

February 16, 2006

Caring

HEADLINES

Celebrating three years of pet therapy at MGH

(See story on page 4)

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Ella, a 9-year-old Boykin Spaniel, and her handler, Lois Cheston (left), visit patient, Loretta Wallace, on the Bigelow 11 Medical Unit

Patients first: historic, far-reaching, patient-safety initiative

Until recently, patients and families choosing a health-care facility had no way of evaluating a hospital's ability to provide safe, high-quality care. On January 27, 2006, that all changed when the Massachusetts Hospital Association (MHA) and the Massachusetts Organization of Nurse Executives (MONE) launched Patients First, an historic initiative designed to reduce medical errors, promote supportive work environments for caregivers, and provide the general public with key information to make informed decisions about healthcare institutions.

The Patients First initiative establishes new standards of transparency and accountability with public posting of staffing plans for every unit in every hospital in the state. MGH and the 67 other acute-care hospitals in Massachusetts are the first in the nation to voluntarily enact a policy that publicly reports unit-by-unit staffing plans. Effective immediately, patients and families can go to the Massachusetts Hospital Association website, www.patientsfirstma.org, to see a comprehensive list of the staffing plans for

every unit in every hospital in Massachusetts. This is unprecedented public access to important, safety-related information.

A 2004 National Quality Forum report observed that, "Nurses, as the principle front-line caregivers in the US health-care system, have tremendous influence on a patient's healthcare experience." I'd be willing to wager that anyone who's been a patient in a

hospital would agree with that statement. So having access to a hospital's staffing plans and other nursing-related quality indicators gives patients and families a tool, a report card of sorts, by which to measure nursing's contribution to, and impact on, safe, high-quality care.

The National Quality Forum compiled a list of standards to help measure, or quantify, the quality of nursing care (see

list below). It's the first time a set of national standardized performance measures has been compiled for the purpose

of assessing nurses' contribution to quality of care and patient safety.

According to a recent *Boston Globe* article by Liz Kowalczyk, there is "a growing body of evidence that suggests the more time nurses spend with patients, the fewer complications patients have, and the more likely they are to survive their illness or surgery."

It's understandable, then, that consumers would want to know how much time nurses spend with patients and how frequently complications occur at various hospitals.

The next phase of the Patients First initiative will involve publicly reporting nursing-sensitive indicators the same way staffing plans are reported now. Drawing from the list compiled by the National Quality Forum, hospitals will submit data each month on three key nursing-sensitive indicators:

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

Standards of Nursing-Sensitive Care (a national voluntary consensus)

<p>Patient-centered outcome measures</p>	<ul style="list-style-type: none"> ● Death among surgical inpatients with treatable serious complications (failure to rescue) ● Pressure ulcers ● Falls ● Falls with injury ● Restraint use (vest and limb only) ● Catheter-associated urinary tract infection for intensive care unit (ICU) patients ● Central-line, catheter-associated, blood stream infection rate for ICU and high-risk nursery patients ● Ventilator-associated pneumonia for ICU and high-risk nursery patients
<p>Nursing-centered intervention measures</p>	<ul style="list-style-type: none"> ● Smoking-cessation counseling for acute myocardial infarction patients ● Smoking-cessation counseling for heart-failure patients ● Smoking-cessation counseling for pneumonia patients
<p>System-centered measures</p>	<ul style="list-style-type: none"> ● Skill mix: registered nurses (RNs), Licensed Vocational/Practical Nurse (LVNs/LPNs), unlicensed assistive personnel, and contract help ● Nursing care hours per patient day (RNs, LPNs, and unlicensed assistive personnel) ● Practice Environment Scale: Nursing Work Index (composite and five subscales) ● Voluntary turnover

Responding to disasters at home and abroad: a look at the MGH IMSuRT team

Question: Over the past few years we've seen a number of international disasters. I know a group from MGH is deployed to help with these emergencies. What is that group, and how did it come about?

Jeanette: The national disaster medical system is part of the federal disaster response plan. It is designed to provide medical care for disaster victims by triaging patients, stabilizing patients, and planning for evacuation. Disaster medical assistance teams (DMATs) are part of the

government response network.

Traditionally DMATs have responded to natural disasters such as hurricanes, floods, and earthquakes. In August, 1998, when US embassies in Kenya and Tanzania were bombed, the US government sent traditional (military medical) teams to assist. They quickly realized there was a need for civilian disaster medical teams to assist when help was needed for our citizens on foreign soil.

In 1999, at the request of the US State Department, MGH was

asked to sponsor the first civilian international medical surgical response team (IMSuRT).

Question: Had MGH done this before?

Jeanette: MGH has been responding to disasters for a long time. Records show that medical teams were assembled during World War I and World War II to help meet wartime needs. When a ship exploded in Halifax in 1917, a number of Boston hospitals, including MGH, sent medical teams to assist with that disaster.

Question: How did the IMSuRT team get started at MGH?

Jeanette: Susan Briggs, MD, one of our surgeons, was charged with organizing the team, which was the first IMSuRT team in the country. Today, there are three teams based in different parts of the country.

