA pumps. Can you give us an update on when these new pumps will be put into circulation?

Jeanette: The Bedside Technology Task Force, co-chaired by associate chief nurse, Dawn Tenney, RN, and director of Systems Improvement, George Reardon, is leading the effort to replace all our old pumps with new, 'smart' pumps. Syringe pumps in the ICUs were replaced with smart pumps last fall, and PCA pumps are next on the list. We've been waiting for a PCA pump that meets our needs to come on the market, and we've identified a promising one we hope to pilot in five clinical areas in the fall. I'll keep you updated on our progress.

Question: The black boxes used to store precaution supplies outside of patients' rooms aren't very attractive. Can we find a better solution?

Jeanette: Yes. We'll be piloting a new precaution cart on several units in the coming weeks, and I want to hear your feedback. We're confident a solution will be forthcoming in the near future.

Question: I've heard colleagues talking about 'COWs.' What are they?

Jeanette: (No, we're not opening a farm.) COWs is an acronym for, 'computers on wheels,' laptop computers on carts that can be wheeled around the unit and used by staff in various locations. All inpatient units now have the wireless technology to support the use of COWs. Pilots are underway on Blake 7, White 8, White 9, White 10, and White 11. We'll be expanding the pilot to include a variety of carts so we can generate feedback on which carts best meet our needs.

Question: I've heard some of my colleagues talking about an equipment-management system called, LEAN. What is that?

Jeanette: LEAN is a collaborative program between Patient Care Services, Materials Management, and Biomedical Engineering designed to improve the flow of equipment throughout the hospital. Members of all three departments came together and looked at ways to make the process 'leaner' by eliminating wasted steps. The program has been up and running since February on Ellison 12, White 12, Blake 12, and Bigelow 14. White 11 and Ellison 11 came on board in April. And Bigelow 7, Bigelow 11, Bigelow 13, Ellison 17, and Ellison 18 will begin this month. The program has been very successful with positive feedback from PCS staff about how accessible equipment is now.

Frequently requested items such as Propaqs, 3M pumps, PCA pumps, feeding pumps, and Sigma pumps are kept on units on a LEAN cart. Par levels are established through unit-based surveys. After being used, equipment is placed on a soiled utility cart, and a (Materials Management) LEAN associate cleans it on the unit and puts it back on the cart. This minimizes the amount of time the equipment is away from the unit. LEAN associates are trained by Biomedical Engineering to do certain quick fixes on equipment that's not working. And Biomedical Engineering has reworked their process for repairing equipment, improving their turnaround time, as well. Staff need to remember to tag broken equipment properly so Biomedical Engineering can quickly diagnose and repair faulty equipment. The plan is to implement LEAN on all patient care units over the next six months.

Question: I've noticed some units have new room-separating curtains, signage, and art in patients' rooms and hallways. Will all units be getting these upgrades?

Jeanette: New room-separating curtains have been ordered for all inpatient units. We anticipate installation will be completed by late fall. New art and signage is being ordered on a unit-by-unit basis. This is a time-consuming effort; our goal is to ensure all units receive new art (and signage as necessary) in the coming year.

Question: My unit has lost some of its unit-based equipment. Is there anything we can do to keep this equipment?

Jeanette: Maintaining unit-based equipment is an on-going challenge. George Reardon and senior project specialist, Dan Kerls, are organizing a multi-disciplinary task force to look at how inpatient units can prevent the loss of much needed equipment. This is a pressing patient-care issue as well as a financial issue. I will keep you informed of their progress.

Jeanette Ives Erickson

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These may be troubled times, but they are times rife with opportunity to help our fellow man, to forge international relationships, and to lead by example. We're fortunate to be part of an organization whose mission is one of altruism and good will. As we shift our perspective toward global thinking and international, humanitarian assistance, I'm thrilled to have the chance to share our mission with the world.

Updates

I'm happy to announce that Jim McCarthy has accepted the position of operations coordinator for the new Emergency Department Observation Unit. Jim has long supported Patient Care Services with his work in Materials Management. Please join me in welcoming him to the PCS team.

Joanne Ferguson, RN, has accepted the position of staff specialist for the Perioperative Service, effective September 10, 2006.

MGH supports the Boston Lobsters

—by James Zachazewski, PT, clinical director, MGH Sports Medicine

MGH is proud to be a sponsor and partner of the Boston Lobsters, a pre-eminent member of the World Team Tennis league. The MGH Sports Medicine Service and the MGH department of Physical Therapy have teamed up to provide the Lobsters with access to the best sports-medicine physicians, physical therapists, athletic trainers, and massage therapists in the country. Our primary responsibility in this capacity is to ensure that some of the world's greatest tennis players (whether members of the Lobsters, or members of visiting teams) receive the best health care possible while in Boston.

The MGH Lobsters Sports Medicine staff provide on-site coverage and services for players before, during, and after matches. Before matches, staff is available to help players warm-up, stretch, and provide any other services necessary to prepare them for competitive play. During matches, should an injury occur, physicians, therapists, and trainers respond immediately to provide emergency care, and ensure that follow-up diagnostic, medical, or surgical care is received if required. Players have access to the entire MGH medical staff. Following matches, staff provide whatever care players may need to recover and get ready to play again. Staff is available to assist all members of World Team Tennis whenever they're in Boston.

