May 4, 2006

Caring HEADLINES

Inside:

The meaning behind 'speech-language pathology'

—by Carmen Vega-Barachowitz, CCC-SLP, director, Speech, Language & Swallowing Disorders

About five years ago, I had the privilege of being part of an ad hoc committee of the American Speech-Language-Hearing Association to update the scope of practice for Speech-Language Pathology. The field had changed significantly since the prior scope of practice had been written more than two decades earlier. Speech-language pathologists representing various practice settings and areas of clinical practice from across the country were invited to revise the scope of practice and re-define the role of speech-language pathologists. The resulting document, The Scope of Practice in Speech-Language Pathology, describes the breadth of our professional practice, capturing the diversity of disorders, patient populations, practice settings, and professional roles and activities encompassed by the field. The objective of speech-language pathology is to optimize an individual's ability to communicate and/or swallow in natural

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Speech-language pathologists, Danny Nunn, CCC-SLP (right), and Rebecca Santos, CCC-SLP, perform Modified Barium Swallow exam with patient, Eugene Foster, to determine the cause of his swallowing difficulties

MGH Patient Care Services
Working together to shape the future

Nursing, global health, and the journey of a lifetime

For the past year, I've had the pleasure and privilege of working with Project HOPE and the US Agency for International Development as senior nurse consultant on a very special project. As you may know, the healthcare system in Iraq has deteriorated significantly over the past few decades, which has had a devastating impact on Iraqi children who now account for more than 50% of the Iraqi population. Efforts are under way to build a much-needed, state-of-the art children's hospital in the southern Iraqi city of Basrah. I was asked to serve as senior nurse advisor and consultant on the creation of this 94-bed, pediatric oncology hospital, scheduled to open later this year.

I couldn't have been more excited to accept this challenge, and I'm energized by the work that lies ahead. But I must admit, I didn't fully appreciate the enormity of the chasm that exists between the actual healthcare-delivery system in southern Iraq and the vision we have for the Basrah Children's Hospital. This project will, indeed, be a challenge.

In my role as consultant, I'm responsible for ensuring that Iraqi nurses who will be staffing the Basrah Children's Hospital are appropriately trained and prepared to provide high-quality, specialized care to children. This work began in earnest when I agreed to mentor Sukaina Matter, the nurse who was chosen by the Iraqi Ministry of Health to be chief nurse at Basrah Children's Hospital.

Sukaina is one of only a handful of baccalaureate-prepared nurses in southern Iraq (only a few of these baccalaureate-prepared nurses will work at Basrah Children's Hospital—Sukaina, as chief nurse, another as director of education.) Sukaina made the long and arduous trip from Iraq to Boston, all by herself, to learn from MGH nurses about modern, western, nursing practice and the role of chief nurse. Sukaina arrived in September, 2005, and for three months was precepted by me and a group of committed MGH nurses who quickly became her friends.

Despite cultural and language differences, Sukaina was an exceptional student. She quickly grasped unfamiliar concepts, mastered administrative strategies, and showed great respect and interest in our advanced technology and equipment. When Sukaina left MGH in November, she had a much more sophisticated understanding of the work that needs to be done and the challenges that lie ahead.

In February, I traveled to Jordan and Oman to meet with the first group of Iraqi nurses being trained to work at Basrah Children's Hospital. The more than 200 nurses who will staff the hospital are training at King Abdullah Hospital in Jordan and the Royal Hospital of Muscat in Oman.

I had an opportunity to review the curriculum, talk with nurses, share some thoughts and ideas, and get a sense of the progress being made in terms of preparing these nurses to practice in a new specialty. I was struck by the 'thirst for knowledge' I sensed in

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First training class of nurses for Basrah Children's Hosptial

Clockwise from top left:

- Senior vice president for Patient Care, Jeanette Ives Erickson, RN, at early orientation session with Sukaina
- Visiting Iraqi chief nurse, Sukaina Matter
- Ives Erickson with nurse educators in Oman
- Basrah Children's Hospital under consturction
- Members of the first nursing training class at King Abdullah Hospital in Jordan

Jeanette Ives Erickson

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every member of the group. Currently in Iraq, nurses enter into practice after:

- completing sixth grade and three years of nursing training
- completing ninth grade and three years of nursing training
- completing twelfth grade and two years of nursing training

Typically, higher educated nurses are recruited to teach in universities.

Cultural differences add another dimension to training. In Iraq, most nurses are male, and only female nurses can care for female patients. It's customary for women, including nurses, to wear clothing that covers their head, neck, arms, and legs. This presents countless challenges to infection-control and prevention. But despite cultural, educational, and clinical differences, there was an overwhelming spirit of unity and commitment among trainees.

I continue to talk to Sukaina every week to discuss important decisions and curriculum choices. She will return to MGH for more training, and I plan to go back to Jordan and Oman to meet future training classes.

When I accepted this position as senior nurse consultant, I imagined it would last through the construction and opening of Basrah Children's Hospital. I now feel it will be a life-long journey, one I will cherish forever.

I'm hopeful that the Basrah Children's Hospital will be a source of healing and renewal for the Iraqi people. I've learned so much from this experience. It really is a privilege to be part of a global effort to care for children and families, share knowledge and expertise, and contribute to what I hope will be a peaceful future for all.

The CEO in all of us: executive function and executive-function disorder

—by Kim Stewart, CCC-SLP
senior speech-language pathologist

What is executive function?

Executive function is a term used to describe the important set of skills that helps us be organized, get places on time, and feel in control of our work and life. These skills include the ability to organize, prioritize, manage time, plan projects, follow through on tasks, and monitor our performance. Most of us don't remember learning these skills, yet we use them all the time—we leave the house in the morning and arrive at work on time, we know how to plan a birthday party, and even though it's sometimes a challenge, we know how to organize our desk and file our bills.

Children and adults with executive-function disorder have a very different experience when dealing with time, organizing their space, and planning projects. Imagine the frustration of constantly being late, not being able to find important papers, or giving up on the science project altogether because it feels too overwhelming. The difficulty is not a lack of motivation or interest. The person with executive-function disorder fails to perceive the underlying structure or process inherent in time, space, and projects.

What does executive-function disorder look like?