The MGH IMSuRT team consists of nurses from a number of acute-care settings, surgeons, anesthesiologists, pediatricians, physicians, respiratory therapists, pharmacists, and non-medical staff who deal with operational issues and communication. About thirty clinicians staff each team, but teams are flexible and can be

modified to meet the needs of each disaster situation. IMSuRT team members are always on call and need to be available within six hours of being called.

Question: What is the mission of the team?

Jeanette: The original mission was to supplement the work of local medical staff. They are expected to stay for two weeks if deployed inside the United States, three weeks in other countries. Team members assist in triage, evacuation, and providing emergency medical care.

Teams were originally deployed at the request of the State Department. Now the department of Homeland Security oversees the IMSuRT teams.

Question: How do they train?

Jeanette: IMSuRT team members are affiliated with disaster training medical teams (DMATs) and train in the same way. They undergo intensive training in a specialty field each year.

IMSuRT is a multidisciplinary team designed to respond to any national or international disaster.

For more information about the IMSuRT team, contact Marie LeBlanc, RN, staff specialist, at 3-2864.

Jeanette Ives Erickson

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number of falls, number of falls that result in injury, and number of instances pressure ulcers occur. One other indicator will be chosen by each hospital, to be selected from: ventilator-associated pneumonias, central-line infections in the ICU and high-risk nursery, or Practice Environment Scale: Nursing Work Index.

The preliminary work for this phase of the initiative will begin in March, and roll-out is expected in the coming year.

This is an exciting time. We're part of a ground-breaking effort to improve the quality of health care, give consumers an honest look at information they need to make informed decisions, and recognize nurses for the invaluable contributions they make to patient care and safety.

Over the past few months, MGH Nursing has launched its own website devoted to quality and safety. Thanks to the efforts of a team led by Joan Fitzmaurice, RN, director of the Office of

Quality & Safety, and Carol Camooso, RN, staff specialist, the website can be accessed at: www.massgeneral.org/nursingquality. A dynamic, frequently updated website, it offers pledges, testimonials, and a number of quality measures and indicators. Currently, pledges include:

- A registered nurse will be responsible for your nursing care at all times
- If you have pain, your nurse will take your pain seriously

Quality measures, which will be changed and updated periodically, currently showcase data from the 2005 Press

Ganey Patient Satisfaction Survey, hours of nursing care delivered per day at MGH, and the success rate of recruiting and hiring new nurses.

Our Nursing Quality and Safety website is another example of our desire to provide consumers with meaningful information they can use to make well-informed choices.

I hope you'll visit the Massachusetts Hospital Association website and our own Nursing Quality and Safety website to see the important work we're doing to keep patients safe and healthy.

Alternative Therapy

Sometimes a warm heart and a cold nose are just what the doctor ordered!

—by Mandi Coakley, RN, staff specialist

The Pet Therapy program at MGH, which is co-managed by Volunteer Services and the department of Nursing, turns three years old this month with more than 5,000 patient visits under its belt. The program started on three inpatient units in 2003 and has grown to encompass ten units, including the Cardiac Intensive Care Unit. And patients aren't the only ones who benefit from visiting with pets. Therapy begins the moment volunteers enter the hospital with their dogs, bringing smiles to all they encounter.

Pet Therapy volunteer, Bobbi, and her black Lab, Sammy, went to a patient care unit they'd visited before and went into the room of a patient who hadn't been able to speak since suffering a stroke. When he saw the Lab, he leaned forward with bright eyes and mouthed the word, "Sammy!" It was the first time he'd tried to speak.

In the Gray Family Waiting Area, anxious families are grateful for a chance to pet Ella, a Boykin Spaniel, who's accompanied by her handler, Lois. Families report that visiting with pets helps pass the time and ease the anxiety.

Even end-of-life situations can be softened by a visit from a gentle pet. Recently, as a family gathered at the bedside of an ill daughter, she requested a visit from George, a friendly, oversized St. Bernard, and his handler, Jack. In an otherwise still and somber room, George provided a link to happier times and gave the family a chance to enjoy interacting with a playful dog for a few moments.



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*They don't call it pet
'therapy' for nothing!*



The Enteral Feeding Unit: what is it and what do they do?

—by Martha Lynch, RD, senior manager, Clinical Nutrition Services

Boxes start to arrive from patient care units requesting highly specialized food products: 500cc Nepro plus 500cc Suplena divided evenly into three Abbott

bottles; Premature Enfamil 24 with ProMod, corn oil, and Neosure; a quart of high-calorie, high-protein sherbet shake.

Not everyday jargon for most, but it's routine language for employees

in the Enteral Feeding Unit (EFU). It's in the EFU that tube feedings, infant formulas, and liquid food supplements are prepared every day. Why is this necessary? Many patients (adults,

adolescents, and toddlers) are unable to take food by mouth, or the amount of food they can take by mouth isn't enough to meet their calory and protein needs. Many premature and newborn infants require special formulas and nutrients to meet their individual needs. We're fortunate to have a special unit where these products can be

prepared. It adds a dimension to patient care that many hospitals can't or don't offer.