The MGH Lobsters Sports Medicine staff consists of:

- Jim Zachazewski, PT, physical therapist and clinical director for MGH Sports Medicine
- Anne Viser, PT, physical therapist
- Jean Jonah, PT, physical therapist
- Bruce Price, MD, medical director
- Peter Asnis, MD, orthopedic surgeon
- Thomas Gill, MD, co-director, MGH Sports Medicine
- Kai Mithoefer, MD, orthopedic surgeon
- Michelle Connolly, massage therapist

During home matches MGH sponsored an educational booth to promote various services offered by the hospital, including:

- the MGH Vascular Center
- Physical Therapy and MGH Sports Medicine
- Womens Health and Dermatology
- the MGH Cancer Center

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Staffing the educational booth at a recent World Team Tennis match at Harvard University's Bright Arena (home of the Boston Lobsters), are (l-r): Anne Viser, PT, physical therapist; Suzanne Curley, OTR/L, occupational therapist; Jessica Nadraga, physical therapy student; Theresa Jacobs, PT, physical therapist; Abby Folger, PT, physical therapist; and Robert Ratcliffe, PT, physical therapist. Staff fielded sports-related questions and offered instruction to fans on how to have a safe and healthy tennis season.

MGH Supports the Boston Lobsters

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- Food &Nutrition Services
- the MassGeneral Hospital *for* Children

Staff fielded sports-related questions and offered instruction to fans on how to have a safe and healthy tennis season. Brochures prepared by MGH staff describing general stretching and flexibility exercises were available.

Physical therapists who staffed the educational booth included:

- Jennifer Miraglia, PT
- Lisa Duncombe, PT
- Jean Jonah, PT
- Stephanie Gallup, PT
- Marie Brownrigg, PT
- Abby Folger, PT
- Jessica Nadraga, PT
- Theresa Jacobs, PT
- Robert Ratcliffe, PT

Copies of pamphlets and instructions can be found on the MGH Physical Therapy website at: http://www.massgeneral.org/pcs/heal_phys.asp; or the MGH Sports Medicine website at: http://www.massgeneral. org/ortho/Boston_ Lobsters_ Tennis_Tips.htm.

For more information about any of the services offered by the Physical Therapy Department, call 4-0125.

Photos, clockwise from top left: Boston Lobster and long-time international tennis super-star, Martina Navratilova.
Enjoying the match, court-side, are (l-r): Anne Viser, PT, physical therapist; Jim Zachazewski, PT, clinical director for MGH Sports Medicine; and Bruce Price, MD, medical director, MGH Lobsters Sports Medicine.
Before a match, Viser tapes the ankle of Boston Lobster, Kristen Schlukebir.

Providing quality health care: images from Rwanda and southeast Asia

On June 7, 2006, Lucinda Langencamp, RN, of the MassGeneral Hospital for Children, and Chanda Plong, RN, of Bigelow 11, became this year's recipients of the Thomas S. Durant, MD, Fellowship in Refugee Medicine. Langencamp is working in an under-served area of Rwanda; Plong is aboard the USNS Mercy in Indonesia and Cambodia. Both are sharing their experiences via on-line blogs (to view blogs directly, go to: http://chanda-durantfellowship.blogspot.com/ or http://www.rwandahealthjournal.blogspot.com/) Below are excerpts from their on-line journals.

Monday, July 3 (Plong)

Saturday was the first day of Operation Smile. I was assigned to work in Casualty & Receiving, or their Emergency Department. Before I knew it, we were consumed with work—vital signs, x-rays, labs, call reports. It was interesting to see the mesh of cultures immersed together. Women's brightly colored sari's against the drab military uniforms .

Happiness, anger, sadness, anxiety, frustration, and relief filled the air. Some women were crying. Some sat quietly, afraid to say anything. Some laughed and played, amazed at where they were. It was a hectic day, but we eventually worked out the logistics. Looking back, it must have been scary for them to have been in such an unfamiliar environment with different sounds, smells, and tastes.

Tuesday, July 4 (Plong)

The past few days have been pretty busy getting patients prepped for surgery. We're working with many patients who have cleft lips and palates.

It's amazing to see such drastic results on these patients. A cleft lip only takes an hour and a half to repair. When patients come out of the PACU, they're brought to the Post-Op Ward where discharge teaching starts immediately. It's wonderful to see the looks on parents' faces when they see their child after surgery. I'm so glad to be part of this mission.

Friday, July 14th (Plong)

We arrived at the Indonesian island of Simeulue on Tuesday after a five-day voyage from Bangladesh. While en route, we kept ourselves busy by preparing lectures for teaching opportunities. We picked up about 20 Indonesian interpreters but only a few of them speak English.

Once in Simeulue we used speed boats to travel to and from the ship. The hospital is amazingly clean. Before anyone enters, we take off our shoes. The hospital was just recently re-built after being ruined by earthquakes in 2005.

We're performing minor surgeries on board and will finish up with primary care on Saturday, doing immunizations, physicals, teaching, etc.

Sunday, July 23 (Plong)

We left the island of Nias yesterday, and arrived in Banda Ache last night. The mission began with patients being brought aboard via boats and helocopters. I had the opportunity to go ashore and give vaccines and immunizations at the hospital in Gunungstatoli. We were given a small room with no windows or air conditioning. After five minutes we were drenched with sweat. We saw more than 70 people of all ages. It was so rewarding to be with patients and families in their own environment.

The hospital is still being re-built. We set up stations in the fairly new main building. Each department had a room: Physical Therapy, Immunization, OB/GYN, Internal Medicine, Dental, Optical, Pharmarcy, and Surgery.

The rest of the week, I worked back on the ship. Patients were a mix of adults and children awaiting some type of surgical procedure. Procedures ranged from simple cataract surgeries to hysterectomies, cyst-removals and amputations.

