

Caring

HEADLINES

June 15, 2006

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Clinical Recognition Program celebrates advancement

—by Mary Ellin Smith, RN, professional development coordinator

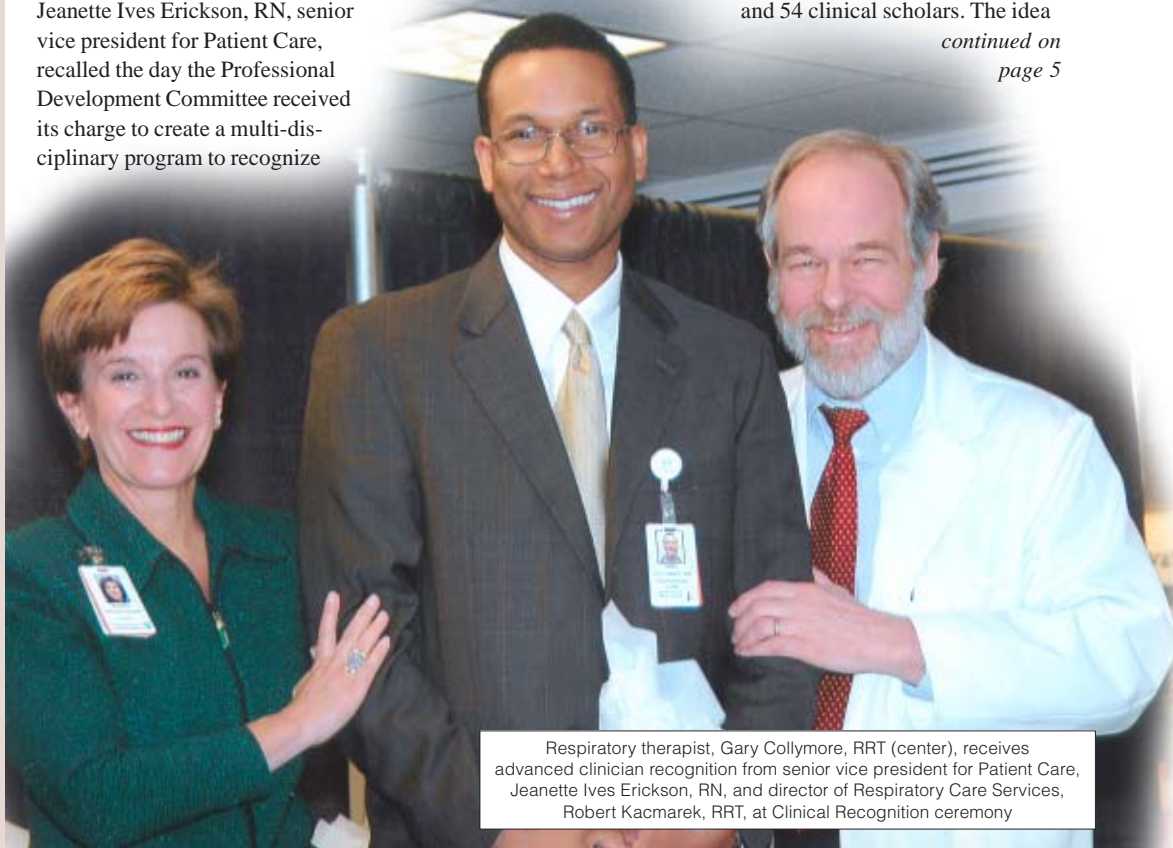
On April 11, 2006, a reception was held in the Wang Ambulatory Care Center lobby to honor the 177 advanced clinicians and clinical scholars recognized by the Clinical Recognition Program. In her remarks, Jeanette Ives Erickson, RN, senior vice president for Patient Care, recalled the day the Professional Development Committee received its charge to create a multi-disciplinary program to recognize

clinical expertise. An important tenet of the program was that excellent care is delivered by clinicians at all levels of practice and every level is valued and important. Through the hard work and creativity of clinicians and leaders

throughout Patient Care Services, we now have the only multi-disciplinary recognition program in the country.

At the recognition ceremony, Ives Erickson, associate chief nurses, and directors presented pins to 123 advanced clinicians and 54 clinical scholars. The idea

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Respiratory therapist, Gary Collymore, RRT (center), receives advanced clinician recognition from senior vice president for Patient Care, Jeanette Ives Erickson, RN, and director of Respiratory Care Services, Robert Kacmarek, RRT, at Clinical Recognition ceremony

(Photo by Abram Bekker)

MGH Patient Care Services
Working together to shape the future

JCAHO: unannounced visits and a new tracer methodology

By the time you read this, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) may already have visited MGH. Or not. Unannounced visits are one of the changes implemented by the JCAHO this year. Unannounced surveys provide a more realistic look at a hospital's practices and its ability to care for patients in a safe environment. Unannounced

visits give the public an honest look at a healthcare organization's commitment to quality and safety. And since quality and safety are our highest priorities, meeting JCAHO standards is a welcome by-product of our efforts.

Another change implemented by the JCAHO has to do with the method used to conduct accreditation surveys. Though the survey still incorporates a review of patients' records, interviews with staff, personal observa-

tions, and interviews with patients, a new 'tracer' methodology is being introduced for the first time this year. Surveyors will follow the progress of one patient throughout his/her entire hospital experience. Using the patient's medical record as a 'roadmap,' surveyors will visit the various test sites and units where the patient has received care in a patient-centered approach to evaluating care and services.

In anticipation of this



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

change and to help us identify our strengths and weaknesses, Patient Care Services has been using a similar tool since March to evaluate the quality of care, assess the physical

environment, monitor the condition of equipment, and look at our compliance to policies and procedures.

The tracer tool actually replaced and improved upon some of our earlier tools, such as the monthly restraint audits, unit environmental rounds, and documentation audits. The tracer tool gives us the same information in a more meaning-

ful and patient-focused way.

Data obtained with the tracer tool is sorted and collated by the Office of Quality & Safety. It is grouped by unit and department and reported back to staff to highlight opportunities for improvement. The tool has been very well received. We're hearing that staff enjoy having the opportunity to talk about their practice, and at the same time become more comfortable with the new JCAHO process.

I think we can assume that the survey will focus largely on the National Patient Safety Goals released earlier this year (see box on this page). Much of our preparation has centered on these goals, with an emphasis on reducing patient falls, using two patient identifiers, and medication reconciliation.

I'd like to thank members of the Patient Care
continued on next page

National Patient Safety Goals (abridged)

- Improve the accuracy of patient identification
 - Use at least two patient identifiers
- Improve the effectiveness of communication among caregivers
 - Verify the complete order or test result by having the person receiving the order or test result 'read-back' the complete order or test result
 - Standardize a list of abbreviations not to be used
 - Measure, assess, and improve the timeliness of reporting critical test results and values
 - Implement a standardized approach to 'hand off' communication
- Improve the safety of using medications
 - Standardize and limit the number of drug concentrations available
 - Identify and review 'look-alike/sound-alike' drugs and take action to prevent errors involving the interchange of these drugs
 - Label all medications and medication containers
- Reduce the risk of healthcare-associated infections
 - Comply with current CDC hand-hygiene guidelines
 - Manage as sentinel events, all cases of unanticipated death or major permanent loss of function associated with healthcare-associated infection
- Accurately reconcile medications across the continuum of care
 - Implement a process for obtaining and documenting a complete list of the patient's medications upon admission
 - A complete list of patient's medications is communicated to next provider
- Reduce the risk of patient harm resulting from falls
 - Implement a fall-reduction program and evaluate its effectiveness

What you should know about guardianship

Question: I've heard of certain patients needing 'guardianship,' but I don't really know what that means. What is guardianship?

Jeanette: Guardianship describes the legal process by which a court determines whether or not a person is capable of making decisions about some or all areas of his/her life. As a result of certain medical conditions, disabilities, mental retardation, dementia, mental illness, or an inability to communicate, a person may not be able to make medical decisions, take care of financial matters, or understand the need for assistance to maintain safety at home.