Decisions about specialized food products are individually tailored to each patient. Registered dietitians (RDs) read the medical record to learn the reason for admission and determine the best nutritional plan for each patient. Patients and family members are often able to provide information about current weight, weight history, and eating issues that help the RD make a decision about what will be needed during hospitalization. The RD makes recommendations to the medical staff and orders are written.

Why does an RD select one product over another? The protein, fat,



At left: Mildred Taylor (39-year veteran of MGH; 33 years in the EFU) prepares special formula for premature infant.

Below left: Rosa Sanhueza (newest member of the EFU staff, joined the team six months ago) sets up tray of nourishments for patient care units. Trays will be delivered with patient meal trays.

Below right: Ginny Chang (14-year veteran of MGH; 11 years in the EFU) pours tube feeding she's just prepared into bottles for adult patients.

Not pictured are weekend employees: Francisca Nogbou and Katie Tobias



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Durant Seminar Series: a forum for sharing knowledge and strategies on global health care

On January 20, 2006, Kristian Olson, MD, presented, "Primary Health-care Rehabilitation in Tsunami-Affected Areas of Aceh," the second offering in the Durant



Seminar Series on global health care. Olson, a veteran humanitarian caregiver who has served in Thailand, Darfur, and Aceh, shared his experiences working in politically unstable and underserved areas. He spoke about, "the disease of displacement" that occurs when people are uprooted by natural disasters, war, and political unrest.

Olson noted that, though it's not widely reported in mainstream media, the universal effect of these catastrophic events is high death tolls, a lack of education in how to respond, poor tracking and surveillance capabilities, and limited access to basic medical care and immunizations.

In many cases, the ensuing political climate and limited resources make it difficult, often impossible, to provide care to those who need it most. Olson stressed the need for those involved in humanitarian aid to share the lessons they've learned, teach one another, and publicize best practices.

In some of the poorest areas, medical services are non-existent. Midwives may be the primary source of health care for an entire region. Specialized equipment, even basic medical instruments, are simply not available. Accurately assessing the needs and capabilities of local medical services is key.

Olson recommends establishing a system of case management and sharing clinical skills. He recognizes a need for donations of basic medical equipment and sup-

plies as well as building materials, bricks, and mortar.

Perhaps the most important element in providing care in underserved areas, said Olson, is establishing an infrastructure and creating sustainable systems to support that structure. Establishing effective surveillance and tracking systems are other important steps you can take. Eliminating duplication of efforts, and finding ways to encourage creative financing are high on the list.

Olson hopes that the MGH community will continue to provide care and services to those areas around the world that are in most need.

Durant Seminars are held twice a month and focus on global health issues. Seminars are open to the entire MGH community. For more information, call Larry Ronan, MD, at 6-7930.

Enteral Feeding Unit

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and carbohydrate content of each food varies. Some products contain fiber, others have no fiber at all. The electrolyte and mineral content of products vary, too. All decisions are based on the patient's condition.

Patients with burns require both calories and protein for healing. Patients with end-stage renal disease have impaired ability to process protein, electrolytes, and certain fluid. Some in-

fant's are unable to process specific amino acids. And many patients have multiple issues that must be taken into account.

RDs check orders each morning and send a fax to the EFU with a list of tube feedings, infant formulas, and supplements needed for each patient care unit. They provide recipes for patients requiring ingredients or products to be mixed. And EFU employees take it from there,

using ready-to-eat products, products that need to be diluted, powders that need to be blended, and products enhanced with additives such as protein powder. EFU employees maintain an index of all the special recipes. They print labels with the patient's name, unit, room number, product, rate of delivery, and expiration date. They prepare products, separate them by unit, and double-check everything. There is no way to over-emphasize the need for accuracy and safe preparation techniques.

Data Center employees deliver all adult products to refrigerators near the nursing stations. One EFU employee delivers formulas and feedings to the pediatric units. Outdated products are discarded when new products are delivered.

EFU employees are experts at what they do. They pay attention to every detail and carefully follow safe, sanitary, food-handling practices. Though seldom seen, EFU employees quietly provide behind-the-scenes preparation of tube feedings, infant

formulas, and supplements for many of our sickest patients.

Says Mildred Taylor, EFU team member, "I try to do a good job. I work hard to make sure that patients' feedings are accurate and safe. Even though I don't see them, I want patients to receive the same quality care I would want for my family."

For more information about the work of the EFU, contact Martha Lynch, senior manager, Clinical Nutrition Services, at 6-2587.

Paradigm experience allows PT to add new tools to her toolbox

Caroline Fitzgibbons is a clinician in the PCS Clinical Recognition Program

Cancer: a word that has a scary definition. The dictionary defines cancer as, “something evil or malignant that spreads destructively.” Over the past year I’ve seen first-hand how cancer can invade a healthy body and slowly or quickly destroy it. A diagnosis of cancer is often interpreted as a death sentence.

Hope: a word that signifies light at the end of the tunnel. A word that has many meanings to many people. Hope is defined as, “an expectation of fulfillment of success.” To many, it is the will to live, the will to keep fighting, or the will to see a grandchild one last time. For others it’s the readiness to die at peace.

It wasn’t until I spent time on Ellison 14, the Oncology Unit, that I began to understand the connection between these two very different words: cancer and hope.