(Photos provided by staff)

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Humanitarian Aid

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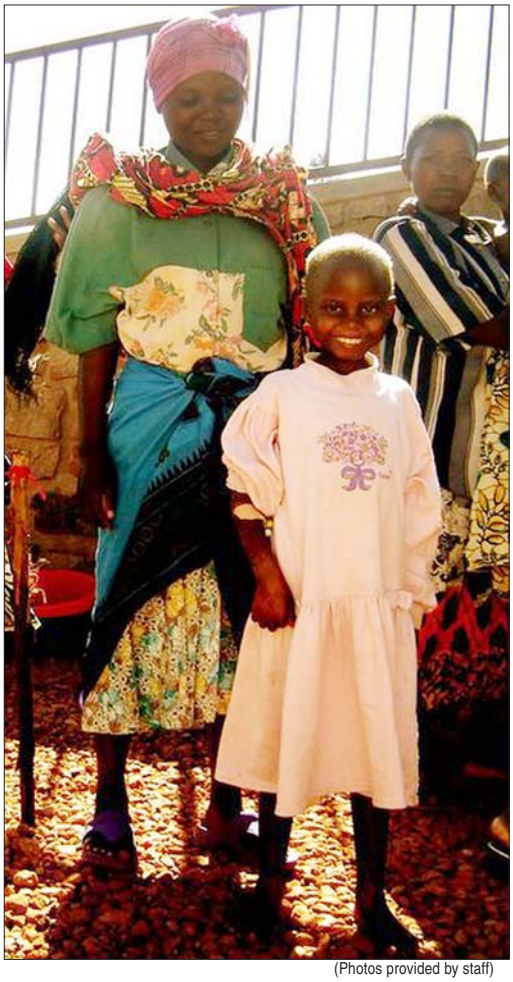
Tuesday, July 4 (Langencamp)

It's malaria season. Toward the end of May when wet season ends and dry season begins, p.falciparum rears its ugly head. The majority of children in the pediatric ward have been admitted for malaria. They are so sick, I can't fathom how their parents walked for hours to get them to the hospital.

Prior to coming here, I didn't know there was a malaria season. Nor did I feel the tragedy of it. Yes, I knew many children died of it in poor countries, but it was a 'textbook' understanding. Like most people in the United States, I had never been exposed to these things. I've always had the luxury of a wealthier life. I've always known the world isn't fair. I guess that's why I'm here—to try to make it a little more fair. It's a drop more than not doing anything. But who knows, maybe we can figure out a way to fight this disease, drop by drop.



(Photos provided by staff)

Tuesday, August 3 (Langencamp)

It's been weeks since I last wrote. It's amazing how the time escapes me. I don't even know where July went. We had two important visitors recently. Bill Clinton and Bill Gates each came to Rwanda to get a sense of the situation here. It was reassuring to see caregivers advocate for the poorest of the poor here. Clinton and Gates were greeted as VIPs, but there was no question that our primary mission was to advocate for our patients.

The children who get better from malnutrition are as wonderful and darling as any children can be. My efforts may be little—one person at a time, one family at a time—but I can do something every day. I can be present to the moments at hand.

I like being here among the rural poor. We are as close to the medical, social, and economic issues of this area as anyone in the country. What I'm seeing as I work in the hospital and out in the community, is that access to medical care, water, land, food, and education are tantamount to a fair and just life. Children die here every week. These children would not die in the United States or Europe or Japan; these deaths are preventable. It's not freedom of speech or freedom of assembly they struggle for here. It's access to food and water and education and medical care.

Until the country can figure out how to provide for the common good of its people, we provide the best medical care we can to one of the poorest areas in the world. And that, in truth, is the most a non-government organization can do—relieve human suffering with support, medical aid, and compassion. We can make things better here. And yes, despite the hardships that exist every day, there is hope for the poor. But not without our help.

Photos in this spread (l-r): Cleft-palate patient and a family member after surgery aboard the USNS Mercy. Plong with Hirschsprung's disease patient. Young Rwandan girl "looks fantastic" after treatment. At one of the Rwandan health centers, Langenkamp assesses baby with a suspected ventricular defect.

Sometimes comfort comes in the form of trust, respect, and compassion

Katherine O'Meara is an advanced clinician

Katherine O'Meara, RN
staff nurse, White 10

My name is Katherine O'Meara, and I am a staff nurse on White 10. As a three-year veteran of a medical unit, I've encountered many patients who choose not to cooperate with the plan of care. This particular patient proved to be one of the most difficult. Mr. K was well known to staff on our unit. He was a homeless man who was admitted frequently to White 10 for alcohol-withdrawal. At the time of this admission, he had been seen in the Emergency Department 26 times in the past two months. He had been admitted 15 times and left against medical advice (AMA) all but three of those times. In my past experiences with Mr. K, he had been rude and verbally abusive toward staff and other patients. He paid little attention to personal hygiene, allowing his urostomy bag to overflow, giving him a potent, unpleasant smell. His typical course on White 10 consisted of heavy doses of Valium starting at 15-minute intervals, a number of upsetting interactions with staff, and piles of dirty linen. And usually, after disrupting operations, Mr. K would leave AMA.

From previous experience with Mr. K, I had learned that the best plan of action was to tend to his needs early. I gathered his 8:00pm medications, grabbed some peanut-butter crackers and ginger ale (his favorites), and headed straight to his room. Patients with as many psycho-social issues as Mr. K don't like to wait, and I've realized that it's better to head off problems before they comes looking for you.