To understand the components of executive function, think of the responsibilities of a chief executive officer (CEO). To be successful, a CEO must initiate tasks, inhibit distractions, monitor performance, shift focus, plan, organize, prioritize, sequence, solve problems, and communicate effectively. As it turns out, the business world is not that different from the classroom; our children are required to perform the same tasks. When they're younger, parents and teachers help structure them. But as they grow up, children gain independence and are called upon to clean their rooms, be ready for the bus, or write a book report. Children who intuitively use the implicit structure in life are able to get their work done, often with enough time left over to play. Some children with executive-function disorder spend their time trying to figure out what they need to do instead of doing it; others impulsively jump into the task before creating a plan that will let them succeed. For these children, homework assignments and permission slips may not make it home. Because the day demands frequent use of executive function, children with executive-function disorder often feel overwhelmed, frustrated, and ineffective. Their intelligence and creativity is undermined by disorganization as they struggle to succeed at home and school.

Does executive-function disorder impact language?

There is a structure associated with the language skills of listening, speaking, reading, and writing. If a child doesn't see structure in space and time, it can impact his/her ability to process language. Children with executive-function disorder may not perceive structure in abstract language. They may have difficulty understanding or telling a story because they don't recognize the critical components of the story (characters, setting, initiating event, plan, attempts, and resolution). They may have difficulty comprehending what they read or composing a paper if they're not aware of the structure of exposition (topic, main ideas, details). Children with deficits in executive function may have difficulty retrieving words and information when

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Speech-language pathologist, Kimberly Stewart, CCC-SLP (right), uses the Story Grammar Marker to help 11-year-old, Taylor Aspeslagh, organize and communicate her thoughts

Speech-language pathology and head and neck cancer

—by Tessa Goldsmith, CCC-SLP, clinical specialist

Patients who've been diagnosed with cancer of the head and neck frequently experience difficulty with speech and swallowing. Changes in speech or voice quality or trouble swallowing may, in fact, be the reason patients seek medical advice in the first place. Treatment for cancer, such as surgery, radiation therapy, or chemotherapy can also affect swallowing and communication. Some of these effects are long-lasting and can persist after treatment is completed. Patients with head and neck cancer account for a unique population served by the MGH department of Speech, Language & Swallowing Disorders.

Head and neck cancer can affect any part of the oral cavity, pharynx (throat) or larynx (voice box). In some cases, the cancer spreads to the lymph nodes in the neck. Typical speech disorders include impaired articulation or pronunciation of certain sounds—the exact nature of the disorder depends on which structure has been affected. For example, difficulty articulating 't' or 's' sounds may indicate that the tip of the tongue has been affected. Sometimes air escapes through the nose causing hypernasality when the palate is involved. Difficulty speaking impacts a patient's ability to communicate with loved ones, caregivers, and community members. Speech impairment draws attention, causing patients to feel embarrassed. The role of a speech language pathologist in this instance is to try to improve function through exercise and teaching strategies to slow the rate and increase the precision of speech. Sometimes, we need the help of a maxillofacial prosthedontist (someone who makes artificial plates to improve speech intelligibility).

Patients with cancers of the larynx or voice box present with problems in communication. In cases where the larynx has been surgically removed, an artificial electrolarynx is needed to provide a source for speech. Laryngectomy patients may also be fitted with a one-way prosthesis in their stoma to allow them to use a more natural sounding voice. In either case, patients need instruction from a speech-language pathologist to be able to use their device optimally.

Head and neck cancer patients frequently have difficulty swallowing. Typical complaints include food getting caught

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Speech-language pathologists, Allison Holman, CCC-SLP (left) and Tessa Goldsmith, CCC-SLP (right), provide swallowing treatment to patient, Roberta Brundrett, following head and neck surgery

(Photo provided by staff)

Helping babies eat safely

—by Jean Ashland, CCC-SLP

Speech-language pathologists assess and treat feeding and swallowing disorders across the age spectrum from newborns to elders. Premature infants may have trouble coordinating sucking and swallowing responses because of immature lung- and muscle-development. Speech-language pathologists collaborate with nurses, physical and occupational therapists, physicians, and families to evaluate feeding and swallowing difficulties. The evaluation can include a fluoroscopy exam in Radiology, a test that examines the swallow action to determine if aspiration is occurring (if liquid is entering the airway). The Inpatient Feeding Team provides interdisciplinary evaluation and intervention for babies and children with complex medical issues that affect their ability to feed and swallow. Some techniques used to maximize safety while helping babies feed include changing nipples on bottles to better control the flow rate, supportive positioning, or alternative feeding methods during bottle- or breast-feeding.

Above: three-month-old, William, learns to feed in the NICU with the help of speech-language pathologist, Jean Ashland, CCC-SLP. Below, speech-language pathologist, Cheryl Hersh, CCC-SLP, works with 13-month old, Ben Kosty, to improve his feeding and swallowing abilities.

Head and Neck Cancer

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in their throat, coughing or choking on liquids, or liquids being regurgitated through the nose. Since many patients require a gastrostomy feeding tube during treatment, an important post-treatment goal is to help wean patients from their tube. A videofluoroscopic swallowing study (video-x-ray of swallowing) is needed to understand the nature of the patient's swallowing problem. In this test, patients are asked to drink or eat small amounts of liquid or food coated with barium, and a video x-ray is taken.

Based on the findings of the test, swallowing strategies are introduced that may improve swallowing efficiency and function. Often, simple strategies, such as alteration in head posture, make a substantial difference in the patient's ability to swallow. It is particularly helpful for patients to view the video-swallow study so they can understand the nature of the problem and the value of the therapeutic strategy.

Successful management of a patient with head and neck cancer demands the dynamic and collaborative efforts of a multi-disciplinary team of specialists who follow patients from diagnosis through treatment and beyond. Our Head and Neck Cancer Team is comprised of practitioners from MGH and the Massachusetts Eye and Ear Infirmary, and includes medical and radiation oncologists, otolaryngologists, nurses, social workers, and nutritionists. Speech-language pathologists from MGH participate actively on this team to provide patient assessment, treatment, support, education, and advocacy. The focus of treatment is on assisting patients to return to eating and drinking as normally as possible when acute treatment effects have subsided. Since many patients are fearful of choking, our goal is to teach patients to swallow safely and, where possible, wean patients from their feeding tube.