Question: At what point does the hospital seek guardianship for an adult patient?

Jeanette: We would seek guardianship as a last resort when:

- the medical team agrees the patient is unable to meaningfully engage in decision-making.
- the patient is unable to make important decisions that a family can't make on the patient's behalf

If the patient has an involved family member who appears to be making decisions in the patient's best interest and if all family members agree, it's usually not necessary to seek guardianship for medical decision-making.

Question: Who is involved, and what is the process for seeking guardianship for a patient?

Jeanette: If team members question a patient's ability to make decisions for him/herself, a social worker is consulted (if one is not already involved). The social worker assesses the social and family situation and contacts the necessary professionals. If a patient is thought to lack capacity because of a mental illness, an evaluation will be completed by a psychiatrist. Otherwise, the physician involved with the patient's medical care can evaluate and determine capacity. The physician completes the medical certificate documenting the patient's status. At the same time, the social worker contacts the hospital's guardianship attorney. The guardianship attorney gathers documentation, completes the necessary

petition, and the court decides on a date for a guardianship hearing.

Question: What is competency or capacity, and who determines it?

Jeanette: All adults are assumed to be competent in the eyes of the law until determined otherwise by a court. Because the process takes away certain basic rights, courts are very cautious about granting guardianship. In order to secure a guardian, it must be established that the adult patient does not have the capacity to understand the risks of the decisions he/she is making, including medical decisions.

Question: When is a guardian appointed?

Jeanette: A guardian may be appointed when a probate court determines that a patient is 'incapacitated,' unable to care for him/herself and his/her estate by reason of

physical incapacity, mental illness, or mental retardation. Guardianship of an adult gives the guardian the right to make personal and financial decisions for the patient.

Question: How can I find out the status of a patient's guardianship petition?

Jeanette: The hospital's guardianship attorney provides regular updates to social workers and the Office of General Counsel.

Question: How long does the process take?

Jeanette: The length of time varies depending on the complexity of the case.

Question: How many patients are awaiting guardianship at MGH?

Jeanette: The hospital has an average of 6-8 patients awaiting guardianship at any given time.

Jeanette Ives Erickson

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Services JCAHO Continuous Readiness Team and the MGH JCAHO Operations Committee for their hard work in keeping staff informed through articles in *Caring Headlines*, posters, talking papers, department-based presentations, grand rounds, and the MGH JCAHO website, (<http://intranet.massgeneral.org/jcaho/>) which

is a great source of information for staff.

As we perpetually work to improve patient care and meet JCAHO standards, I look forward to this opportunity to showcase our accomplishments. One area where MGH staff have always excelled is their ability to communicate their passion for patient care. This new tracer methodology

will allow us to do just that. If you should find yourself talking to a JCAHO surveyor, let your knowledge, skill, and pride show through. We work hard to keep our patients safe and healthy, and we want everyone to know it!

Updates

I'm happy to announce that Bessie Manley, RN, has accepted the role of nurse manager for Phillips 22 effective immediately. Bessie has been

nurse manager in the Pre-Admission Testing Area since 2002. I'd like to acknowledge the many contributions of Donna Jenkins, RN, who served as clinical nurse specialist and nurse manager for Phillips 22. Donna has decided to work full-time as nurse manager for Ellison 19.

Suzanne Cassidy has joined the Patient Care Services team as a project specialist. She will be supporting key initiatives of Patient Care Ser-

vices and the Partners' Chief Nurse Council.

Joyce McIntyre, RN, has accepted the position of clinical nurse specialist for the ED Observation Unit.

Brian French, RN, has a new title, reflective of his contributions to The Knight Nursing Center for Clinical & Professional Development. His new title is professional development and education manager.

The MGH Patient Education TV channel

—by Judy Gullage, RN, Donna Lawson, RN, and Alexa O'Toole, RN
of the Patient Education Committee

One of the most important factors affecting a patient's successful transition from the hospital to the home setting is education. Patient education helps ensure safety and improve compliance with medication, treatment, and home-care regimens. Using the MGH Patient Education TV Channel is one way to help patients become more knowledgeable about their condition and take a more active role in making decisions about their care.

Every patient admitted to the hospital requires teaching on some health-related topic. Watching a video on cardiac wellness, diabet-

es, or any other condition, can help a patient formulate questions, make decisions, and feel more confident about returning home.

The MGH Patient Education TV Channel can help clinicians educate patients. The chan-

You'll need the three-digit video identification number to request the video you want.

You can select a video from the list on channel 31 or print the list of videos from the Partners Handbook under Patient Education Information. A

description of the video is available online to help patients and clinicians select the right video. To select a topic online:

- Click on Partners Applications

- Click on Clinical References
- Click on Partners Handbook
- Click on Visit Patient Education Info
- Click on MGH Patient Education Television Channel
- Click on the topic you're searching for:
 - Instructions for using on-demand patient-education videos
 - List of patient education video titles
 - Patient education video description

Topics

- Palliative care
- AIDS
- Ethics
- Pain management
- Cardiac Conditions
- Geriatrics
- Patient safety
- Cardiac Procedures
- Gynecology

- Pediatrics
- Cardiac Wellness
- Health Promotion
- Respiratory
- Communicable diseases
- Maternity
- Substance abuse
- Coping with illness
- Medications
- Urology/renal
- Congestive heart failure
- Mental Health
- Diabetes
- Neurology
- Digestive system
- Nutrition
- Orthopaedics
- Ostomy care

One staff nurse explains how the TV channel helped one of her patients. Mrs. D had been admitted with congestive heart failure (CHF). She was given a CHF packet and the information was reviewed with her, but a follow-up conversation

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nel offers more than 100 educational videos accessible directly from the patient's room at no charge 24 hours a day.

The list of available videos can be found on channel 31. Using the bedside telephone, dial 4-5212 to order a video.

Patient education fair and filmfest

Members of the Patient Education Committee will be on hand to talk about resources available for patient education. Enjoy popcorn and a demonstration of the MGH Patient Education TV channel.

**June 28, 2006
12:00–3:00pm
Main Corridor**

For more information, call 4-3822



Staff nurse, Alexa O'Toole, RN (left), assists patient, Casey Spicer in accessing the Patient Education TV Channel on the Blake 13 Newborn Unit

Clinical Recognition Program

continued from front page

for the pin came from focus groups comprised of advanced clinicians

and clinical scholars who spoke about their experiences going through the clinical recognition process. They expressed a desire to make the program more visible, to have a way of letting staff know who had gone through the process so they could make themselves available to support others. Several designs for a recognition pin were created and evaluated by advanced

clinicians and clinical scholars. Their selection was shared with the Clinical Recognition Steering Committee and approved by the Patient Care Services Executive Committee. The pin shows the Clinical Recognition Program logo with a silver



Clinical Recognition Program Pin

(advanced clinician) or gold (clinical scholar) rim depending on the level achieved.

Ives Erickson acknowledged nurse managers, clinical specialists, associate chief nurses, and directors whose guidance and support allowed clinicians to achieve this recognition. "The Clinical Recognition Program has allowed you to expand your knowledge and skill to a new level of professional competence," said Ives Erickson. "Wear your pin with pride; it symbolizes exquisite practice."



At the April 11th Clinical Recognition Program celebration, photos from the top left: associate chief nurse, Dawn Tenney, RN (right) with Cheryl Gomes, RN, pediatric nurse, Same Day Surgical Unit and advanced clinician; director of Physical and Occupational Therapy, Michael Sullivan, PT, with inpatient physical therapist and advanced clinician, Denise Montalto, PT; Above: group shot of advanced clinicians; At right: group shot of clinical scholars



(Photos by Abram Bekker)

Breaking the silence: a response to sexual assault

—by Matt Thomas, investigator, Police, Security & Outside Services

What would you do if you heard a whistle blow every two minutes someone is sexually assaulted in the United States.

Sexual assault is defined as inappropriate touching, penetration, unwanted sexual intercourse, rape, attempted rape, or child molestation. It doesn't matter if the offender uses a weapon, fists, or overt or implied threats. It doesn't matter if the victim has used drugs or alcohol.