In a year on Ellison 14, I learned a lot about cancer, its treatment, and the physical-therapy management of patients with cancer. One lesson I took away from this experience is the importance of making a connection with patients who are going through this momentous

time in their lives. Through many discussions, quiet moments, exercises, and walks, I’ve learned what it really means to my patients to have cancer. I’ve learned how to have discussions with people about their goals during a very difficult time in their lives.

Through these interactions, I’ve realized that being a physical therapist on a cancer unit is a unique opportunity. In a sense, you get to be part of that ‘ray of hope’ as you may be, “the one who gets me strong, gets me home, gets me out of this bed, this room, this hospital.”

There have been many, but one patient interaction was particularly meaningful to me in my understanding of the end of life and my growth as a physical therapist.

Joe was a 39-year-old lawyer diagnosed with metastatic melanoma that started as a mere freckle on his thumb. Over a period of months, Joe went from working 60–80 hours a week and spending time outdoors with his girlfriend, to being completely dependent for mobility and activities of daily living.

When I met Joe, he and his family were in discussions with the medical team about whether

to pursue further treatment. He was contemplating whether to have another round of chemotherapy, which would be considered palliative, or receive comfort measures only.

Going into a situation like this is never easy no matter how many times you’ve done it. For me, it hadn’t been many, so it was just plain hard. When I decided to be a physical therapist, I thought I’d be helping patients ‘get better.’ I never really thought about caring for patients who were dying. After working in a hospital for two years, I knew this was part of the reality. But you never really learn to handle a situation like this until you’re in one.

I walked by Joe’s room to get a mental picture of what I was getting into and how I would position myself in the room. I thought about the words I would say and how I would say them. I had had a consult on this patient, and I knew the nurses had had difficulty getting him out of bed. What I didn’t know was how this patient and his family were going to react to me. Part of me thought they’d want nothing to do with me as they had more important things to think



Caroline Fitzgibbons, PT
physical therapist

about. Part of me knew I had skills that could help Joe achieve his goals and make him more comfortable at the end of his life.

As I entered Joe’s room, I introduced myself to Joe, his girlfriend, and his mother. I was nervous and felt like I was imposing a little. I tried to put myself in their situation—how would I feel if a physical therapist came into my room when I was dying. I was afraid they’d abruptly say ‘No thank-you,’ or ‘He’s dying, he doesn’t need to exercise!’

I entered with a friendly upbeat manner and showered them with niceness. I soon realized I needed to change my tone. Joe’s girlfriend was sitting at his bedside crying quietly. Joe’s mother was holding his hand. I softened my voice and asked if I could sit with them for a few moments to talk about what I had to offer as a physical therapist while Joe was in the hospital.

I began by addressing Joe directly, speaking and looking directly at him. I explained that I was there to examine him to determine if there was anything I could do to assist him in his ability to mobilize or be more comfortable. I quickly learned that Joe was only able to communicate minimally. He occasionally answered, ‘Yes’ or ‘No,’ in a mumbled fashion and moaned to express discomfort. The family was interested and came closer to be part of the conversation and to help answer questions. They were doing their best to answer and include Joe in the conversation, saying, “Right Joe? You like to exercise, be on the go, be busy?”

Joe’s family was eager to tell me about his hobbies and work as a lawyer. They told me he didn’t like being in bed and had expressed a desire to go to work, go home, but most of all, get out of bed.

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Some portions of this text have been altered to make the story more accessible to non-clinicians.

Clinical Narrative

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I guess you could say Joe's family made things easy for me, as easy as they could be in this situation. They responded well to me and were interested in what I had to say. Still, I found myself having to think carefully about the words I chose and how I said them. I consciously tried to use the present tense, avoiding statements about what he couldn't do, and emphasizing how I could help.

As we moved through

the examination, I noted how swollen Joe's extremities were and how little he was able to move his body. Joe followed commands inconsistently and moved minimally. His mother commented that she liked how gentle I was with him and would appreciate my help in assisting her son to move in any way possible. I could tell we were all on the same page. Joe's family had hope, not that he'd get stronger or live,

but that he wouldn't suffer. And they looked to me for hope.

The next day, Joe's condition continued to deteriorate. He and his family decided on comfort measures only. The medical team determined that Joe had only days or weeks to live.

I proceeded with my plan of care to achieve Joe's goals. I felt the best way to help him get out of bed was to dependently slide him to a chair. I ordered a bariatric stretcher chair because of the amount of swelling he had. Over the next four days, I saw Joe every day for positioning in the bed and the chair, range-of-motion exercises for his extremities, and gentle stretching of his neck and shoulder muscles. I included his girlfriend and mother, and they performed these tasks meticulously as Joe indicated it made him feel better.

The day before Joe died, I entered his room at my scheduled time. His father was sitting at the bedside holding his hand, both of them asleep. As I turned to leave, Joe's father woke up and told me to come in. I could see the hope in his eyes as he stood quickly to greet me. He showed me a picture of Joe and his brother playing basketball. He called Joe, "my boy," and I could see how proud he was. His father was eager and hopeful for me to help. He didn't have false hope.

He knew his son would never play basketball again, but he had hope that I could help his son be comfortable.