Our focus is on helping patients recover from their diagnosis and treatment and restore their quality of life to the highest level possible. Clear, open, and regular communication between patients, caregivers, and family members helps us achieve our goals.

To contact the department of Speech, Language & Swallowing Disorders, call:

- Joey Buizon, 617-643-2902, SLP associate or 617-726-2763

For information about speech, language and swallowing disorders, call:

- The American Speech, Language, and Hearing Association (ASHA): www.asha.org

For information about head and neck cancer, call:

- The MGH Cancer Resource Room: 617-724-1822
- SPOHNC: Support for People with Oral and Head and Neck Cancer:1-800-377-0928, or http://www.spohnc.org
- The Yul Brynner Foundation at www.yulbrynnerfoundation.org

Executive Function

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they speak, write, or take a test. Just like a piece of paper in a filing cabinet, if new information isn't stored in an organized manner, it's hard to find later on.

Who can help?

Many things can cause difficulty with organization and language. It's important to have an accurate diagnosis to determine the most appropriate treatment. Diagnosis and treatment are available for children and adults.

Consider executive function

Imagine a CEO...

- Initiate
- Inhibit
- Monitor
- Shift focus
- Plan (toward a goal)
- Organize
- Prioritize
- Sequence
- Problem-solve
- Communicate effectively

Now imagine your child…

- Initiate (homework)
- Inhibit (distracting thoughts)
- Monitor (performance while working on a task)
- Shift focus (between thoughts and then come back!)
- Plan (how to do a science project)
- Organize (desk to be able to find things)
- Prioritize (what homework to do first)
- Sequence (steps in making a bird house)
- Problem-solve (to address unexpected events)
- Communicate effectively (with parents, teachers, and peers)

Diagnosis

Executive-function disorder is diagnosed primarily by psychologists, psychiatrists, and neurologists. If comprehension and expression of language are in question, a language assessment by a speech-language pathologist will be needed.

Treatment

Treatment for executive-function disorder with or without language disorders can be provided by speech-language pathologists. Although treatment varies based on the individual needs of the person, skills are introduced to improve the ability to organize, prioritize, estimate time, break down tasks into steps, predict, and monitor performance. Treatment addressing language may focus on improving effective storage and retrieval and providing strategies for efficient listening, speaking, reading, and writing.

- For a speech-language evaluation, contact Speech, Language & Swallowing Disorders at 617-726-2763
- For individual or group treatment and/or parent education sessions, contact Speech, Language & Swallowing Disorders at 617-726-2763
- For services provided at the Chelsea and Revere Healthcare Centers, contact Carol Dinnes at 617-887-3527 (Chelsea), or call 781-485-6120 (Revere)

Speech-Language Pathology

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environments, thereby improving his/her quality of life.

Speech-language pathologists practice in a variety of settings. The general public is probably most familiar with our role as speech therapists working in the school setting. Because so many people associate us with schools, there's an assumption that we're primarily involved with children. In reality, our involvement with children's disorders such as articulation (when a child has difficulty pronouncing 's' correctly) represents a small part of our overall practice. In recent years, we have become more involved with the complexities of language and cognition and how they impact communication. A large part of our current practice addresses oral and written language and cognitive disorders. The evaluation and treatment of swallowing disorders in children and adults are areas of specialty that have become common practice in our field, especially in the healthcare setting.

At MGH, the department of Speech, Language & Swallowing Disorders provides services to inpatients and outpatients of all ages who present with the following disorders:

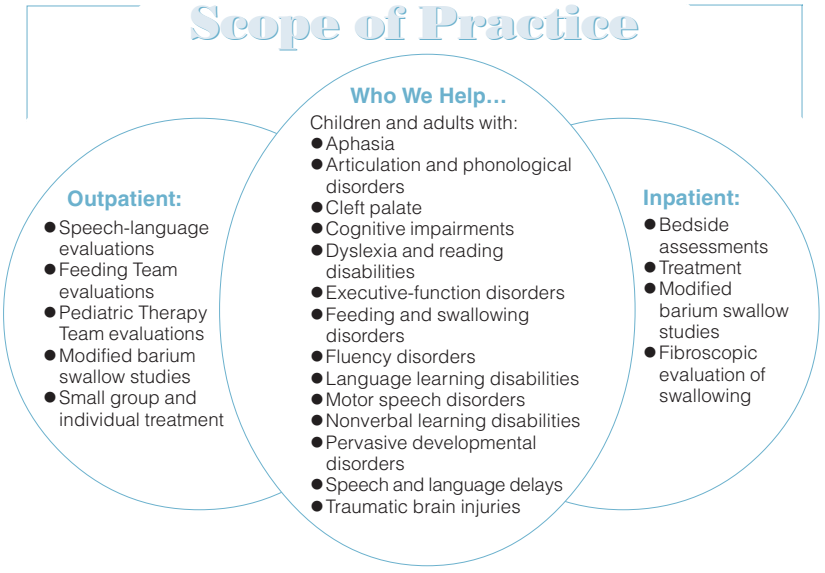
- Language (phonology, morphology, syntax, semantics, pragmatics)
  - Comprehension of oral and written language
  - Expression of oral and written language
  - Language processing
  - Pre-literacy and language-based literacy including phonological awareness
- Speech
  - Articulation
  - Fluency
  - Resonance
- Swallowing
  - Infant Feeding
  - Oral and pharyngeal stages of swallowing in children and adults
- Cognition
  - Attention
  - Memory
  - Executive Function

Like other healthcare professionals, speech-language pathologists make a profound impact on the individuals and families they serve. Sometimes this impact is related to body functions or structures and how they affect an individual's ability to actively participate in society. A patient may present with a degenerative disease that makes his tongue and face muscles weak. This change impairs the individual's ability to eat. It also impacts the individual's willingness and ability to go to a restaurant for a meal with family and friends. The speech-language pathologist's responsibility in this case is to assess the oral and pharyngeal stages of the swallow, determine the cause of the problem, and provide recommendations. When appropriate, speech-language pathologists provide treatment and recommendations to improve an individual's ability to eat by mouth. For some patients that means working with a speech-language pathologist toward the goal of resuming the important social activity of 'going out to eat,' thereby positively impacting quality of life.