Sexual assault is not always perpetrated by strangers in dark alleys. Attackers are often some-

one the victim knows. Studies show that 88% of sexual assault survivors know their perpetrator. One in every seven adult women (about 340,000 women) in Massachusetts, has been the victim of rape at some time in her life. One in nine Massachusetts high school students (16.3% of female students, and 6.4% of male students) has had sexual contact against his/her will.

Sexual assault is one of the most under-reported forms of domestic violence because many victims don't recognize it as a crime. A marriage license is not a license to

have unwanted sex. Past sexual activity doesn't entitle a person to future sexual contact if one person doesn't consent.

Sexual violence in an intimate relationship can include forced sex or being forced into prostitution, pornography, and/or watching your partner have sexual relations with others. What ever form it takes, sexual violence can have long-term physical and psychological consequences.

'Rape drugs' or 'club drugs' are drugs used to facilitate sexual assault. These drugs render victims physically helpless and unable to resist their

attackers. Some victims can't remember anything that happened to them while under the influence of these drugs. Rape drugs are colorless, odorless, tasteless, and can easily be slipped into a drink without the victim's knowledge. The National Institute on Drug Abuse says that uncertainties about the source, chemicals, and contaminants used to manufacture club drugs make it extremely difficult to determine toxicity and resulting medical consequences. *Alcohol is the number one rape drug.* Other rape drugs include Ecstasy, Rohypnol, GHB, and Ketamine.

All MGH Emergency Department nurses and doctors are specially trained to care for vic-

tims of sexual assault. Patients and employees have access to experts who can help them. The HAVEN Program, Police, Security & Outside Services, the Employee Assistance Program, the MGH Emergency Department Sexual Assault Program, and the Child Protection Consultation Team work together to ensure the best possible response to sexual assault and domestic violence. Victims have the right to choose what they want to do. Victims do not have to report an incident of sexual assault to the police in order to seek medical treatment.

For more information about preventing sexual assault, contact Corinne Castro, resource specialist, Social Services, at 617-726-2621.

The Employee Assistance Program
presents:

Organize Your Workspace for Success

Having an organized workspace allows you to work more effectively and with less stress. Professional organizer, Cristin Lind, guides you through a step-by-step process called, "Organized for Success" that will allow you to reach your professional goals, spend less time looking for things, project a professional image, and be in control of paper and information.

**Thursday, June 15, 2006
12:00-1:00pm
Thier Conference Room**

For more information contact the Employee Assistance Program at 617-726-6976. Registration is required.
www.eap.partners.org
Feel free to bring a lunch

Improving the health of women through research

Call for Abstracts

An invitation to submit abstracts to the
3rd Annual Women's Health Research Celebration on October 4, 2006
Guest Speaker: Dr. Vivian Pinn
director, Office of Research on Women's Health at NIH

The Women's Health Research Committee invites the MGH community to participate in the 3rd annual Women's Health Research Celebration. We are now accepting abstracts for clinical and basic science research topics addressing women's health care. This can include studies specific to the health concerns of women throughout the lifespan or studies that include the separate analysis of outcomes for women as part of the study population. Abstracts submitted to or presented at national or local meetings within the last year are eligible.

Cash prizes for the six best abstracts will be awarded. All accepted posters will be displayed in the hospital the week of October 2, 2006.

Deadline for submission is Friday, July 14, 2006

Abstracts may be submitted on-line at <http://intranet.massgeneral.org/whcc/abstractform.htm>

For more information, call Mary Ellen Heike, RN, at 4-8044 or send e-mail

Reading Disabilities graduation 2006

On May 18, 2006, the department of Reading Disabilities held its annual graduation ceremony in the Walcott Conference Room, recognizing those who successfully completed the Orton-Gillingham Training Program. Graduates, who come from a number of schools throughout the area, will use this approach to tutor children with dyslexia.

Every year at graduation, a set of Wilson Readers is presented to a deserving trainee in memory of Mary Chatillon, a former director of Reading Disabilities. This year, the Wilson Readers were presented to Betty-Jeanne Constable for the commitment and enthusiasm she brought to the program.



Above: director of Reading Disabilities, Phyllis Meisel (left) presents Wilson Readers to trainee/graduate, Betty-Jeanne Constable during graduation ceremony in the Walcott Conference Room

At left: Meisel presents certificates of completion to trainees/graduates (l-r): Mary Wilson, Karen McGrath, and Marion Monaghan Bok

Northeastern at MGH

Fall course offerings
for the Masters/CNS program:

Theory and Practice of Nursing Research
4 credits, Mondays 5:00–8:00pm

Health Care Systems and Professional
Role Development
3 credits, Thursdays 5:00–7:30pm

Registration begins in July
Classes start September 6, 2006
Classes held at MGH

For more information, contact
Miriam Greenspan at 4-3506

MGH is committed to improving hand hygiene

- Patients and visitors should be encouraged to wash their hands with soap and water as needed
- Patients and visitors should use Cal Stat when disinfection is appropriate
- Visitors should be encouraged to use Cal Stat when assisting with patient care, visiting a patient on precautions, or visiting more than one patient



Stop the Transmission
of Pathogens
Clinics 131
726-2036

Combining creativity with patient education in the Anticoagulation Unit

—by Palmie Riposa, RN, staff nurse, Anticoagulation Unit

My name is Palmie Riposa, and I started working at MGH in 1987 on Baker 7. I've always loved being a primary nurse and teaching my patients about their health. For most of my career at MGH, I worked as a staff nurse. Unfortunately, following

back surgery, I was told I would no longer be able to practice unit-based nursing because I was unable to lift patients. Fortunately, I was able to find a position at MGH where I could still be a primary nurse, still teach patients, and still have personal contact with patients while they were

in the hospital.

Anticoagulation Management Services (AMS) is an outpatient clinic where I'm responsible for 262 primary patients. When patients begin in our program, they usually come to our office with a friend or family member for a comprehensive educational session. We re-

view drug knowledge, safety, dosages, administration, factors influencing a stable response to therapy, the importance of periodic blood-testing to monitor the therapeutic effect, and what to report to the AMS primary nurse.

In interacting with patients, I've come across a way to give a little of myself to patients and educate them at the same time. I've started decorating our teaching rooms with colorful posters on topics related to anticoagulation education. One of my passions is scrap-booking. I've found I can combine my love for nursing, teaching, and scrap-booking to create helpful teaching posters for our patients. When patients are learning about atrial fibrillation or DVTs, they can look at

beautiful paper, fun fonts, and pretty embellishments, making the educational experience more interesting and enjoyable. My grandmother used to work at Jordan Marsh wrapping gifts, and she taught me that presentation is everything. I believe this is true.

Taking Coumadin can be the beginning of scary journey. That journey can be made less frightening and more pleasant with a little effort and a few personal touches.

Stop by the Anticoagulation Unit in Clinics 144, and take a look at the original art work/educational posters of Palmie Riposa. Maybe the Anticoagulation Clinic isn't the only unit that could benefit from a few personal touches.

Staff nurse, Palmie Riposa, RN, with two of her recent educational posters in the Anticoagulation Management Clinic



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

The Medication Education Safety and Approval Committee: an update

—by Miriam Greenspan, RN, professional development coordinator

Have you ever wanted to check on a potential drug-drug interaction? Do you know how to find guidelines for the safe administration of specific drugs? To answer these and other questions, visit the Medication Education Safety and Approval Committee (MESAC) website. It can be accessed easily from any Partners computer. From the Start menu, select Partners Applications, then Clinical References, then MESAC.

The Medication Education Safety and Approval Committee is a multi-disciplinary, hospital-wide group comprised of nurses, physicians, pharmacists, administrators, information systems staff, quality assurance coordinators, and many others. Because of the large number of medications available and the varied complexities surrounding their use, MGH developed a program to ensure the safe use of all drug therapy. MESAC has become the organizational cornerstone for ensuring the safe and rational prescription, distribution, and administration of medications at MGH.