Unfortunately, before I made it to Mr. K's room, I was intercepted by another patient's family member. As I stood in the hallway talking, I smelled the odor of stale urine and heard the grumbling of an angry Mr. K approaching from behind. I quickly excused myself and went to head him off.

I was prepared for his usual behavior, but something was slightly different. Although he'd only been admitted that afternoon, he wasn't confused or heavily sedated. He actually seemed to know what he was doing. He walked straight for the nurses' station with a steady gait. He was on a mission.

I tried my best to redirect him, wanting to avoid a confrontation in the hallway, but he walked right past me, went to the desk, and demanded to speak to a doctor. He started screaming that he was being neglected, that no one cared about his pain, and he was going to die in misery if someone didn't address the throbbing in his jaw! Seeing my distress, the intern on call came immediately to my aid. He told Mr. K that he'd consider adjusting his pain medicine if Mr. K would go back to his room and let me check his vital signs. Mr. K continued to yell as he walked back to his room. He reluctantly allowed me to close his door to spare other patients from his tirade. I had cared for Mr. K often enough to know that, although he was upset, he wouldn't harm me. I knew I was safe alone with him in his room. Furthermore, I knew that what he really needed was some one-on-one attention.

As I took his blood pressure and heart rate, I confirmed what I already suspected. Mr. K was in a good deal of pain. His systolic blood pressure was close to 200, and his heart rate was in the 120s. I knew his baselines were much lower. Alcohol-withdrawal can present with many of the same symptoms as pain, but it was easy to see the difference. Mr. K had been admitted that afternoon, which meant it was too soon to be seeing such severe signs of withdrawal. He continued to rant about how no one cared about him because he was a drunken bum and all we wanted to do was throw him back out on the streets. I tried to get a few words in, but finally gave up because he just wouldn't listen. He went on and on about how sick and frustrated he was and how unfair his life had been. I knew he wasn't mad at the doctors, or me; he was mad at the world. And I knew the best thing I could do for him right then was sit and listen.

With patients like Mr. K, my ability to listen and facilitate healthy communication is often my most important skill as a nurse. I pulled a chair up next to Mr. K's bed and sat down. I removed my gloves and put the thermometer and oxygen-saturation monitor down. He looked surprised that I'd actually stuck around to hear what he had to say, but he kept talking. What had begun as a yelling tirade turned into a baring of his soul. He poured his heart out about how hard his life had been. He told me he'd been diagnosed with bladder cancer at the age of 20 and had lived with a urostomy ever since. He hadn't been able to have children due to the surgery (something he'd always dreamed of.) He had lost two wives to cancer, was divorced by a third, and estranged from his fourth because of his drinking. His family lives in Texas and "didn't bother with him." As if that weren't bad enough, he'd just been diagnosed with cancer again, in three places on his face, including his jaw (which explained the pain he was experiencing). Doctors told him he'd probably need a steel plate in his jaw, and another round of chemotherapy, which he said he wouldn't wish on his worst enemy.

As Mr. K continued to talk, I noticed that, although he was still upset, his voice had changed. He was no longer yelling, he was lamenting. By the end of our conversation, he was actually weeping.

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Clinical Narrative

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For a long time, I just sat by the bed with my hand on his and let him cry. I told him how sorry I was, and how I couldn't imagine what it must be like for him. For the first time in months, I felt like I was giving Mr. K exactly what he needed. I was able to show him that I recognized he wasn't just a patient in need of medical attention. He was a person who should be treated like one. He wiped his nose and actually cracked a smile. He told me I was the first person in months who'd touched him without gloves.

"I know I'm homeless and need a shower," he said. "But my illness is cancer and that ain't contagious. Sometimes I feel like I'm treated like a rabid dog." He said it jokingly, but I knew he was serious.

I asked Mr. K what we could do for him. He laughed and said he appreciated my asking.

"Usually I just get Valium and shoved back out on the street."

He went on to tell me that he didn't want to be treated for the cancer. He'd gone through that before and didn't feel he had the fight left in him. He understood he was living his life because of his own choices, and he didn't want to be in pain anymore.

"I've been in so much pain lately," he said, "I haven't been able to stay out of the Emergency Room for more than a few days." He asked me to ask the medical team if he could start taking two Percocets instead of one. He said he didn't want IV pain medication; he didn't want Oxycontin. Percocet worked for him, he just needed a larger dose. He knew he didn't have much time left, and he wanted to be comfortable.

I told him I'd talk to the team about increasing his Percocet, and I got him to agree to a pain consult. Finally, I asked if I could have a social worker check on him. I knew he'd be resistant to this, because he adamantly insisted he was managing on his own. As is often the case with homeless patients, he didn't want to accept outside support. I reminded myself that, although I may not understand or agree with his choices in life, it wasn't my job to judge. I was there to support him. But it had become clear to me that Mr. K was not currently able to manage on his own. I wanted him to talk with someone about his social and emotional needs. I knew a social worker could introduce him to a number of resources and help him choose the one(s) he felt comfortable with. He said it would be okay as long as they didn't make him go to a shelter.

"I live on the streets because that's where I'm happiest. You might not understand, but it's my choice to make."

I agreed to explain that to the social worker.