Sometimes speech-language pathologists address contextual factors, such as the environment or personal factors, and how they act as barriers or facilitators to function. Environmental factors can include attitudes or physical barriers; personal factors may include age, race, and/or gender. An adult who suffers a stroke, whose listening, speaking, reading, and writing skills are impaired, can return to work if certain job modifications are made. Accommodations and modifications coupled with an attitude of inclusiveness and understanding are environmental factors that could facilitate a positive impact on this individual's life. Regardless of the disability or disorder, contextual factors can facilitate or challenge activity and participation in society and in turn enhance or diminish the quality of an individual's life.

The Scope of Practice in Speech-Language Pathology encompasses all aspects of this model, including improving quality of life by reducing the impairment and helping to increase activity and participation. Our ability to influence social and attitudinal factors while minimizing the impact of personal factors such as educational background and lifestyle is key.

Individuals are referred to speech-language pathologists for many reasons, some of which can be confusing. "Why do I have to see a speech pathologist when my problem is swallowing?" Similar questions may be asked by patients in our ambulatory practice who have impaired memory; or difficulty with reading comprehension or writing skills; or someone who presents with poor organizational or study skills. "Why do I have to see a speech therapist? My speech is fine." Or when a patient has a tracheostomy tube and needs a speaking valve; when a patient is admitted with aspiration pneumonia; when a patient is diagnosed with throat cancer and undergoes radiation and chemotherapy. Speech-language pathologists could be involved in all these scenarios. Our scope of practice is vast and continues to evolve. Hopefully, in the coming years, our role and the impact we have on improving quality of life for children, adults, and families will be well understood.



Orren Carrere Fox Award

—by Mary Ellin Smith, RN, professional development coordinator

On March 23, 2006, Orren Carrere Fox returned to the Newborn Intensive Care Unit (NICU) with his family and friends to congratulate staff nurse, Anita Carew, RN, the 2006 recipient of the award that bears his name. Orren's parents, Elizabeth and Henry, established The Orren Carrere Fox Award to acknowledge the compassionate care they received from the MGH community during Orren's hospitalization when he was an infant.

Today, Orren is a healthy, athletic nine-year-old who sports the nickname, 'Brown Potato,' in deference to his resemblance to Olympic snowboarder, Shaun White, also known as the 'Flying Tomato.'

NICU nurse manager, Peggy Settle, RN, shared that clinicians from many role groups were nominated for the award, demonstrating the importance of the contributions of all members of the team. "It really does take a village," said Settle, "to deliver comprehensive, expert, compassionate care."

Acknowledging this year's recipient, Settle described Carew, as a nurse who epitomizes the high standards of this award. She's an exceptional nurse and a role model for family-centered care.

Accepting the award, Carew thanked her NICU colleagues and stressed the importance of partnering with families in the care of newborns. Said Carew, "I always tell families, 'We're going to get through this together. I'll be by your side no matter what.' "

Speaking for the family, Orren's father said, "Every time we drive by MGH, we look up at the third floor and remember what we all went through, and what the families of the children currently in the NICU are experiencing. We send them our good thoughts and encouragement."

New CRP website

Visit the updated Clinical Recognition Program web site.

See examples of portfolios, tips from clinicians on how to develop your portfolio and prepare for your interview, and a listing of advanced clinicians and clinical scholars.

Visit: http://www.massgeneral.org/pcs/CCPD/Clinical_Recognition_Program/abt_Clinical_Recognition.asp

Award recipient, Anita Carew, RN (second from right), with nurse manager, Peggy Settle, RN (right), and members of the Orren Carrere Fox family

(Photo by Abram Bekker)

GCRC celebrates 80 years of research

—by Dayna Bradstreet, operations associate

What does Harry Potter have in common with research at MGH? In the late 1990s, scientists in Great Britain engineered what they called, Harry Potter mice that didn't experience puberty. At the same time, investigators at MGH's Mallinckrodt General Clinical Research Center (GCRC) were studying people who never experienced puberty. When these researchers got together, they discovered a gene that triggers puberty.

This is only one of many important accomplishments of investigators in the GCRC. Early MGH researchers wrote about the physiology and therapy of lead poisoning and treated many diseases of the thyroid. Subsequent scientists created an immunoassay for digoxin and explained the clinical role of calcitonin. Recent studies treated diabetes with implantable insulin pumps, studied the brain during cocaine craving, and treated HIV lipodystrophy with insulin-sensitizing agents.

The GCRC celebrated its 80th anniversary last year. It began as Ward 4, was later re-named Mallinckrodt Ward IV, and is currently called the Mallinckrodt General Clinical Research Center.

In 1925, Ward 4 was a research unit on the first floor of the Bulfinch Building, complete with outpatient beds, kitchen, nurses' station, and two laboratories. According to early director, J. Howard Means, "The ward's professional people, devoting their full time to its affairs and nothing else, have been the head nurses and dieticians... It is they who have kept the ward going smoothly, always ready to serve the cause of research, yet at the same time seeing that the nursing and dietetic care of all patients satisfied the diverse requirements of several investigators."

Nurses play an essential role on the GCRC. They are responsible for patient safety, ensuring the rights of the research participant, and maintaining informed consent throughout the study. GCRC nurses use clinical knowledge and skills to assess participants. They educate participants about their medical needs, within and outside of the trial. Nurses have regular contact with participants and are able to establish trusting relationships with them.

Nurses assist with data-collection for studies and also do their own research. One study found normal saline to be just as effective as heparin in blood sampling lines. GCRC nurses have completed many evidence-based projects on topics such as ergonomics and quality-improvement. A project is currently under way to study the use of complementary and alternative medicine among research participants. GCRC nurses are active on the Nursing Research Committee and have created posters for Nursing Research Day and other venues.

Over time, bionutrition has contributed to expertise in the design and implementation of feeding studies to assess energy-expenditure, bone-mineral density and body composition, anthropometrics, and a detailed quantification of nutrient intake from food diaries and questionnaires.