MESAC is involved in policy-development around the evaluation, selection, and therapeutic

use of drugs; coordinating on-line medication-related clinical information; designing, developing, and preparing programs and documents for education and publication; approving formulary requests; and ensuring the safe administration of medications.

The group has formed five subcommittees: Adverse Drug Event Monitoring, Drug Approval, Drug Utilization, Education and Publication, and Quality Assurance.

The Education and Publication Subcommittee recently launched the MESAC website to serve as the portal for all MGH drug-related information. The site links users to on-line drug information, MGH policies and procedures, information about herbs and food supplements, and a variety of clinical guidelines and procedures. An interactive feature allows users to ask ques-

tions about drugs; the questions are screened by MGH pharmacists and directed to appropriate MGH experts.

The New Initiatives link contains the latest information on medication reconciliation and sound-alike, look-alike drugs (SALAD).

Some of the information that can be found on the MESAC website can also be found in the Partners Handbook. For example, CareNotes/Micro-medex, the MGH Drug Formulary, AHFS, Mosby's Drug Consult, and the Nursing Drug Guide are available from both

websites. MESAC focuses exclusively on drug information, so information related to other aspects of patient care can be accessed through the Partners Handbook.

The MESAC website was created by MGH clinicians for MGH clinicians, so there's no need

to wade through information intended for other institutions.

MESAC welcomes feedback on how the website can be enriched and how navigating the site can be made more efficient. Contact us at mghmesacedupub@partners.org

Robert W. Carey, MD, Lecture

Thursday, June 15, 2006

5:30–7:30pm

Simches 3110 Conference Room
185 Cambridge Street

5:30–6:00pm: reception
6:00–6:15pm: opening remarks
6:15–7:15pm: lecture

Speaker: Laurel Radwin, RN
"Patient-centered care: the patient's perspective"

RSVP to: Carol Ghiloni at 617-724-5420 or
cghiloni@partners.org

contact hours provided



NICU care offers unique challenges as well as personal and professional rewards

Shanna Heffernan is a clinician in the PCS Clinical Recognition Program

My name is Shanna Heffernan, and I am a staff nurse in the Neonatal Intensive Care Unit (NICU). St. Patrick's Day will always be embedded in my mind as the day I truly became a nurse.

I first met 'Jake' on March 17, 2005. I knew he was 100+ days old, a former 23-week twin with a very complex history. He had come to MGH from another state for surgery to repair Retinopathy of Prematurity (ROP), but nothing could have prepared me for what this day would bring.

During admission, a fellow nurse suggested I be his primary nurse. Despite my initial reluctance due to his many scars from prior surgeries and a 22-page history, the moment I took off his hat and saw his face, my heart was captured. I was going to be his primary, no doubt about it.

Jake's head was badly misshapen after months of lying on his back and an obvious lack of neurological development. Once we admitted him and got him tucked in, I met his parents, Mary and David, for the first time. It was obvious this transfer had brought fear and anxiety. I reassured Mary and Dave that their

son was going to receive the best of care during their stay at MGH. I sat with them, and we talked about Jake. I knew I'd get a better understanding of him from his mother than from the long history that accompanied him. Mary seemed to know Jake better than anyone. During the next several days Jake settled into the NICU and we quickly became acquainted with one another. He was taken for his ROP surgery in a few days and returned to the NICU uneventfully.

No one could have predicted the events that were about to unfold.

Within a few days after surgery when we tried to feed him, Jake couldn't tolerate any of his feedings despite many attempts. This led to an upper GI and abdominal ultrasound. The tests revealed fluid surrounding a grossly enlarged liver and a necrotic spleen. A bedside aspiration of the fluid was performed.

In response to these procedures and complications, Jake arrested and required immediate resuscitation, including chest compressions. He was sent to the operating room for an emergent splenectomy. Jake's parents witnessed all of these

setbacks and interventions.

In the ensuing months, Jake became well known to many staff and departments including Neurology, Pediatric Surgery, Endocrinology, Infectious Disease, Hematology, Respiratory Care, Physical and Occupational Therapy, and the Chaplaincy. I remember fellow staff nurses coming to Jake's bedside to inquire about his progress only to share my discouragement at what little progress there was.

As a result of having his spleen removed and many other procedures, Jake developed acute, severe diabetes insipidus (DI) for which he was treated with fluctuating doses of Vasopressin for eight weeks. Jake frequently developed fungal and bacterial infections which had to be treated with long-term courses of antibiotics. It seemed that with every step forward, we took two steps back. I felt like every day brought something new for us to treat or investigate. We just couldn't get ahead.

Lack of food, his weakened immune system, surgeries, procedures, and the sheer volume of medications took a toll on Jake, his family,

his nurses, and the medical staff. There was little or no improvement in his status. Then, thanks to some higher power, Jake finally became able to tolerate his feedings, and ever so slowly he started to come to life. There was color in his skin, brightness in his eyes, and a profound strength that at times took both his mother and me to contain. I remember one day, Jake was in an inconsolable mood. Mary was holding his binky in his mouth and patting his bum, while I fanned him to keep him cool. He was always hot. For his entire three-month hospitalization he was clad in a diaper and little else. He would have preferred being naked. We used to call him our 'little exhibitionist.' I loved seeing his strength and determination, pulling at everything, after seeing him sick for so long. Jake and I got to know many physicians, residents, fellows, interns, and therapists

who were part of his daily regime.

I remember fondly the many hours I spent holding and rocking Jake, endotracheal tube in tow, because I didn't want to leave this bright, inquisitive seven-month-old in bed with no visual or physical stimulation. Jake's bright blue eyes stopped people in their tracks as they walked by. We sang together to the radio at night. Our favorite song was *We are the Champions* by Queen.

I think back to those long night shifts when Jake would lie awake for hours. At 4:00 in the morning, I'd be leaning over his crib on one arm while the other rhythmically patted his bum to the sound of the mobile for fear he'd wake up. How I miss that routine!

As Jake progressed, my time with him took on a more normal routine that included turning the lights on, whispering, "Good morning," and

continued on next page



Shanna Heffernan, RN
staff nurse, Neonatal Intensive Care Unit

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

Clinical Narrative

continued from previous page

getting him ready for his bath. I welcomed his reaction as I slathered his little belly with baby lotion. I memorized every nook and cranny of him, including all 20 fingers and toes.

I was sorry Jake's mother couldn't be present during these daily rituals. I felt as though it was time lost, never to be experienced again at this phase of his life. Mary's life was divided between spending time with her two other children in her home state and frequent trips to Boston to be with Jake. She had difficulty bonding with Jake during his long stay at MGH because for most of that time, he was intubated. She was understandably fearful of his endotracheal tube and often refused to hold him. I often had to explain to my co-workers why I was holding Jake and not his mother. But I respected her fears and knew she would hold him if she could.

After months of unsuccessful trial extubations, which once resulted in full respiratory and cardiac resuscitation, the medical team recommended a tracheotomy for physical and developmental reasons. Jake's parents were faced with the life-altering decision of whether to trach their son. After many family meetings and consultations, Jake's parents reluctantly

decided to transfer him to their home state for further evaluation. Without a tracheotomy, we had no other alternatives.

Witnessing the personal and professional growth of human systems and how they operate in conjunction with one another has given me an invaluable life lesson. Patience, love, and commitment are critical parts of nursing, especially in the NICU. Sometimes nurses are faced with situations that push us to our limits. It makes us ask ourselves, "Why do I do this?"

In my five years as a NICU nurse, I had never been as challenged as I was during those months taking care of Jake. The frustration and burn-out were evident not only to me but to my co-workers. But my inner determination won out; I couldn't give in to this infant's ongoing critical health issues. He needed me, and maybe I needed him, too. I didn't know I possessed that level of commitment; I fought for him, advocated for him, and spoke for him when no one else could. I loved him. He was my dedication. He was my purpose.