After leaving Mr. K's room, I went straight to the intern on call. We discussed my conversation with Mr. K and I told him I thought increasing his Percocet was a reasonable request. He was glad Mr. K had calmed down but leery about prescribing more Percocet in case Mr. K was 'med-seeking.' I told him I felt strongly that Mr. K was demonstrating actual pain. His vital signs supported that assessment, and according to report, he hadn't been able to eat much, a direct result of the pain in his jaw. I went on to say that, in my experience, patients who are med-seeking ask for stronger medications not higher doses of Percocet. I reminded the intern that I knew this patient very well and that Percocet had worked for him in the past. He said he'd write a prescription for the increased dose and we'd see what the Pain Service recommended the next day.

I immediately returned with the Percocet for Mr. K. I re-checked his vital signs, knowing that he'd calmed down. His blood pressure and heart rate had improved with his mood, but they were still higher than his baseline. This reinforced my belief that he was still in pain. He took the pills, thanked me, and asked me to close his door. I checked on Mr. K throughout the night; he seemed to be sleeping comfortably. Within an hour of taking his medication, his heart rate went to the 70s and stayed there for the rest of the night. I was satisfied that the medication had worked.

At 6:00 the next morning, I peeked into his room to see if he needed anything before I left. He politely asked if I'd help him into the shower. He thought a shower would make him feel better and he realized how offensive he smelled. When he got out, he combed his hair, shaved, and brushed his teeth. He told me how much he appreciated what I'd done for him the night before. He said it had been a long time since he'd been treated like a human being and he felt 'changed.' Mr. K admitted that he owed a lot of people an apology for being so rude. He said his behavior had been an emotional response to the stress he'd been under. It was easier to drink and be rude to people than deal with his problems. He had decided to give up on the world because the world had given up on him.

"But last night," he said, "I realized you were only trying to help. It's not your fault I'm the way I am—the drinking, the cancer, none of it. I know I'm never going to get better, but I'd like to work together to make the time I have left a little less painful."

In report at the end of my shift, I took a lot of time explaining to the incoming nurse what had happened overnight. I wanted her to be able to continue caring for Mr. K with an open mind and give him the respect he deserved. I wanted my fellow nurses to experience the same sense of reward and satisfaction I had felt caring for Mr. K.

Mr. K stayed with us for more than a week during that admission. Although I had advocated for an adjustment in his pain medication, I knew the more important intervention was an even stronger dose of trust, respect, and compassion.

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

This narrative is eloquent in its simplicity. What could be more basic than treating people with trust, respect, and compassion? When Katherine took the time to listen to Mr. K, simply listen, it changed everything. Katherine was willing to look beyond the 'homeless' label and see the person. She took off her gloves and held his hand, a gesture so powerful, Mr. K was moved to tears.

Katherine's experience and intuition told her that Mr. K was telling the truth when he asked for a higher dose of Percoset. She advocated for him with the intern on call. She shared the night's events with the nurse coming on duty to ensure continuity of care. In short, Katherine gave Mr. K the same individualized, high-quality care she would have given any other patient.

Thank-you, Katherine.

ENCARE: educating the public about safety and prevention

—by Ines Luciani-Mcgillivray, RN; Karen Celentano, RN; and Sabrina Fedrico, RN

ENCARE is a group of trauma nurses that uses its considerable knowledge and experience to try to educate communities about health risks and prevention. ENCARE, (Emergency Nurses Care) was created in the 1980s by two Emergency Department staff nurses. After a particularly busy weekend that involved a number of alcohol-related tragedies, these nurses looked at each and said, "If people could see what we see, maybe they'd think twice before drinking and driving." So they set about bringing that message to the people who need it the most.

ENCARE is the Injury Prevention Institute of the Emergency Nurses Association (ENA). ENA is comprised of emergency healthcare professionals world-wide, with almost 23,000 members. ENCARE has trained more than 8,000 healthcare professionals (registered nurses, emergency medical technicians, and paramedics). These individuals volunteer their time to educate the public about injury-prevention, the dangers of underage drinking, the importance of using safety belts, gun safety, pedestrian safety, bicycle safety, and helmet safety. ENCARE is active in all 50 states and Canada. Today, ENCARE reaches approximately 300,000 youths and 150,000 older Americans annually with its injury prevention programs.

Nurses and healthcare professionals who participate in these programs say the rewards are priceless. Being able to influence public opinion about injury-prevention is a powerful thing. Said one ENCARE volunteer, "As parents ourselves, we have many teachable moments and many stories to share."

Being an ENCARE volunteer can make a real difference in the community. Informing people about the choices they have and the potential outcomes of their decisions can prevent untold catastrophes. The ENCARE program focuses on real people not just statistics. Presentations are meaningful, and people relate closely to the stories. Using actual case scenarios, re-enactments show what happens when people make different choices about drinking, driving, seat belts, etc. There's a parable that goes along with this program that speaks to how one person can make a difference in the lives of others:

Once upon a time, there was a little girl standing on the beach. As she stood on the shore, waves threw starfish onto the sand. As that happened, she threw them back, one after another.

A man walked by and watched the little girl throwing the starfish into the water one at a time. After watching for a few minutes, he said, "What you're doing

continued on next page

During a recent ENCARE presentation at a local school, trauma nurses, Karen Celentano, RN (left) and Ines McGillivray, RN, demonstrate various pieces of equipment used to save lives in the Emergency Department

Staff Perceptions of the Professional Practice Environment Survey

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, answers questions about the Staff Perceptions of the Professional Practice Environment Survery

Question: What is the purpose of the Staff Perceptions of the Professional Practice Environment Survey?

Jeanette: The survey was developed to obtain feedback from staff about the environment of practice at MGH. We know that in order to enhance the quality of care, it's important for staff to feel supported in their professional practice. The survey is a 'report card' that I take very seriously. The Patient Care Services leadership team uses this feedback to identify opportunities to improve the practice environment for clinicians.