Scientific inquiry initiated by bionutrition includes a research study that compared three methods to determine energy-expenditure in overweight and obese individuals. A study to assess blood glucose response to two insulin regimens in individuals with type 1 diabetes has been proposed, designed, and funded, and will soon be implemented on the GCRC.

Today, metabolism and endocrinology research has expanded to include the fields of Neurology, Pediatrics, Psychiatry, Infectious Disease, and Anesthesia. But the basics have not changed: a dedicated staff of nurses, bionutritionists, lab assistants, administrators, and support staff provide resources to a large group of investigators and coordinators conducting diverse studies.

The GCRC has inpatient and outpatient rooms, a kitchen, research laboratory, nutrition/metabolic assessment area, and office space for GCRC staff. We also have locations at the Charlestown Navy Yard and MIT.

The GCRC has always been at the forefront of clinical research. It was one of the first human subjects research laboratories in the country. Ward 4 was the prototype for the clinical research center in Bethesda and for the more than 80 other clinical research centers in the United States now supported by the National Institutes of Health (NIH).

Soon, the NIH will convert from GCRCs to Clinical Translational Science Awards, which will dramatically change the face of clinical research. The new program is intended to break down barriers that currently exist between bench and bedside research. Each clinical and translational science entity will fall under the umbrella of a medical school, allowing connections between researchers and education and training of new investigators.

Throughout its history, the GCRC has led the way through periods of great scientific evolution. Looking at the past helps guide the future. As we celebrate 80 years of research, our committed team of nurses, researchers, volunteers, and others continues to lead in this time of transition for clinical research.

1920s

- J. Howard Means and David Edsall establish Ward 4 laboratory for human investigation
- Ward 4's first study published, the first physiological and therapeutic study of lead poisoning

1930s

- National Institutes of Health (NIH) established
- After 17-month closure during Great Depression, Ward 4 re-opens with grant from Hyams Foundation
- Albright, the "father of modern endocrinology," describes and treats hyperparathyroidism

1940s

- First use of radioactive iodine for Graves' disease (Hertz)
- During World War II, Ward 4 used by Office of Scientific Research and Development
- Metabolic aspects of convalescence are studied (Reifenstein)
- Ward 4 re-named 'Mallinckrodt Ward IV' for Edward Mallinckrodt, Jr.
- Nuremberg Code published

1950s

- Ward 4 renovated to increase space
- First description of syndrome of inappropriate anti-diuretic hormone secretion (Leaf and Bartter)
- Mallinckrodt starts endowment to ensure continued operation of Ward IV
- GCRC program established by NIH

1960s

- Ward IV receives support as a metabolic research center from NIAMD
- Declaration of Helsinki
- Dr. Henry K. Beecher's article, "Ethics and Clinical Research," published
- Howard receives Passano Award for research on calcium metabolism

MGH nurses present at National General Clinical Research Center annual meeting

—by Karen Hopcia, RN, nurse practitioner, GCRC

The National General Clinical Research Center (GCRC) annual meeting was held March 15–18, 2006, in Washington DC. GCRCs are a network of 78 centers across the country that provides an appropriate setting and nursing care for safe clinical studies involving adults and children. Each year, representatives from these centers, including nurses, physicians, bionutritionists, administrators, research advocates, and information-system managers, convene to discuss advances in clinical science and care of research participants. This year, MGH GCRC nurses were a strong presence at the meeting with formal presentations, interactive sessions, and poster presentations.

A focus of this year's meeting was the reorganization of GCRCs to Clinical Translational Science Award (CTSA) centers over the next few years. CTSAs are an initiative of the National Institutes of Health to incorporate basic medical research into the clinical research arena.

Six members of the MGH GCRC team presented at this year's meeting, including the nurse manager, clinical nurse specialist, nurse practitioner, staff nurses, and operations coordinator. Bonnie Glass, RN, nurse manager and Mary Sullivan, NP, presented, "Integrating Clinical Research Nursing at MGH." The session provided a forum for discussion about the role of advanced practice nurses in clinical research.

Kim Smith, RN, presented posters on, "The protocol process and its effect on data-collection outcomes," and "Participant reporting patterns for side-effects of study medications." Sharon Maginnis, RN, presented posters on, "Complementary and Alternative Medicine," including one on, "Evidence-based practice related to acupuncture," and one in collaboration with Jane Hubbard, RD, on a survey tool used to collect information on complementary and alternative therapies used with research participants. Gerry Cronin, operations coordinator, presented a poster documenting mile-

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(L-r): Karen Hopcia, RN; Gerry Cronin; Bonnie Glass, RN; and Mary Sullivan, RN, bring their expertise to the nation's capital

(Photo provided by staff)

- Digitalis toxicity treated with antibodies (Haber)
- Physiology and clinical role of calcitonin described (Potts)
- National Advisory Council for Protection of Subjects of Biomedical and Behavioral Research established
- Ward IV becomes NIH General Clinical Research Center (GCRC)
- National Commission publishes Belmont Report

- GCRC re-locates to larger space on White 13
- GnRH agonist treatment of central precocious puberty established (Crowley)
- Glycoprotein secretion of pituitary tumors studied (Klibanski, Ridgway)
- First treatment of type 1 and type 2 diabetes with implantable insulin pumps (Nathan, Blackshear)
- Replacement therapy for Gaucher's disease (Mankin)
- First treatment of type 2 diabetes with glucagon-like peptide-1 (Nathan, Habener)
- National Center for Research Resources formed
- Parathyroid injection treatment to prevent osteoporosis (Neer)
- MGH forms Partners Health Care with Brigham and Women's Hospital
- Elucidation of the physiology and pathophysiology of inhibins in women and men
- Functional magnetic resonance imaging (fMRI) technology shows how specific areas of human brain react to cocaine and cocaine cravings (Breiter)
- rhIGF-1 used to treat bone loss in anorexia nervosa (Klibanski)
- Pulsatile GnRH used for ovulation induction in women with idiopathic hypogonadotropism (Hall, Crowley)

- MGH GCRC renovated
- Research Subject Advocate (RSA) program founded
- Clinical Research Center at MIT becomes satellite of MGH GCRC
- Human Genome Project completed
- NIH Roadmap for Medical Research announced
- BioImaging Core established at Charlestown Navy Yard
- Alternative way of blocking hormone activity in prostate cancer patients, with fewer side-effects and improved bone density (Smith)
- NIH launches Clinical Translational Science Awards (CTSAs)
- HIV lipodystrophy studied and associated metabolic disorder treated with metformin (Grinspoon)
- Successful islet transplantation in kidney transplant recipients (Cagliero, Nathan)

Nursing presence is powerful intervention on GCRC

Mary Sullivan, RN
nurse practitioner, GCRC

My name is Mary Sullivan and I am a nurse practitioner (NP) on the GCRC, the General Clinical Research Center. In my role as nurse practitioner, I take histories, conduct physical examinations, formulate appropriate diagnoses, and identify the needs of patients and families based on the data collected.