I'd like to mention a fellow nurse who supported me through Jake's care and constantly reminded me of the role I needed to play as Jake's primary nurse. I respect

and admire Diana Grobman for her professionalism and guidance.

Though twice nominated for the Ben Corrao Clanon award, I feel rewarded enough that my co-workers recognized my hard work and determination in caring for Jake. I truly believe he touched the lives of every staff member, and they in turn had the pleasure of knowing him. The personal and professional lessons Jake taught me and the sweet memories he left will be carried in my heart forever. That's award enough.

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

What a wonderful story of compassionate care and self-discovery. Shanna may have had doubts about her readiness to take on the role of primary nurse for this medically complex infant, but her colleagues didn't. Jake's condition was precarious, taking many turns throughout his hospitalization, but Shanna rose to the challenge providing comfort and constancy with every new development. Caring for Jake was an invaluable learning experience for Shanna, drawing from the wisdom and expertise of her co-workers and from Jake himself.

I think every clinician would agree with Shanna's assessment that our patients are our purpose.

Thank-you, Shanna.

The Employee Assistance Program

Helping Kids Make Healthy Choices

Young people face many pressures and decisions in today's complex world. When young people talk openly with parents or adults they trust, they tend to make better choices. Many parents need help initiating these important conversations.

Join Jeanne Blake of Blake Works and Paula Rauch, MD, of MGH Psychiatry to learn information, strategies, and skills that will help you raise kids who make smart choices.

Thursday, May 18, 2006

12:00–1:00pm

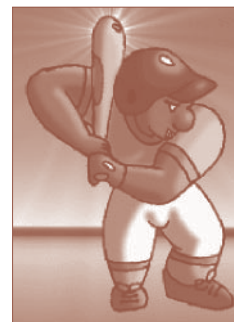
Thier Conference Room

For more information, please contact the Employee Assistance Program (EAP) at 726-6976.

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*



Final classes scheduled for:

Wednesday July 19, 12:00–3:00pm
Monday, August 14, 10:00am–1:00pm
Monday, September 18, 11:00am–2:00pm
Wednesday, October 18, 12:00–3:00pm
Wednesday, December 6, 12:00–3:00pm

All classes held in GRB-015
Conference Room A

pre-registration is required
To register, call Theresa Rico at 4-7840

Obstetrical Nursing retreat: reflecting on the past, planning for the future

—by Cuartor Wynne, RN, and Harriet Nugent, RN

On March 20, 2006, the day of the vernal equinox, members of the Obstetrical Nursing Service gathered to take stock of their practice; to look back and look forward to get a sense of the dynamics of this blossoming 12-year-old service. The group included two nurse managers, three clinical nurse specialists, and 25 resource nurses who represent the full spectrum of obstetrical care.

- High-risk antepartum care encompasses women at varying stages of pregnancy whose medical or obstetrical risk factors make them too tenuous to be followed on an outpatient basis.
- Intrapartum care en-

compasses patients in labor who can move from a stable, routine delivery to a risky, life-threatening delivery very quickly

- Postpartum care is a challenging and essential area of obstetrics. Postpartum care monitors hemodynamic changes following a vaginal or Caesarian-section delivery, the adjustment to a new family dynamic, and education of a patient who is often too exhausted or overwhelmed to retain information
- Well newborn care requires the stabilization of babies' feeding patterns, elimination patterns, and recognizing an un-well newborn

- Transitional newborn care is for newborns who require more frequent assessment, routine diagnostic procedures, and minimally invasive interventions
- The Special Care Nursery cares for infants who are too gestationally and/or developmentally immature to be discharged. Many are learning to regulate their own cardio-respiratory systems or tolerate the environment, or be fed without medical assistance

The Obstetrical Service began in 1995 with a birth census of 776 babies. In 2005, census was up to 3,484. To accommodate this rapid growth, we had to, literally, knock down walls.

Blake 14 expanded its labor room and triage area. Ellison 13 was added to house antepartum and postpartum patients, and more nursery beds were needed resulting in the Ellison 13 Special Care Nursery.

We have seen the nature of our patient population become increasingly more high-risk, with staff expanding exponentially to meet the demand of acuity and the projected medical challenges of the future. In 1994, we had five obstetricians, five midwives, and no nurse practitioners. In 2006, we have 24 obstetricians, 14 midwives, and six nurse practitioners.

A staff of 30 in 1994 has grown to approximately 200. We have recruited staff from all over the country, capitalizing on years of experience and creating a team that includes some of the best in the Maternal/Child field. The team

includes nurses; lactation consultants who address breast-feeding issues; social workers; and four clinical nurse specialists who facilitate ongoing staff-development as the need for expertise in this patient population increases.

We recently welcomed two new nurse managers, Susan Caffrey, RN, and Lori Pugsley, RN, who share the positions formerly held by Lori Carson, RN, and Peggy Settle, RN.

This past year, Brenda Pritchard, RN, completed the MGH Clinical Pastoral Education Program to become a spiritual caregiver. In her new role, she provides consolation and spiritual support to patients and co-workers on the unit.

Associate chief nurse, Debbie Burke, RN, reminded us that our unit boasts one the largest number of advanced clinicians and clinical scho-

continued on next page



(Photo provided by staff)

Using two identifiers to ensure safe transport

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

On Monday, May 1, 2006, Materials Management and the department of Nursing instituted a new procedure for identifying patients prior to transport. Two identifiers must be used when identifying patients at time of treatment, procedure, medication-administration, and transport. Patient Care Services has selected the patient's name (first and last) and medical record number as the two identifiers used throughout the department.

Previously, upon initiation of transport, the patient transport associate would arrive to pick up a patient with only the patient's name. Under the new procedure, when a request for transport is

initiated, the patient's (first and last) name and medical-record number are included with the request. When the patient transport associate arrives on the unit or test site, he/she has the name and medical-record number to ensure the correct patient is being taken for transport.

Feedback about the new procedure has been overwhelmingly positive. Operations associate, Khadija Afdal, says, "There has been an important change in the procedure when escorting patients to test sites. Transporters have the patient's medical record number on their log sheets when they arrive, making it much easier to be sure they have the right patient."

Since implementation of the new procedure, fewer patients have been moved incorrectly, and all patients transported from units wear a wristband.

William Timmins, dispatcher for Materials Management, says, "It might seem like an imposition, but everyone has been cooperative and pleased with the new process."

The positive response shows how committed staff are to providing safe care. The addition of a second identifier when transporting patients not only ensures safe transport, but provides staff with the tools they need to do their job safely, effectively, and with less opportunity for error.

Obstetrical Nursing Retreat

continued from previous page

lars in the PCS Clinical Recognition Program. Jenny Sweet, RN, our first clinical scholar in September, 2002, inspired those who followed to have their accomplishments and expertise recognized.

As the day progressed, we explored goals for the future. We reflected on the collaborative nature of our practice and the strong communication we enjoy between

the obstetrical, anesthesia, pediatric, neonatal, social services and nursing teams. We wouldn't have been able to thrive throughout our dynamic expansion without strong collaboration and cross-training. As we continue to grow in census, acuity, and technology, the need for specialized OB nurses is surpassing the need for generalists. As we plan for the future, our primary goal is to strengthen

the bonds we've formed by building on a foundation of communication and common goals, ensuring we continue to nurture the kind of relationships that can withstand expansion.

We re-dedicated ourselves to providing the leadership needed to facilitate the outstanding patient care that is our mission. We've been an integral part of building this exciting practice, and our perseverance on our patient's behalf can only lead to greater success.

Men's Cancers Awareness Fair

The MGH Cancer Center will host a Men's Cancers Awareness Fair

**Friday, June 16, 2006
10:00am–2:00pm
Under the Bulfinch Tent**

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

Patient Education TV Channel

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revealed that Mrs. D had misunderstood the teaching; she thought she'd had a heart attack.

The nurse suggested Mrs. D watch the CHF video on the MGH Patient Education TV Channel. She turned on the television to channel 31 where she found video #008, Congestive Heart Failure. Using the bedside telephone, she dialed 4-5212 and entered the video number. A recording told her to turn to channel 33 where the video began within 30 seconds.