That morning, Joe's nurses and I assisted him into his chair and wheeled him into the lounge. Joe and his family sat in the lounge on a bright and sunny day looking out over the city.

The next morning as I stepped out of the elevator onto Ellison 14, I saw Joe's family. They were crying as they got into the elevator. They quietly said hello and the elevator doors closed. I realized Joe had died and they had just said good-bye to him. Unfortunately, I didn't have an opportunity to express my condolences.

The following week, I was approached by Joe's primary nurse. She told me Joe's family wanted to thank me for making their son comfortable at the end of his life. I felt honored and proud that I had been able to provide hope.

I chose to write about this patient because I felt I helped Joe and his family have a positive experience in achieving their goals at the end of Joe's life. I chose this case because it was extremely challenging in terms of approach and communication. The experience taught me to approach each situation with an open mind, knowing that people's goals at the end of life may vary greatly. I learned to focus on pa-

tients' values and what's really important to them. I became more confident in my skills working with patients at the end of life. I learned to modify my tone, voice, and words according to verbal and non-verbal feedback from patients and families.

This case impacted me personally, as it made me think about death in a different way. It made me think about death and the process of dying as *part* of life instead of the end of it. It made me realize that as a physical therapist, I can impact another person's life during this very significant phase.

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

In this beautiful narrative, Caroline describes a paradigm experience in her understanding of the work of physical therapy and her role as a therapist. Not only did she use her clinical knowledge and skills, she let her compassion guide her interactions with Joe and his family. She was honest, direct, and caring as she learned about Joe, his condition, and his goals. She actively involved his family in his care. Her interventions brought him comfort and helped him achieve his goal of getting out of bed.

This is a wonderful story of hope and caring and learning, three things we all strive for.

Thank-you, Caroline.

Quick Hits to improve your writing!

A low-stress, high-yield class aimed at helping you develop your writing style and eliminate some of the angst commonly associated with writing

Offered by Susan Sabia,
editor of *Caring Headlines*



Classes now scheduled for:

Monday, February 27, 10:00am–1:00pm
Wednesday, March 15, 12:00–3:00pm
Monday, April 17, 11:00am–2:00pm
Tuesday, May 30, 11:00am–2:00pm

All classes held in GRB-015
Conference Room A

Classes limited to 12; pre-registration is required
To register, call Theresa Rico at 4-7840

Job Shadow Day, a career-exploration opportunity for high-school students



—by Galia Wise
manager, MGH-East Boston
High School Partnership
Program

Ground Hog Day is the annual event that piques our anticipation of spring's arrival. As legend has it, the ground hog emerges from his den, and if he sees his shadow, it means six more weeks of winter. MGH is part of another tradition that involves shadows—Job Shadow Day.

On February 2, 2006, more than 20 students from East Boston High School, MGH's partner in education, visited MGH to learn more

about careers in health care by 'shadowing' staff for several hours in the morning.

Job Shadow Day provides students with an opportunity to learn about professionalism, work decorum, and the 'nuts and bolts' of health care by spending time with, observing, and in many cases, participating in hands-on experiences with healthcare professionals. Students have a unique opportunity to see what careers in health care can offer and decide whether they're suited to work in a hospital setting. Job Shadow Day is a mutually beneficial experience for students and hosts as they exchange ideas and learn from one another. Like the ground hog who sees his shadow, stu-

dents emerge with a better understanding of what the future may hold.

At MGH, students shadowed employees in a number of departments, including: Social Services, Radiation Oncology, Information Services, Cardiac Surgery, Infectious Disease, Neurology, Radiology, Outpatient Pediatrics, Nutrition & Food Services, the Bulfinch Medical Group, Human Resources, Materials Management, and many others.

Almost 800 Boston high-school students shadowed more than 120 employees in various businesses throughout the city on February 2nd. What started as a small program in Bos-

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Above: administrative manager of the ambulatory Shoulder and Sports Medicine Clinic, Christine Simmons (standing), with East Boston High School student and the Job Shadow Day ground hog.

At right: Clinical social worker, Sue Streater, LICSW (left), with student (right) interviews patient, Arieh Katz, and his wife, Pamela Adams Katz, on the Transplant Unit.



Right patient, right treatment, two identifiers

—by Katie Farraher, senior project specialist
Office of Quality & Safety

We all know how busy it is at MGH. We're constantly reminded what needs to be done to keep patients safe; and in this fast-paced environment, that's not always easy. But patient safety is something we take very seriously. You may think it's routine, but proper patient verification needs to remain a top priority. Proper patient verification is one of the National Patient Safety Goals established by the Joint Commission of Accreditation of Health Care Organizations (JCAHO), and it will be a key area of focus as we approach our 2006 survey. As you're probably aware, JCAHO no longer announces its arrival, so we could be surveyed at any time.

One National Patient Safety Goal mandates that two patient identifiers be used before any treatment. MGH has elected to use the patient's name and medical-record number as the two standard identifiers in all *inpatient* care areas. In *outpatient* areas, the patient's name and birth-date are used.