Question: Who receives the survey?

Jeanette: The survey is mailed to all direct-care providers within Patient Care Services because I want to hear what every person has to say. Every year, I hope for a high response rate, and this year, I'm looking forward to the best response rate yet.

Question: I know there have been changes in the survey in past years. Is there anything new this year?

Jeanette: Since 2003, clinicians have reported a desire to be able to complete the survey on-line. This year, for the first time, the survey will be available on-line. The Institute for Health Policy at MGH, will independently distribute the survey and analyze responses. They will collaborate with Dorothy Jones, RN, senior nurse scientist, in preparing the final report. If the on-line response is as strong as anticipated, the survey may be distributed on-line exclusively in subsequent years. During this year of transition, staff may choose to complete the survey on-line or by hard copy to ensure that everyone's voice is heard. The on-line survey will be distributed on September 7, 2006; the hard-copy version will be distributed on September 11th.

Question: Does my participation really matter?

Jeanette: Yes. If you have comments or suggestions about our practice environment, this is one of the best ways to make your opinions heard. Many programs and initiatives have been implemented based on feedback from this survey, including, the Culturally Competent Care Lecture Series, the Materials Management Nursing Task Force, pagers for social workers; even the question-and-answer column in *Caring Headlines* is the result of feedback from this survey.

Question: Are my responses confidential?

Jeanette: Yes. All survey answers are completely confidential. Each survey is tagged with a randomly generated ID number. That number is used *only* to allow clinicians to complete the on-line survey over several sessions (if they're unable to complete it in one sitting) and to prevent multiple surveys from being submitted by the same individual. Neither the ID number nor survey answers will be shared with anyone within Patient Care Services. Responses are not linked to individual names.

Question: Who sees the results?

Jeanette: Data from the survey is reported at three organizational levels: my executive team, discipline-specific leadership of the departments comprising Patient Care Services, and at the unit level. At each level there should be discussion about what the survey tells us and how we can use the information to improve our environment. This survey is an effective vehicle for capturing feedback, but it's only as effective as the people who respond. I hope you'll help me to make sure that MGH continues to be the "employer of choice" for the best and the brightest clinicians and caregivers.

ENCARE: Educating the Public

continued from previous page

makes no sense. You can't possibly keep up with the waves. What you're doing will make no difference at all."

As the little girl looked at the man, another wave threw a starfish onto the beach. She picked it up and threw it back into the water. She looked at the man and said, "It made a difference to that one."

We see and care for victims of many tragedies. We have special skills and knowledge and a credibility that only emergency healthcare professionals can bring to the community. We tailor our programs to specific age groups, starting as early as fifth grade. Collectively, the authors of this article have more than 60 years experience as MGH Emergency Department nurses. As emergency healthcare professionals, we have an obligation to educate people about how they can live healthy, safe life styles. Our mission is to reduce preventable injuries and death through education.

ENCARE nurses provide injury-prevention education to young people, parents, older adults, and the general public. Our programs include:

- DARE to CARE, aimed at middle schools and high schools. The program graphically show the consequences of drug use, under-age drinking, drinking and driving, and driving without a safety belt
- LEARNING to CARE, targets elementary schools, focusing on injury-prevention, bicycle- and helmet-safety, and an introduction to the dangers of drug and alcohol use. It is an interactive program with games, J-ello molds, and role playing
- TAKE CARE, is geared toward older adults, and it focuses on the effects of alcohol use, the interaction of alcohol and prescription (and non-prescription) drugs, safe medication use, doctor/patient relationships, and highway and pedestrian safety

For more information about any of the ENCARE programs, call Ines Luciani-Mcgillivray at 617-548-0096, or by e-mail: ilucianimcgillivray@partners.org.

The meaning of food and nutrition: a complex issue at the end of life

—by Marion Phipps, RN, clinical nurse specialist

Marion Phipps, RN
clinical nurse specialist

Providing end-of-life nursing care for individuals after a severe stroke is an important part of patient care on the neuroscience units. As one of the clinical nurse specialist on this service, I know that we learn much from every one of our patients and their families. From the experiences we've gained caring for these patients, we've built a repertoire of approaches that has improved care to all our patients. In doing this, we've established a rich narrative source to assist us in recognizing the complexities inherent in this practice. The following story demonstrates how difficult end-of-life care can be for families and clinicians.

In December of last year, an elderly man, I'll call him 'Mr. J,' was admitted after sustaining a devastating stroke. Upon admission to the unit, he was comatose and had a nasal feeding tube because he'd lost the ability to swallow. Though he couldn't move, he seemed quite distressed. His family was exhausted and anxious. Mr. J's daughter described her 86-year-old father as having been in a period of declining health. Two years before, he had developed sudden blindness and become confused and agitated, eventually requiring a psychiatric hospitalization. She told me her father was a Holocaust survivor who'd spent several years in a concentration camp. When he was released at the end of the war, he met his wife who was also a camp survivor, and together they emmigrated to the United States. After the war, her father talked very little about his experience in the concentration camp. One exception was when he described how he'd nearly starved during those years, and the importance that having enough food had taken on for his family. With the onset of his blindness, he had become frightened and began to imagine he was back in the camp. He became paranoid and required a psychiatric evaluation. Mr. J was able to return home with the support of his family and community agencies.