After Mrs. D watched the video, reviewed the CHF material, and completed a 'teach-back' session (where the patient explains back what she's been taught), Mrs. D was discharged with a better understanding of

her diagnosis, treatment plan, and follow-up care. She knew what to do in an emergency, and most importantly, she felt she was now taking an active role in her care.

When you teach, be sure to document your patient education on the Interdisciplinary Patient/Family Teaching Record.

The Patient Education Committee will host a patient education fair and filmfest on June 28, 2006, from 12:00–3:00pm in the Main Corridor. Members of the Patient Education Committee will be on hand to talk about the many resources available for patient education. Inside the Patient and Family Learning Center, enjoy popcorn and a demonstration of the MGH Patient Education TV Channel.

Critical care nursing: yesterday, today and tomorrow

—by Katie Brush, RN, clinical nurse specialist

Critical care is approximately 40 years old as a field of practice.

Nurses have played a major role in the development of this specialized care, here at MGH and elsewhere. The first intensive care unit at MGH was the four-bed Respiratory Intensive Care Unit (RICU), one of the first ICUs in the country, and mechanical ventilation was one of the first critical-care innovations. When it was first introduced, mechanical ventilation only had one variable: volume. When Positive End Expiratory Pressure (PEEP) was

introduced, it was delivered using a baby bottle with 5 centimeters of water that had to be carefully observed for volume. Red, rubber endotracheal tubes were the only endotracheal tubes available at that time, and they were frequently associated with tracheal malacia.

Early on in the evolution of critical care, nurses made their own IV drips, counting the number of drops per minute. This was before IV pumps. Nurses would frequently titrate medications with roller clamps to keep blood pressure in the desired range. Nurses checked the drip rate

every 15 minutes to ensure a steady rate of medication was infusing. IV fluids came in bottles, and if the height of the bottle changed, it would affect the drip count.

Chest tubes were drained using a three-bottle system, which was cumbersome and difficult to maintain. A patient with two chest tubes required six bottles (and so on), often making it difficult to get close to the patient.

An EKG rhythm was read via an oscilloscope, which had no memory or print-out capabilities. A clinician could see approximately three to five beats, and then it faded

off the screen of the oscilloscope. If a strip was desired the leads were hooked up to an EKG machine, and one lead was run at a time. Nurses marked each lead, making the whole process much longer. The intra-aortic balloon pump had not yet been developed.

Central intravenous lines existed, but catheters were placed peripherally and threaded into the larger veins. Shorter IVs were made of steel needles and were also placed peripherally. Arterial lines existed and were used to measure blood pressure using rudimentary transducers.

Intramuscular injections were common for pain medicine. Syringes were made of glass and had to be re-sterilized after every use. It wasn't uncommon for plungers to slip out of syringes splattering nurses with blood. The use of gloves and other protective barriers for viral or bacterial infection were not yet accepted practice and were rarely used. Needlesticks were common, and

the screening of blood for transfusion was far more limited than it is today.

CT scans, MRIs and PET scans did not exist. Nuclear radiology and angiography had yet to be developed. There were only X-rays. Portable X-ray machines were used for chest films only. Other studies required moving patients from the ICU to Radiology, which could be an ordeal. Diagnoses were made by physical examination, laboratory studies, X-rays, and an understanding of pathology.

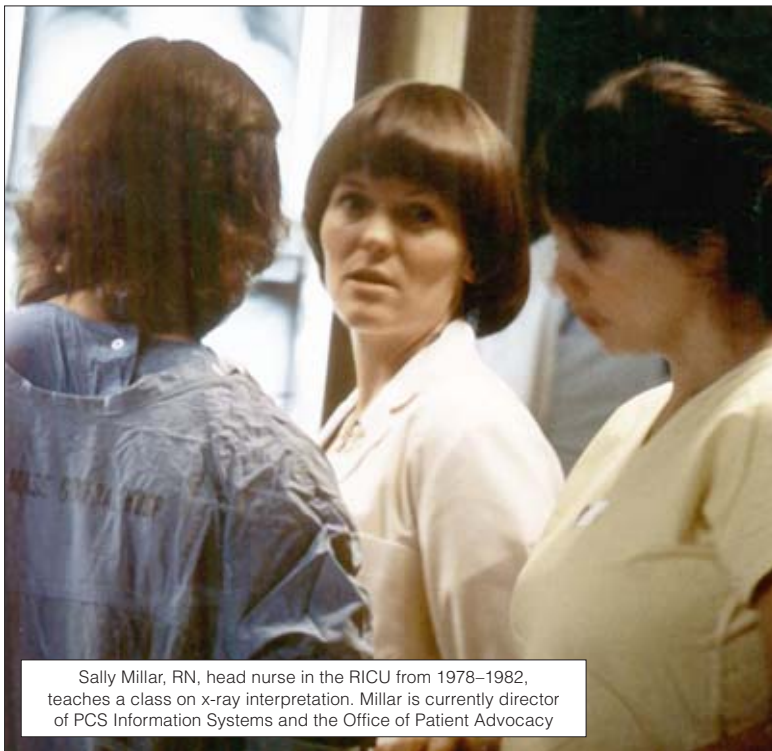
Nurses frequently 'invented' gadgets and interventions as they pioneered this new, highly specialized field of care. Many of those 'inventions' went on to become products that are used in practice today.

Critical care nursing was not recognized as a specialty until the late 1960s and early 1970s when the American Association of Critical Care Nursing (AACN) came into being. The AACN recognizes all specialties

continued on next page



Katie Brush, RN
clinical nurse specialist



Sally Millar, RN, head nurse in the RICU from 1978–1982, teaches a class on x-ray interpretation. Millar is currently director of PCS Information Systems and the Office of Patient Advocacy

(Photo provided by staff)

Clinical Nurse Specialist

continued from previous page

of critical care nursing and offers nurses the opportunity to achieve certification in critical care.

The fundamentals of critical care nursing have changed very little. We still provide compassionate care for patients, lead them toward wellness, or try to provide peace at the end of their lives. We relieve pain, try to prevent pressure ulcers, falls, ventilator-associated pneumonia, urinary tract infections, catheter- and line-related bacteremias, and medication errors. Staff of the Surgical Intensive Care Unit (SICU) have become adept at meeting these chal-

lenges, including fighting nosocomial infection. But critical care nurses face new challenges every day. We may no longer have to invent gadgets to care for our patients, but patients we see today would not have survived in an ICU equipped with the technology we possessed just ten years ago.

I'm privileged to be the clinical nurse specialist for the Surgical ICU. It's a fast-paced, dynamic, high-acuity unit where we're constantly learning new technology, new strategies in patient care, new techniques in nursing care, and changing practice based on new evidence.

My job is to translate evidence into practice and be vigilant for ways to improve practice every day. I often send reports of new research and evidence to staff and follow up by working with them to translate those findings into practice.

Another part of my job is working with colleagues across the MGH community to improve systems that may pose obstacles to high-quality care.

Some of the projects SICU nurses have undertaken include efforts to prevent the spread of nosocomial infection, ensure tighter glycemic control, and introduce goal-directed therapy. Though I'm not a direct-care provider, I help staff effect improvements in patient care every day.

A message from the Department of Health & Human Services

A certain combination of street drugs is having a lethal effect in many communities across the country. The root cause appears to be the addition of fentanyl, a powerful narcotic analgesic, to heroin or cocaine sold on the street. Fentanyl, prescribed most often to treat severe or chronic pain, is 50–100 times more powerful than morphine.

Clinicians need to be aware of this new drug combination. When used illegally, particularly in combination with drugs such as heroin or cocaine, fentanyl can result in irregular heart beat, inability to breathe, and death. Please be vigilant in your community for the presence of this potentially deadly drug mixture and help educate colleagues, coworkers, and patients.