Before beginning any treatment, clinicians must ensure that the name and medical-record number on the patient's wristband match the patient's name and the number on the requisition or medical administration record (MAR). If there is a mismatch with either the name *or* medical-record number, clinicians should stop, verify the information, and correct the pro-

blem. If the patient is not wearing a wristband, *no treatments should be provided* until a wristband has been applied and the information on it is verified and matches the requisition or MAR.

Because two identifiers need to be checked before any treatment is provided, diagnostic tests are included. Never send a patient off the unit for a test or procedure without checking that he/she is wearing a wristband.

The purpose of using two identifiers is to ensure that *the right patient* is receiving *the right treatment at the right time*. To avoid errors in patient identification, always match both the name and medical-record number on the wristband with the name and medical-record number on lab or procedure requisitions, treatment sheets, and MARs.

In meeting JCAHO's National Patient Safety Goals for 2006 and maintaining our own high standards for quality and safety, we must be vigilant in our use of two identifiers before performing any treatment or procedure.

For more information about the National Patient Safety Goals or the JCAHO survey, call Katie Farraher in the Office of Quality & Safety at 6-4709.

Ground Hog/Job Shadow Day

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ton in 1996, Ground Hog/Job Shadow Day now involves thousands of Massachusetts students and hundreds of thousands of students nationally. Locally, Job Shadow Day is a partnership sponsored by the Boston Public School System, the Boston Private Industry Council, and the Massachusetts Department of Education and Junior Achievement.

Ground Hog/Job Shadow Day is supported by the MGH-East Boston High School partnership and is a program of the School Partnership Initiatives in the MGH Community Benefit Program.

For more information about the MGH-East Boston High School Partnership program, please call 4-8326.

MGH Chaplaincy Ash Wednesday Schedule

**Ash Wednesday, March 1, 2006
Services in the MGH Chapel on Ellison 1**

- Roman Catholic Mass: 11:00am and 4:00pm
- Ecumenical service: 12:15pm
- Ashes will be distributed in the Chapel between 9:00am and 5:00pm
- Every effort will be made to bring ashes to patient care units between 8:00am and 4:00pm

Chapel services are broadcast on channel 16 of the in-house television system

Ashes will be distributed at:

- Charlestown Navy Yard
- Charlestown Health Center
- Chelsea Health Center
- Revere Health Center
- Massachusetts Eye And Ear Infirmary

For further information, call the MGH Chaplaincy at 6-2220

New medication information available on MGH Intranet

The Medication, Education, Safety, and Approvals Committee (MESAC) is pleased to announce the new website:
<http://intranet.massgeneral.org/mesac>,
the best source of information on the safe prescription and distribution of medications.

Website includes:

- guidelines for clinical practice
- clinical policies and procedures
- information on herbs and dietary supplements, drug interactions, formulary changes, and new drug approvals
- procedures for obtaining new drug approvals,
- tools for calculating correct drug doses
- links to on-line continuing education sources.

An interactive component, "Your medication questions answered by MGH experts," is also available.

Visit: <http://intranet.massgeneral.org/mesac>
for the most up-to-date drug information at MGH

For more information,
call Miriam Greenspan, RN, at 4-3506

New products and innovative thinking contribute to patient safety on Bigelow 9

—by Susan Gavaghan, RN, clinical nurse specialist

My name is Susan Gavaghan, and I have worked as a nurse at MGH for 25 years, most recently as clinical nurse specialist on Bigelow 9. Bigelow 9 serves two very different populations with ten respiratory acute-care beds and eight beds for medical patients. The medical beds are served by Medical Team 4, which is comprised of physicians, a nurse practitioner, and case managers. Mr. D was a Medical Team 4 patient, and I hope his story will demonstrate how we're always looking for creative ways to care for patients safely and thoughtfully.

Mr. D is a 71-year-old man who was admitted from home due to a decline in cognitive status

and a gait disturbance. He had a complex medical history and a history of dementia, which until this admission had been fairly mild. Mr. D's medical work-up included thorough neurological testing, but neurologists found nothing they attributed to the cause of Mr. D's increased dementia and gait disturbance. There was not going to be an easy solution.

Medical and neurological services felt an admission to a rehabilitation facility would help increase his endurance, at which time a follow-up neurological appointment would be appropriate to reassess the situation.

Mr. D's family was very supportive and wanted to do whatever was

possible to help him regain the highest level of functioning he could achieve. Physical and Occupational Therapy set up daily routines for his activities. Staff nurses and PCAs would ensure the routine was carried out on a daily basis. Still, Mr. D required a 1:1 observer, because he was impulsive and at high risk for falling. Observers stay at a patient's bedside and alert the nurse if the patient tries to do anything that might put him/her at risk.

The Team 4 case manager began the screening process for rehabilitation facilities, but she knew Mr. D had to be free of an observer for 24–48 hours before a facility would accept him. As time went on, Mr. D and his family became frustrated with the situation. The question became how to safely care for Mr. D, and at the same time discontinue his observer.

The Team 4 nurse practitioner and I assessed the situation. She had experience with a similar situation where she'd been able to use several special devices to help keep the patient safe, freeing him of the need for an observer. These devices included: a 'low bed' (a bed, which, in its lowest position, is only 17 inches from the floor);



Sue Gavaghan, RN
clinical nurse specialist

mats placed around the bed; and hip protectors that pad the hips to help prevent fractures if the patient falls. Also, some patients are unable to lift themselves to a standing position from 17 inches off the ground, so the bed reduces the risk of falls in that way, too.