The goal of care for research patients includes: achieving optimal health, facilitating entry into the healthcare system, promoting a safe environment, and collaborating in the provision of comprehensive, holistic care. Most importantly, it's about being present with patients.

Patients on the GCRC can be healthy, underserved with many healthcare needs, chronically ill, or nearing the end of life, presenting many challenges to care. The caring interaction within the nurse-patient relationship is the most critical component and reflects the true essence of nursing.

I'd like to share this story about my relationship with 'Eddie.' Eddie was a 74-year-old, Italian man, married, with four grown children and several grandchildren. Eddie had been diagnosed with congestive heart failure (CHF) about four years earlier. He had reached end-stage disease and had limited physical ability.

Eddie enrolled in a study that required intravenous medication to be infused once or twice a week. Patients participating in the study received active study medication or a placebo, a substance containing no medication. For this study, patients required one-on-one observation by a nurse practitioner during the infusion due to a potential for hemodynamic instability, frequent dose adjustments, and the possibility of unexpected adverse events.

As I read Eddie's medical history, I realized how sick he was, not only with heart disease, but several other medical issues. I wondered why he'd want to enroll in a research study knowing he might only get a placebo? He was at the end of his life, and I questioned why he'd want to spend his remaining months coming to the hospital twice a week, hooked up to an infusion and monitor, not even knowing if it would help. I realized I needed step back and look at the situation from his point of view. It didn't matter what I thought, felt, wanted, or would do for myself. This was what Eddie wanted. I needed to understand him and his needs, and support his decision.

In our first meeting, as Eddie received his infusions, he talked about his life, marriage, and family. As I monitored his hemodynamic measurements and potential for electrolyte imbalance, I listened to his stories and came to know him. He talked about his illness, how it impacted his life, and how he was no longer able to travel, which he loved to do. He described the feeling of freedom he felt when he drove his car, and recounted stories of cross-country family vacations. He was no longer able to travel and found it difficult to lose his independence. But he handled it gracefully, relying on memories to fulfill him.

One day during his visit, I asked Eddie why he joined the study. He responded, "You know, I don't know." He stopped reading the paper, cocked his head sideways, looked out the window and thought for a moment. Turning toward me he said, "I thought this medication might help me."

I knew from our conversations what he meant; he hoped it would let him spend more time with his family and give him time to get things in order. His family was his world, and he lived and breathed for them.

After a while, the disease began taking a toll on his body. He started experiencing increased shortness of breath, fatigue, and abdominal girth. Emotionally, he was sad and withdrawn. He required repeated hospitalizations lasting from a few days to a couple of weeks. His health was deteriorating, yet he still came in for study visits.

At times during his visits, Eddie would experience horrible bronchospasms that took his breath away and made it difficult for him to speak. Despite these attacks, he still wanted and needed to talk. Without saying it, we both knew his time was limited, and he wanted to be known. He wanted to celebrate his story of a simple, quiet, yet rich and full, family-centered life. He continued to talk while I provided an audience for his stories, validating the fullness of his life.

As I listened, I knew that advance care planning had not been addressed. Eddie was a full code (every effort would be made to save him if he went into cardiac arrest). Again, I had to respect his wishes. But at the same time, I knew I had to address his disease progression with him and the team. Eddie wasn't ready to talk about ending treatment, hospice, or resuscitation, but that door needed to be opened. I discussed his code status with the team. Eddie wanted to continue with the medication because it usually made him feel better. A code status was not his priority at this time. He wasn't ready to leave the study despite fatigue, weight-gain, and failing health. I respected his wishes, but I had opened the door, giving him permission to think about possibilities.

Eddie's wife and son came with him to every visit. Most days they went to a movie or sightseeing around town. It might seem strange, but this was what Eddie wanted. He didn't want to burden them. He took this time as an opportunity to sit back and talk. He was a planner who needed to know everything was going to be

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Narrative

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okay. His plans included caring for his wife financially, and also making sure she was emotionally taken care of. He planned for a good friend to watch over her after his death.

I remember one visit that was extremely difficult for both Eddie and me. He spoke openly and honestly about his death. As he sat in the chair after getting back from the bathroom, he was short of breath and exhausted. After he caught his breath, with his head hung low, he looked up at me with tears in his eyes. He told me his thoughts about dying, speaking about it openly. These visits provided an outlet for him to say what he felt. All I could do was listen, give support, and cry with him. This was the point in our relationship when I felt I truly knew Eddie the man.

One day, when Eddie was scheduled to come in for an infusion, he was late, which was unusual. I was paged for a phone call. It was Eddie and his wife. Eddie had decided to end his participation in the study, to stop all treatments for heart failure, and initiate hospice care. Eddie talked about what a difficult decision it had been to accept death, and then he started to choke on his words. We both knew his fight to live had ended. He had planned all he could.

As I listened, my heart was racing, my throat tightened, and my eyes filled with tears. I was so sad because I knew I wouldn't see him again. I wasn't really absorbing all he said.

I was choked up, but somehow I was able to say, "Eddie, this is your time to spend with your family. You need to enjoy the time you have with them." I thanked him for the pleasure of caring for him and his family.

Amazingly, he had wanted to call and thank me for all I had done for him. We said good-bye and hung up. I knew he had reached a point where he could stop fighting and accept death.