Some facts about fentanyl:

- An outbreak of overdoses and deaths involving fentanyl com-

bined with heroin or cocaine has been reported in a number of urban areas in the United States

- Drug Enforcement Administration and Centers for Disease Control and Prevention are alerting first responders, hospital emergency rooms, healthcare providers, and the community about this new public health problem
- Fentanyl, a schedule II prescription narcotic analgesic, is roughly 50–100 times more potent than morphine
- Fentanyl can be produced in clandestine laboratories in powder form and mixed with or substituted for heroin
- The potency of heroin or cocaine is amplified markedly by the addition of fentanyl
- Routine toxicology screens for opiates will *not* detect fentanyl. Some labs can test for

fentanyl when specifically requested

- The effects of an overdose occur rapidly, particularly with this potent combination of drugs. Critical treatment minutes can be lost if emergency-room personnel are not aware that fentanyl cannot be detected in standard toxicology screens
- Fentanyl-related overdoses can result in sudden death through respiratory arrest, cardiac arrest, severe respiratory depression, cardiovascular collapse or severe anaphylactic reaction
- Because these drugs can be lethal, suspected overdoses should be treated rapidly with a naloxone injection, 0.4–2 mg IV, SC or IM every 2–3 minutes which should rapidly reverse symptoms related to a narcotic overdose

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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:

July 6, 2006



Peterson elected

Gayle Peterson, RN, staff nurse, was elected to the House of Delegates of the American Nurses Association in April, 2006.

Mannix receives Phi Kappa Phi award

Catherine Mannix, RN, nurse manager, Radiation Oncology, received the Phi Kappa Phi Honor Society Award, April 26, 2006.

Carroll receives MARN award

Diane Carroll, RN, clinical nurse specialist, received the 2006 Excellence in Nursing Research Award from the Massachusetts Association of Registered Nurses, April 28, 2006.

Quinn elected

Tom Quinn, RN, project director, MGH Cares About Pain Relief, was elected to the Nominating Committee for the American Society for Pain Management Nursing, effective April 1, 2006.

Somerville receives scholarship

Associate chief nurse, Jacqueline Somerville, RN, has been awarded the Scholarship for Nurse Executives, from The American Organization of Nurse Executives at their annual convention in Orlando, Florida, April, 2006.

Dorman and Mulgrew present

Physical therapists, Robert Dorman, PT, and Jacqueline Mulgrew, PT, presented the poster, "Minimally-Invasive Hip Arthroplasty vs. Traditional Hip Arthroplasty 2006," and, "Surgery: Early Functional Outcomes and the Impact on the Frequency and Duration of Acute Care Physical Therapy," at the American Physical Therapy Association Combined Sections Meeting in San Diego, February 1-4, 2006.

Peters-Lewis earns PhD

Angelleen Peters-Lewis, RN, nurse manager for the Endoscopy Unit, received her PhD from Boston College on April 12, 2006.

Callahan presents

Janet Callahan, PT, physical therapist, presented, "The Role of Physical Therapy in the Management of Persons with Ataxia," at the National Ataxia Foundation Membership Meeting in Quincy, March 18, 2006.

Prater presents

Marita Prater, RN, nurse manager, presented, "Stick to the Knitting: Focusing on Nursing," at the Massachusetts Organization of Nurse Executives Leadership Development Workshop, in Waltham on April 11, 2006.

Coakley, Dighe, and Lewandrowski publish

Amanda Coakley, RN, Anand Dighe, MD, and Kent Lewandrowski, MD, co-authored the article, "Analysis of a Laboratory Critical Value Reporting at a Large Academic Medical Center," in the *American Journal of Clinical Pathology*.

Sannella-Fleming presents

Susan Sannella-Fleming, PT, physical therapist, presented, "Position, Body Mechanics/Lifting, and Exercise Pre- and Post-Partum," to a group of teen mothers at the Choice Through Education Center, an extension of Chelsea High School, on April 27, 2006.

Nunn presents

Danny Nunn, CCC-SLP, speech-language pathologist, presented the posters, "Successful Revision of Laryngeal/Tracheal Diversion: a Case Study," and, "Swallowing After Pharyngeal Colonic Interposition: a Review of Six Cases," at the 14th Annual Dysphagia Research Society Meeting in Scottsdale, Arizona, March 23-25, 2006.

Crisalli certified

Keri Crisalli, RN, staff nurse in the Cardiac ICU, received the Critical Care Registered Nurse (CCRN) certification from the American Association of Clinical Nurses (AACN) in April, 2006.

Carroll presents

Diane Carroll, RN, clinical nurse specialist, presented, "Long-Term Effects of the Implanted Cardioverter Defibrillator on Quality of Life," at the Eastern Nursing Research Society meeting in Cherry Hill, New Jersey, April 20-22, 2006.

Carroll presents poster

Diane Carroll, RN, clinical nurse specialist, presented the poster, "Changes in Fears and Concerns in Recipients of an Implanted Cardioverter Defibrillator," at the Eastern Nursing Research Society meeting in Cherry Hill, New Jersey, April 20-22, 2006.

Madigan profiled

Janet Madigan, RN, project manager, was profiled as one of five state nursing organization presidents who graduated from Northeastern University's, Bouve College of Health Sciences in their *Vital Signs* publication, spring, 2006.

Oertel presents

Lynn Oertel, RN, clinical nurse specialist, Anticoagulation Management Services, presented, "Management Strategies for the Noncompliant Patient and a Credentialing Process for the Clinician," at the Seventh Annual Antithrombotic Therapy Symposium, in Dearborn, Michigan, March 27, 2006.

Grinke, Griffith, Walsh, Larkin and Capasso present poster

Kathleen Grinke, RN; Catherine Griffith, RN; Kathleen Walsh, RN; Mary Larkin, RN; and Virginia Capasso, RN, presented the poster, "Promoting Research Utilization: the MGH Nursing Research Committee," at the Eastern Nursing Research Society, in Cherry Hill, New Jersey, on April 20, 2006.

Lavieri publishes

Mary Lavieri, RN, clinical nurse specialist, wrote the article, "Evidence-Based Practice in the ICU," in the *Merrimack Valley Newsletter*, in March, 2006.

Pessina publishes

Monica Pessina, OTR/L, occupational therapist, wrote the article, "Differential Effects of Estradiol, Progesterone, and Testosterone on Vaginal Structural Integrity," in *Endocrinology*, 2006.

Goostray certified

Alan Goostray, RN, clinical service coordinator, Main Operating Room, was certified as a perioperative nurse, by the Association of Perioperative Nurses, in March, 2006.

Hemingway certified

Maureen Hemingway, RN, clinical service coordinator, Main Operating Room, was certified as a perioperative nurse by the Association of Perioperative Nurses, in March, 2006.

Brothers recognized

Sharon Brothers, RN, clinical service coordinator, Main Operating Room, received the Blue Ribbon for Excellence, for her poster, "The Role of the Orthopaedic Technician in the Operating Room," at the Association of Perioperative Nurses in Washington, DC, in March, 2006.

Nurses present poster

Virginia Capasso, RN; Theresa Cantanno-Evans, RN; Vivian Donahue, RN; Joanne Empoliti, RN; Erin Cox, RN; Susan Gavaghan, RN; Catherine Griffith, RN; Sioban Haldeman, RN; Marion Jeffries, RN; Karen Fitzgerald, RN; Susan Kilroy, RN; Cynthia LaSala, RN; Ann Martin, RN; Mimi O'Donnell, RN; Jill Pedro, RN; Marion Phipps, RN; and Susan Stengrevics, RN, presented the poster, "Re-Engineering the Infra-Structure for Wound Management in Acute Care," at the Symposium on Advanced Wound Care held at the Henry B. Gonzalez Convention Center in San Antonio, Texas, April 30–May 3, 2006.

Kilfoyle certified

Marguerite Kilfoyle, RN, staff nurse, Main Operating Room, was certified as a perioperative nurse by the Association of Perioperative Nurses, in March, 2006.

Suchecki certified

Christine Suchecki, RN, staff nurse, Ellison 10, became certified as a cardiac/vascular nurse by the American Nurse Credentialing Center in March, 2006.