I recalled a recent communication about new products available for fall-prevention. Discussion with a CNS colleague led me to bed and chair alarms. The chair alarm is a 'seat belt' the

patient can unbuckle, but an alarm sounds alerting the nurses. The bed alarm is encased in a strip that's placed under the sheets; it sounds when the patient's shoulders move away from the mattress. Neither of these devices is considered a restraint as the patient is able to move about freely.

After discussing these options with Mr. D's family, they agreed all the devices would be helpful. The nursing staff was eager to try them.

continued on next page

Clinical Recognition Program

Advanced clinicians and clinical scholars recognized from November, 2005–February, 2006

Advanced clinicians:

- Lori Darragh, RN, Cardiac Surgery
- Rachel Bolton, RN, Radiation Oncology
- Denise Dreher, RN, IV Therapy
- Mary Louisa Zwirner, LICSW, Social Services
- Amy McCarthy, RN, Orthopaedics

Clinical scholars:

- Janet Kimbrough, RN, Post Anesthesia Care Unit
- Kelley Grealish-Kelly, RN, Same Day Surgical Unit
- Barbara Levin, RN, Orthopaedics

MGH Resources for People with Disabilities

MGH Disabilities Awareness Day gives staff and visitors an opportunity to learn more about resources available to people with sight, hearing, and mobility limitations. The event marks the unveiling of the Blum Patient & Family Learning Center's new Disability Access Center.

The event is sponsored by the MGH Council for Disabilities Awareness

February 28, 2006
10:00am–4:00pm
Blum Patient & Family Learning Center

For more information, contact Carmen Vega-Barachowitz, SLP, at 4-0762

MGH nurses staff flu vaccination clinic at the State House

On January 5, 2006, MGH nurses and others volunteered to staff a flu vaccination clinic at the Massachusetts State House. Sponsored by the Conference of Boston Teaching Hospitals (COBTH), MGH nurses teamed up with nurses and pharmacists

from other local hospitals to set up and staff the clinic.

Approximately 200 state employees, senators, representatives, and members of the general public received flu shots at the State House that day.

Mary Ellen Heike, RN, coordinated staffing from four hos-

pitals for the event. Sheila Burke, RN; Mandi Coakley, RN; Karen Curelli-Nahill, RN; Dorothy Donovan, RN; Linda Kelly, RN; Laurie Shoemaker, RN; Taryn Pittman, RN; Amy Sozanski, RN; and Laura Sumner, RN, volunteered their time to staff the clinic.



Nurses who participated in the flu vaccination clinic at the State House are (l-r, back row): Linda Kelly, RN; Taryn Pittman, RN; Laurie Falaro-Shoemaker; and (front row): Karen Nahill, RN; Mel Heike, RN; and Laura Sumner, RN.

CNS (Gavaghan)

continued from previous page

With the low bed, floor mats, hip protectors, and alarms in place, we were able to discontinue the observer, and Mr. D was discharged to a rehabilitation facility near his house.

Nurses who participated in Mr. D's care felt all the devices employed to protect him were

safe interventions, and they would be amenable to using them again. These interventions may not be appropriate for *all* patients suffering from dementia, but it's nice to know they're available for the appropriate situation.

In my role as CNS, I collaborated with Physical and Occupational Therapy, and the case manager and nurse practitioner of Team 4 to maintain patient

safety and achieve the desired outcome. I was able to follow Mr. D's progress on a daily basis to assess the effectiveness of our interventions. The willingness of everyone involved to try new interventions brought about a positive outcome for Mr. D and allowed us to feel we played a significant role in his success.

It truly was a collaborative effort.

Published by:

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

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Submission of Articles

Written contributions should be submitted directly to Susan Sabia **as far in advance as possible**. *Caring Headlines* cannot guarantee the inclusion of any article.

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

Next Publication Date:

March 2, 2006



MGH is committed to improving hand hygiene



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

Frequently asked questions about hand hygiene:

- Why does hand hygiene need to be performed *before* contact with patients or their environment?
We all have germs living on our skin. We can't see them, but they're there. We can pick up germs simply by touching other people or contaminated surfaces.
The germs we carry can cause infection or illness when conditions are right or our resistance is low. They can be spread to other people and surfaces by direct contact, a simple touch.
Fortunately, germs on our hands can usually be removed with good hand hygiene. This is important to remember, especially when caring for patients at greater risk for infection.
Hand hygiene *before contact* prevents the spread of germs to patients and their environment.
- Can gloves be used as a substitute for hand hygiene?
No. Gloves do *not* eliminate the need for hand hygiene, and hand hygiene does not eliminate the need for gloves when recommended or required.
Hands must be disinfected:
before gloves are worn and *after* gloves are removed
Why?
 - Gloves are not 100% effective in preventing hand contamination
 - Glove materials may contain imperfections that are invisible to the naked eye
 - Warm temperatures inside gloves can promote the growth of germs already present on your skin
 - Hands can become contaminated as gloves are removedCal Stat must be used to reduce the levels of bacteria on your skin *before and after* glove use.
- What are the benefits of Cal Stat?
 - More effective than soap and water
 - Faster than hand-washing
 - Better for your skin than alcohol-based hand cleaners
 - Environmentally friendly
 - Safe

Call for Nominations

Cancer Nursing Career Development Award

The Cancer Nursing Career Development Award recognizes an MGH staff nurse who consistently demonstrates excellence in delivering care to patients with cancer, who is a role model to others, and who demonstrates a commitment to professional development.