When I think of Eddie, two words come to mind —happiness and sadness. Happiness is what I felt when he came to the unit for his infusion and what I think when I reflect on our conversations. Sadness is what I felt knowing he was nearing death and now, knowing he has died. I miss him and what he gave to me. As a nurse practitioner, I have the privilege and honor to meet patients, be present with them, hear their stories, and come to know them in a way that is meaningful. I recognize that as my advanced nursing practice continues to grow and evolve, the collective stories of all my patients guide my thinking in practice.

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

Time and time again, we hear of the power of being present to patients. Perhaps end-of-life care presents one of the *most* powerful opportunities to make a difference with our presence.

At the outset, neither Eddie nor Mary knew what the study would bring. Mary wisely let Eddie discover for himself how coming to the GCRC could help him. Eddie used their time together to take stock of his life, share stories of his family, and ultimately come to grips with dying.

Mary's constancy was affirming, comforting, and empowering. Her ability to balance clinical care, important administrative concerns, and emotional support is the sign of a seasoned veteran. Eddie and Mary were lucky to find each other.

Thank-you, Mary.

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–5:30pm

Appointments are available for blood or platelet donations

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

Quick Hits to improve your writing!

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

Offered by Susan Sabia, editor of *Caring Headlines*

Classes now scheduled for:

Tuesday, May 30, 11:00am–2:00pm
Monday, June 12th, 10:00-1:00pm
Wednesday, July 19, 12:00-3:00
Monday, August 14th, 10:00-1:00

All classes held in GRB-015
Conference Room A

Pre-registration is required. Call 4-7840

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, contact the Employee Assistance Program (EAP) at 726-6976.

Oncology Nursing Career Development Award

On Friday, April 14, 2006, the Oncology Nursing Career Development Award was presented to this year's recipient, oncology radiation staff nurse, Gail Umphlett, RN.

The Oncology Nursing Career Development Award, was established in 1989 to recognize a staff nurse who consistently demonstrates excellence in delivering care to patients with cancer, who serves as a role model to others, and who exemplifies a strong commitment to professional development. The award is funded by the Friends of the MGH Cancer Center, an organization dedicated to providing comfort, support, education and amenities to cancer patients and their families. The recipient is selected by a multi-disciplinary review board and receives $1,000 to be applied toward professional development.

Umphlett has been a full-time nurse for 24 years, joining the Radiation Oncology Team at MGH in April, 2003. In letters of support accompanying her nomination, Umphlett was characterized as a caring, determined self-starter who always gives her all to her patients.

Nurse manager, Katie Mannix, RN, who nominated Umphlett, wrote, "Gail's empathetic manner, assessment, and care encompass all the needs of the patient and family. She regularly presents the HOPES seminar, "Introduction to Radiation." She mentors new nursing staff, and has been a preceptor for the Carol Ghiloni Student Nurse Oncology Fellowship Program."

Colleague, Lorraine Drapek, RN, wrote, "Gail has been a clinical resource and role model in helping me accept the challenge of caring for patients with cancer. She is always available and easily approachable. And she has excellent teaching skills when working with radiation oncology residents."

Clinical nurse specialist, Mimi Bartholomay, RN, said of Umphlett, "Gail has become one of the driving forces in the development of evidence-based guidelines for the nursing management of mucositis at MGH. She has also been an integral member of the group implementing these guidelines. She is committed to professional development, having obtained her oncology nursing certification, and she is currently working toward completing her master's degree."

Other nominees for the Oncology Nursing Career Development Award, were: Theresa Hartman, RN; John Opolaski, RN; and Patricia Ostler, RN.

For more information about the Oncology Nursing Career Development Award, contact Lin-Ti Chang, RN, at 4-7842.

Top left: Katie Mannix, RN; top right: recipient, Gail Umphlett, RN, with associate chief nurse, Jackie Somerville, RN; below: Umphlett with friends, colleagues, and fellow nominees

Photos by Abram Bekker

Prestigious Nathaniel Bowditch Prize shared by nurse and physicians

On April 14, 2006, the sixth annual Nathaniel Bowditch Prize was presented to the team of Theresa Gallivan, RN, associate chief nurse, and Hasan Bazari, MD, program director, department of Medicine Training Program; a separate award went to William Dec, MD, chief of Cardiology. The Bowditch Prize, established in 2000, recognizes significant contributions that enhance patient care while at the same time reduce costs associated with care.

Gallivan and Bazari were nominated for their leadership of the Clinical Process Analysis Project, which sought to optimize bed utilization while enhancing quality and efficiency of care. The project resulted in a new rounding model, a shorter (average) length of stay for patients on Bigelow 11, and an increase in the number of pre-noon discharges.

Said Jeanette Ives Erickson, RN, senior vice president for Patient Care, "Theresa and Hasan led by example, involving clinicians and support staff in every part of the process."

Says Gallivan, "It's an honor to share this award with Hasan. I feel fortunate for the rich and productive relationships we in Nursing have with our colleagues in Medicine. I also share this award with the exemplary nurses in General Medicine. Their talent, ability, creativity, and commitment have created an environment that attracts the highest caliber nurses and support staff. It's a privilege to represent them."

Andrew Warshaw, MD, chair of the selection committee and surgeon-in-chief, compared the Bowditch Prize to the People's Choice Awards as nominees and recipients are nominated by peers and colleagues.

MGH president, Peter Slavin, MD, observed that Nathaniel Bowditch was a pioneer of celestial navigation in the 19th century. Said Slavin, "It's fitting that this award, given in his name, celebrates the ingenuity and creativity of those pioneering solutions to health care's greatest challenges."

Photos by Sam Riley

Above left: Nathaniel Bowditch Prize recipients, Theresa Gallivan, RN, and Hasan Bazari, MD.
Above right: MGH president, Peter Slavin, MD, speaks at award presentation
At left: Andrew Warshaw, MD (center), chair of the selection committee, congratulates Bazari and Gallivan

Occupational Therapy gets in touch with its roots during National OT Month

—by Jessica McGuigan, OTR/L, occupational therapist

This April, occupational therapists across the country celebrated their practice as part of National Occupational Therapy Month. Inpatient and outpatient occupational therapists at MGH took advantage of the occasion to reflect on and share their practice.