Busick elected chair

Laura Busick, PT, physical therapist, was elected membership chair for the Massachusetts Chapter of the American Physical Therapy Association in March, 2006.

Ashland presents

Jean Ashland, CCC-SLP, speech-language pathologist, presented the poster, "Laryngeal Cleft in Children: Dysphagia Assessment and Outcomes," at the 14th Annual Dysphagia Research Society Meeting, in Scottsdale, Arizona, March 23–25, 2006.

Clinician Recognition Program

Advanced clinicians and clinical scholars recognized March–May, 2006

Advanced Clinicians:

- Charlene Gorden, RN, Respiratory Acute Care Unit
- Marilyn Healey, RN, Surgical
- Elizabeth Cole, PT, Physical Therapy
- Jennifer McGaffigan, RN, Obstetrics
- Susan LaGambina, RRT, Respiratory Care
- Patrick Birkemose, RN, Cardiology
- Linda Cahoon, RN, Cardiology
- Marjorie Voltero, RN, GI Unit
- Carole-Ann Sheridan, RN, Neurology
- Karen Ward, RN, Oncology

Clinical Scholars:

- Corrina Lee, RN, GYN Oncology
- Cynthia Finn, RN, Cardiac Surgery

Celebrate MGH Heart Center Nursing

June 22, 2006, 10:30–11:30am

Clinical Rounds, Haber Conference Room

"Raising the Index of Suspicion: Women and Heart Disease," presented by Jean McSweeney, RN, professor, University of Arkansas
Contact Hours will be awarded

11:30am–1:30pm

Poster Presentations, Main Corridor

Clinical staff will present posters on nursing practice, projects, and initiatives across the cardiac patient care units and laboratories

1:30–2:30pm

Nursing Grand Rounds, O'Keeffe Auditorium

"Evidence-Based Prodromal and Acute Symptoms of Myocardial Infarction in Women," Jean McSweeney, RN
Contact Hours will be awarded

2:30–3:30pm

Reception, Blake 8 Conference Room

All MGH staff are welcome

It's a journey, not a destination

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

At our second annual retreat, senior managers of Nutrition & Food Services had an opportunity to revisit our goals, reflect on where we've been in the past year, and talk about where we're going. With the support of the MGH community, we've improved patient satisfaction and delved into Provider Order Entry (POE). Coffee Central is now open 24 hours a day, seven days a week, and our patient food service employees have a 'new look.' Less visible is a

new emergency food system and a re-vamped food-safety program. Some of last year's goals continue to be a primary focus, and we've added to the list.

the experience of our consumers: patients, families, nurses, and the entire MGH community.

We are committed to expanding the open galley project to all inpatient

are committed to expanding the 4Food program to enable greater visibility of nutrition service coordinators on patient care units. Excellent Encounter training will continue this year and be emphasized to all new employees. Customer service—giving patients what they want, when they want it, how they want it—is the

links to learn more about specific diet restrictions for patients.

Now that our POE/CBORD interface has been established, we'll be looking at ways to help our clinical dietitians use their time more effectively. New technology will help us 'work smarter, not harder.'

We will be benchmarking best practices and continue to revere the importance of partnerships. We have formed valuable partnerships this past year, and our goal is to use these partnerships to be a better resource to the MGH community.

This journey is a work in progress. We welcome your comments, suggestions, and feedback as we move forward. For more information, contact senior manager, Susan Doyle at 6-2579.

Our mission: to provide comprehensive, efficient and finest quality food and nutrition services to the MGH Community. To continually establish best practice in all areas of our expertise using evaluation, assessment, and awareness of our body of scientific knowledge, the world around us, the organization, and our client needs.

Several of our goals are 'internal,' such as minimizing expenditures and celebrating the accomplishments of our staff. But all our efforts are directed at improving

units before the end of the year. A number of galleys are still awaiting renovations to install refrigerators, which will allow nurses 24-hour access to the galleys. We

fundamental focus of these training classes. You should notice a greater integration of Be Fit menus into retail operations, and we'll be introducing Be Fit menu items for patients, too.

We'll be improving our website to include retail menus, outpatient nutritional services, and

Senior managers of Nutrition & Food Services are (back row, l-r): Karen Brown, senior manager, Finance; Martha Lynch, senior manager, Clinical Nutrition Services; Deb Boudrow, senior manager, Purchasing & Distribution; Sue Doyle, senior manager, Patient Food Services; Joan Shea, senior manager, Off-Campus Retail Operations; Lillian Sonnenberg, senior manager, Ambulatory Nutrition; Jane Williams, senior manager, Technology (Front row): Lorraine Allan, senior manager, Food Production and On-Campus Retail Operations; Susan Barraclough, director, Food & Nutrition Services; and Kathy Creedon, director, Dietetic Internships/education coordinator



Educational Offerings

June 15, 2006

When/Where	Description	Contact Hours
June 28 8:00am–2:00pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
June 28 7:30–8:00am networking 8:00–9:00am presentation	Advanced Practice Clinician Series “Dermatology Update.” Haber Conference Room	1.2
June 29 1:30–2:30pm	Nursing Grand Rounds “Electronic Medical Record.” O’Keeffe Auditorium	1.2
July 6 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
July 6 8:00–4:00pm	Oncology Nursing Concepts: Advancing Clinical Practice Yawkey 2210	TBA
July 7 8:00am–4:00pm	Assessment and Management of Patients at Risk for Injury O’Keeffe Auditorium	TBA
July 10, 13, 17, 20, 24, 27 7:30am–4:30pm	Greater Boston ICU Consortium CORE Program BWH	44.8 for completing all six days
July 12 8:00am–2:00pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
July 12 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
July 12 4:00–5:00pm	More than Just a Journal Club Walcott Conference Room	1.2
July 18 11:00am–12:30pm	Chaplaincy Grand Rounds “Constructing Faith: a Developmental Perspective.” Sweet Conference Room	---
July 19 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)	---
July 19 11:00am–12:00pm	Nursing Grand Rounds “Patient Education Survey.” Haber Conference Room	1.2
July 20 12:00–4:00pm	Basic Respiratory Nursing Care Sweet Conference Room	---
July 24 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
July 24 and 25 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: BWH; Day 2: VBK401	14.4 for completing both days
July 25 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
July 26 8:00am–2:00pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
July 27 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
August 3 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
August 7 and 14 8:00am–4:00pm	Oncology Nursing Society Chemotherapy-Biotherapy Course Yawkey 2220	16.8 for completing both days

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

Spanish newspapers a hit with patients

—by Sara Burton, Volunteer Department

On inpatient units, the demand for Spanish-language books and magazines is high, but steady sources are hard to find. Book Cart volunteers who deliver reading materials to patients report that books and magazines in other languages are the most frequently requested items, with Spanish leading the way.

Volunteer, John Bruyere, a lab technician in the Neurology lab at the Charlestown Navy Yard, is fluent in Spanish and was looking for a way to use his language skills to help patients. In collaboration with the Volunteer Department and Interpreter Services, Bruyere started visiting Spanish-speaking patients in the

evenings. Though visiting and talking with patients and families was a wonderful gift, Bruyere decided he wanted to

leave something tangible with them.

Bruyere went to the offices of the Spanish-language newspaper, *El*

Planeta in Brookline and asked if they'd be willing to donate copies of the paper for patients at MGH. They were more than happy to comply. Published weekly by Hispanic News Press, *El Planeta* is the largest Spanish-language newspaper in New England.

El Planeta puts aside 40 copies for Bruyere each week.

The newspapers have been a big hit with Spanish-speaking patients and families who are happy for the chance to keep up with current events. Bruyere continues to visit patients after work and volunteer

on the Pediatric Unit.

If you'd like to donate books or magazines, bring them to the Volunteer Department in Clinics 143, Monday–Friday, 8:30am–7:00pm; or to the Warren Library, located in the Bulfinch basement Monday–Friday, 9:30am–4:30pm; or call 617-726-8540 to arrange an after-hours donation.

For more information, call 6-8540.



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