Throughout the first day of Mr. J's hospital stay, his daughter was very anxious. She told staff she couldn't stand seeing her father suffer. She felt the nasal feeding tube was causing him distress. But she said he couldn't be without nutrition. She stressed the fact that both her parents had nearly starved to death in concentration camps and that food was one of the most important aspects of life in their family.

The next morning, the neurology team informed the family that they believed Mr. J's potential for recovery was limited. His daughter told the team that her goal was to take her father home to die with supportive care. The team agreed with this decision and asked her about feeding options. She reiterated that her father could not be without nutrition. "How could he survive a concentration camp only to starve at the end of his life?" she said.

But she felt strongly that the naso-gastric tube was causing her father to suffer. The team suggested placing a gastric tube, and she agreed. His nurses removed the tube in the family's presence, and Mr. J immediately seemed more comfortable and relaxed. The family felt great relief that he no longer appeared to be suffering.

Together with our social worker, staff discussed the possibility of a Palliative Care consultation. The team agreed with this decision. Mr. J's daughter met with the palliative care team and felt totally supported in the decisions she'd made. Two days later, Mr. J had a gastric tube placed and went home the next day with 24-hour care.

Often in end-of-life care, there is a recommendation to discontinue fluids and nutrition because at the end of life there is decreased ability to manage excess bodily fluids, which can cause pulmonary congestion and suffering. In caring for Mr. J, the inter-disciplinary team knew that his family could not tolerate the discontinuation of nutritional support. The team supported this approach because it was appropriate given Mr. J's history. The care plan was developed recognizing that there is no one approach for all patients at the end of life. The inter-disciplinary team was informed and guided by the wishes of Mr. J's family who wanted the best for an honored and cherished loved one. As physician and author, Robert Coles, has told us, "The people who come to us bring us their stories. They hope they will tell them well enough so that we understand the truth of their lives. They hope we know how to interpret their stories correctly. We have to remember what we hear is their story."

Caring HEADLINES

Back issues of *Caring Headlines* are available on-line at the Patient Care Services website: http://pcs.mgh.harvard.edu/

For assistance in searching back issues, contact Jess Beaham, at 6-3193

MGH is committed to improving hand hygiene

Stop the Transmission of Pathogens
Infection Control Unit
Clinics 131
726-2036

Your mother was right…

- Hand-washing is one of the most important actions you can take to clean your hands and reduce the spread of germs
- Healthcare workers must also disinfect their hands to stop the spread of pathogens (germs that cause disease), and use a hand moisturizer to keep their skin healthy and intact

When should hands be washed?

- When visible or known soiling occurs
- After using the bathroom
- Before eating
- After any contact with patients known to be infected with *C. difficile* or their environment
- Hands should also be washed if they feel sticky from build-up of residue after repeated applications of Cal Stat or lotion
- Remember to dry hands well and use Cal Stat after washing (don't use Cal Stat before eating)
- Hand-washing removes build-up of dirt, soil, or Cal Stat residue, but germs can remain on the skin. After hand-washing, dry hands thoroughly and apply Cal Stat to kill remaining germs
- Wash hands but do *not* apply Cal Stat before eating. Cal Stat evaporates quickly, but it can leave a residue on your hands that could affect the flavor of your food

Glove Safety

- Gloves should *never* be worn from patient to patient, or from a dirty to a clean environment. Doing so can:
  - spread pathogens
  - cause infections
- Don't let your gloves become a launching pad for germs. When gloves are removed, microscopic spatter may contaminate hands and/or the environment
- Gloves should be removed carefully, following proper removal procedure, not with a stretch and snap
- After removal, dispose of used gloves immediately in the nearest appropriate receptacle

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A closer look at the nutrition screening process

—by Tiash Sinha, RD, clinical nutrition specialist

Our current nutrition screening process was introduced in 1997 in accordance with JCAHO regulations that required a nutrition screening for every patient within 24 hours of admission. The department of Food & Nutrition Services will soon be conducting a study to look at this screening process in a critical way. We hope to answer several questions that will give Nursing and Food & Nutrition Services a better sense of how well the process is working, and what, if anything we can do to improve it.

Currently, nurses screen all patients admitted to inpatient units at MGH. Nutrition screenings are part of the nursing assessment. This is a crucial component in identifying patients who may be at nutritional risk. Nurses ask a series of questions about the patient's weight, gastrointestinal issues (such as nausea/vomiting/diarrhea), diet prior to admission, and the presence of chronic disease. This helps identify patients with characteristics or risk factors associated with nutrition problems who may benefit from nutritional care. Malnutrition remains largely unrecognized in hospitals and is linked closely to a higher likelihood of complications, longer lengths of stay, and higher hospital costs. Nutrition screenings upon admission can help detect malnutrition as well as many other nutritional issues.

How do dietitians use the information collected in the nursing assessment? When a patient meets the criteria for a nutrition trigger, the registered dietitian (RD) assesses the patient's nutritional needs, establishes priorities, sets goals and objectives to meet the nutritional needs, and implements a plan of care. Patients are monitored, and changes are introduced based on the patient's response.

The study we will be conducting will evaluate the nutrition screening process. We will compare the nutrition screening information on the nursing assessment form with the information in physicians' admission notes. How closely do the two agree in terms of identifying nutritional risk and the presence of disease? Do we need to modify the questions to better capture the patient's nutritional concerns? Does the form reflect physicians' concerns for patients?

The data will be aggregated by service to determine whether there are differences from one service to another. The information will be collected from a review of medical records of adult patients previously admitted to MGH. The study will begin in the fall pending approval from the Institutional Review Board.