Staff nurses whose primary responsibility is direct care of cancer patients and their families (inpatient or outpatient) are eligible for nomination. Recipient will receive \$1,000 to advance his/her professional development.

Colleagues, patients, and family members can nominate a staff nurse.

Nominations are due by February 24, 2006

For more information, please contact
Lin-Ti Chang, RN, at: 617-643-2995

Call For Abstracts

Nursing Research Day May 10, 2006

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

Categories:

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

* Two new conditions for acceptance of
Performance Improvement abstracts:

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

For more information, visit:
www.mghnursingresearchcommittee.org

Deadline for submission is March 1, 2006

Educational Offerings

February 16, 2006

When/Where	Description	Contact Hours
March 1 and 8 8:00am–4:30pm	Phase II: Wound Care Education Training Department, Charles River Plaza	TBA
March 1 8:00am–4:00pm	Assessment and Management of Patients at Risk for Injury Haber Conference Room	TBA
March 2 8:00–4:00pm	Oncology Nursing Concepts: Advancing Clinical Practice Yawkey 10-640	TBA
March 7 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
March 8 8:00am–2:00pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
March 8 11:00am–12:00pm	Nursing Grand Rounds “Lymphedema.” Haber Conference Room	1.2
March 8 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
March 9, 10, 16, 17, 27, 30 7:30am–4:30pm	Greater Boston ICU Consortium CORE Program NEBH	44.8 for completing all six days
March 10 and 27 8:00am–5:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room	---
March 15 9:00am–3:30pm	A Safer Start: Empowering Pregnant Women Living with Domestic Violence Training Department, Charles River Plaza	---
March 15 4:00–5:00pm	More than Just a Journal Club Thier Conference Room	1.2
March 16 8:00am–4:30pm	Workforce Dynamics: Skills for Success Training Department, Charles River Plaza	TBA
March 16 1:30–2:30pm	Nursing Grand Rounds “Provoking Ischemia, Risking Infarction: Stress Testing.” O’Keeffe Auditorium	1.2
March 20 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
March 20 and 22 7:30am–4:30pm	Pain Relief Champion Day Thier Conference Room	1.2
March 21 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
March 22 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
March 22 8:00am–4:00pm	Beat Goes On: Ventricular Devices for Treatment of Heart Failure Bigelow 4 Amphitheater	TBA
March 23 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)	---
March 23 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
March 30 12:00–3:30pm	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>.

Robinson, Waithe, receive NERBNA's Excellence in Nursing Award

On Thursday, February 9, 2006, The New England Regional Black Nurses Association (NERBNA) recognized two MGH nurses with its annual Excellence in Nursing Award. Melissa Robinson, RN, case manager, and Phil Waithe, RN, clinical educator in the Knight Nursing Center for Clinical & Professional Development, were honored at a special ceremony at the Royal Sonesta Hotel in Cambridge.

Since its first meeting in 1972, NERBNA has been an advocate and professional voice for concerns of black nurses and the black community. NERBNA is dedicated to investigating, defining and determining the healthcare needs of African Americans in the New England area. It shares its philosophy



Melissa Robinson, RN
case manager



Phil Waithe, RN
clinical educator

through scholarship programs, conferences, and acts of community service.

The Excellence in Nursing Award Program recognizes the impact African American nurses have in various roles and organizations. Recipients are nurses who have progressed professionally, are role models for others, and are committed to issues affecting the black community.

In a letter of nomination submitted by the Knight Nursing Center for Clinical & Professional Development, Waithe's colleagues said, "Phil is a bright, highly skilled clinician and educator. His 30 years of service, his generosity in helping others, and his expertise as a teacher, clinician, and patient advocate make him an exceptional role model for staff at all levels.

"His teaching is holistic and nuanced. He deftly meets new challenges and works with colleagues to achieve desired outcomes. His clinical expertise, teaching skills, personable manner, and infectious sense of humor make him a valued member of the Knight Nursing Center and a wonderful role model and coach for MGH clinicians and staff."

Robinson was nominated by the department of Case Management. In her letter of nomination, colleagues wrote, "Three things come to mind when we think of Melissa: team player, flexibility, and compassion. Melissa is always willing to lend a hand or adjust her assignment to meet the needs of patients and the department.

"The word, 'No,' is not in her vocabulary. Whenever she's asked to take on a new assignment or help with other patients, she always steps up.

"Melissa advocates for her patients to ensure they have the best options when they're discharged. She does this with kindness and understanding."

Congratulations to Waithe and Robinson for being named recipients of NERBNA's Excellence in Nursing Award.

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