Once the study is completed and the data analyzed, our department will share the results with Nursing and collaborate on any changes that need to be made. The study will help us answer questions such as: Are there ways to improve patient care? Are there ways to improve the timeliness with which patients are seen by an RD? Do RDs need to explain in more detail the questions on the nursing assessment form? Does the form need to be revised?

We hope to be able to answer these questions and many others once the study is completed.

We thank nurses for working with us to identify patients at nutritional risk and for referring them to an RD in a timely manner. Please take a moment to review the nutrition/metabolic section of the nursing assessment form and let us know how we can make this study as useful as possible. If you have questions or comments, please contact Tiash Sinha via e-mail.

Tiash Sinha, RD
clinical nutrition specialist

Blood: there's life in every drop

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building

The MGH Blood Donor Center is open for whole blood donations:
Tuesday, Wednesday, Thursday,
7:30am–5:30pm
Friday, 8:30am–4:30pm
(closed Monday)

Platelet donations:
Monday, Tuesday, Wednesday, Thursday,
7:30am–5:00pm
Friday, 8:30am–3:00pm

Appointments are available for blood or platelet donations

Call the MGH Blood Donor Center to schedule an appointment
6-8177

When/Where	Description	Contact Hours
September 6 8:00am–4:00pm	**The Beat Goes On: Ventricular Devices for Treatment of Heart Failure** O'Keeffe Auditorium	TBA
September 7 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
September 7 8:00–4:00pm	**Oncology Nursing Concepts: Advancing Clinical Practice** Yawkey 2210	TBA
September 7 8:00am–12:00pm	**CVVH Core Program** Training Department, Charles River Plaza	TBA
September 8 and 13 8:00am–4:00pm	**Phase II: Wound Care Education** Training Department, Charles River Plaza	TBA
September 8 8:00–10:00am	**On-Line Patient-Education Resources** FND626	2.4
September 8 and 25 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	- - -
September 11, 13, 20, 22, 28, 29 7:30am–4:30pm	**Greater Boston ICU Consortium CORE Program** (check for locations)	44.8 for completing all six days
September 13 8:00am–2:00pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
September 13 11:00am–12:00pm	**Nursing Grand Rounds** "Mucositis." Haber Conference Room	1.2
September 13 1:30–2:30pm	**OA/PCA/USA Connections** Haber Conference Room	- - -
September 13 4:00–5:00pm	**More than Just a Journal Club** Yawkey 2210	1.2
September 15 and 18 8:00am–4:15pm	**Neuroscience Nursing Review Course** Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	TBA
September 20 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
September 20 8:00am–4:30pm	**Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other** Training Department, Charles River Plaza	7.2
September 20 8:00am–4:30pm	**Medical-Surgical Nursing Certification Prep Course** Yawkey 10-660	TBA
September 21 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)	- - -
September 21 8:00am–4:30pm	**Preceptor Development Program** Training Department, Charles River Plaza	7
September 21 11:00am–12:30pm	**Chaplaincy Grand Rounds** "An Introduction to Hinduism." Yawkey 2-220	- - -
September 26 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
September 27 8:00am–2:00pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
September 28 12:00–4:00pm	**Basic Respiratory Nursing Care** Sweet Conference Room	- - -

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.

You don't need a reason to give blood... But if you did...

- When you give blood, your donation is separated into three parts:
  - red cells can be used to treat trauma and surgical patients
  - platelets are used to care for cancer patients
  - plasma helps burn and hemophilia patients
- One donation can potentially help three people
- Sickle-cell-anemia patients can use up to five pints of blood per month
- The need for blood increases with advances in medical technology
- MGH is the largest transfuser of blood in Massachusetts, and one of the largest in the nation
- Every two seconds, someone needs blood
- Only 5% of eligible donors donate blood
- The number-one use of blood is treating cancer
- There's a 97% chance you'll need blood in your lifetime
- One out of every ten hospital patients needs blood
- Treatment for cancer, organ transplants, and surgery depends on the availability of blood
- The nations blood supply has decreased by 3% *per year* since 1987
- When you donate blood, your blood pressure, pulse, temperature and iron level are checked, and you'll be notified if any abnormalities are found
- Giving blood is safe, simple, and satisfying
- Type O is the most common blood type. Type O can safely be transfused to patients with any other blood type and is frequently used in emergencies. Because of its compatibility with other blood types, type O is the most widely used and frequently needed blood type

Call for Nominations

Stephanie M. Macaluso, RN, Excellence In Clinical Practice Award

The Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award recognizes direct-care providers throughout Patient Care Services whose practice exemplifies the expert application of values reflected in our vision. Nominations are now being accepted for the 2006 awards. Staff nurses, occupational therapists, physical therapists, respiratory therapists, speech-language pathologists, social workers and chaplains are eligible.

- Direct-care providers may nominate one another. Nurse managers, directors, clinical leaders, health professionals, patients, and families may nominate a direct-care provider
- Nominations can be made by completing a brief form which is available on patient care units, in department offices, and at the Gray information desk.
- Nominations are due by October 9th
- Nominees will receive a letter informing them of their nomination and requesting they submit a professional portfolio. Written materials on resume-writing, narrative-writing, and endorsement letters will be enclosed
- The review board that selects recipients is comprised of previous award recipients, administrators, and MGH volunteers

Award recipients will receive $1,500 to be used toward a professional conference or course of their choosing. Recipients will be recognized at a reception in their honor, and their names will be added to the plaque honoring Macaluso award recipients.

For more information or assistance with the nomination process, contact Mary Ellin Smith, RN, professional development coordinator, at 4-5801

Caring HEADLINES

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