Occupational therapists in inpatient and outpatient settings specialize in hand therapy, neurology, pediatrics, medically complex, acute-care, and psychiatric populations. This eclectic group of practitioners mirrors the variety of specialties that have emerged within the profession.

Occupational Therapy (OT) originated in the late 1800s and early 1900s, when it focused on the moral treatment of mentally ill patients. Therapists advocated the use of music, exercise, and occupation for the treatment of mental illness. With the great number of soldiers who survived World War I and World War II, OT evolved into treating the physically wounded, with the focus shifting to physical disabilities impacting job-related activities. The profession began moving toward specialization in two distinct areas: physical disability and psychosocial dysfunction.

Over the next century, the profession continued to change in response to the political and social climate, technological advances, and public-health issues. Most recently, the Massachusetts Department of Mental Health has ammended its regulations around the use of restraint and seclusion with agitated and aggressive clients. There is now a mandate for the use of sensory tools to help clients manage emotions and behaviors that can typically lead to restraint and seclusion. This has been an opportunity for occupational therapists to use a combination of skills and knowledge from our roots in mental health with the specialized practice that has evolved over the last century.

Using academic training in mental health, sensory and neurological stimulation, and adaptive environments, the MGH Occupational Therapy Department is working with the department of Psychiatry to develop a sensory room. A sensory room provides clients with a safe space to explore the use of senses (touch, smell, sight, etc.) as a means to cope with mental illness. Using sensory-integration theories developed and studied by occupational therapists and creating a calming environment (glider chairs, a waterfall, relaxing music and lighting) helps clients cope with the stress of being hospitalized. Aroma therapy, stress-relief balls, and weighted blankets give clients access to new coping mechanisms with the goal of increasing their health and wellness once they return to work, home, and leisure activities.

As the profession revitalizes its roots in mental health, Occupational Therapy continues to bring a unique perspective to its practice with a focus on participation in occupation. Regardless of physical or mental constraints, the mind-body connection continues to be the foundation of occupational therapy practice.

Occupational therapist, Jessica McGuigan, OTR/L, in the OT area (below) and the soon-to-be completed sensory room (above) on Blake 11

The Beat Goes On: a closer look at ventricular assist devices

—by Kathy Sweezey, RN, staff nurse

On Wednesday, March 22, 2006, the Cardiac Surgical Nursing Service presented a day-long workshop entitled, "The Beat Goes On: Ventricular Assist Devices for the Treatment of Heart Failure." Sixty nurses and other health-care professionals from MGH and other Boston hospitals attended.

A joint presentation of the Blake 8 Cardiac Surgical Intensive Care Unit (CSICU) and the Ellison 8 Cardiac Step-Down Unit, the workshop was developed to share information about the care of patients with stage IV heart failure who require mechanical assistance to support cardiac function. Some patients go on to receive a heart transplant, others are 'destination' patients, living with the permanent assistance of a ventricular assist device (VAD).

Presenters included staff nurses, a nurse practitioner, a cardiac surgeon, and a multi-disciplinary team involved in the daily care of VAD patients. Some of the topics included:

- Historical Perspective and Evolution of VAD Technology
- Patient Selection and Informed Consent
- Nursing Care in the Progressive Care Unit
- Medical Management
- Nursing Care in the Immediate Post-Op Period
- Preparation for Home
- It Takes A Village: the VAD Patient's Multi-Disciplinary Team
- Respiratory Care
- Social Services
- Occupational Therapy
- Physical Therapy
- Case Management
- Future VAD Technology

A panel of VAD patients and family members shared their experiences living with a VAD. They talked about the highs and lows of living 'on a machine,' trouble-shooting, modifying their homes and lives, battery-maintenance, and how it feels to depend on friends and family members for many of their day-to-day needs.

One patient in her 40s, described how difficult it was to relinquish her place as coordinator of family activities and how she missed getting up early, getting her son off to school, and having everything done by breakfast. "Now," she said, "I move slowly and feel tired a lot of the time."

One family member described an emergency situation in which he had to hand pump his brother's VAD while in a helicopter being transported from another state.

Patients were effusive in their praise of nurses and other providers. One young woman told how she depended on nurses and looked forward to seeing them, even if they weren't assigned to her. "Just stopping by to say 'Hi' made me feel like everyone cared about me."

One patient was emphatic that if it weren't for the nurses, "I think I would have given up. They made me exercise. Not with a chain or a whip, but with kindness and understanding."

Patients and family members spoke of how nurses had helped them maintain hope through their long and difficult journeys.

Attendees agreed that hearing the patients' perspective was enlightening and helped them realize that even the smallest efforts have an impact on patients.

The Beat Goes On will be offered again on Wednesday, September 6, 2006. For more information, or to register, call The Knight Nursing Center for Clinical & Professional Development at 6-3111.

Beat Goes On presenters include, top: staff nurse, Jennifer Carr, RN. Left to right are: Stephanie Ennis, ANP, Jackie Mulgrew, PT, and Kathy Schultz, RN. Below, panel of patients and family members share their experiences with attendees

Think clean with hand hygiene

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

At MGH, we're on a journey to make hand hygiene routine for everyone. Hand hygiene is the single most important factor in preventing the transmission of pathogens (germs that cause infection) and reducing the risk of infection for patients. It seems simple, but it's so important that JCAHO made it a National Patient Safety Goal to "comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines."

Hand hygiene is required *before* and *after* contact with patients or patients' environment. The preferred method of hand hygiene is disinfection with an alcohol-based, waterless hand rub, such as Cal Stat. Hand-washing with soap and water is still necessary when hands are visibly soiled, after using the toilet, before eating, and after contact with a patient on precautions for *C difficile*-associated diarrhea. Hand-washing should be followed by a Cal Stat hand rub (except before eating because it can leave a distasteful residue).

Fingernails are included in the CDC's hand-hygiene recommendations. Evidence suggests that artificial and long natural fingernails can aid the transmission of infections by healthcare workers. MGH policy is that artificial nails and nail jewelry may not be worn. Natural nails must be kept clean, and no longer than 1/4 inch. If nail polish is worn, clear polish is preferred to provide better monitoring of nails (but colored polish is acceptable). Nail polish must be well maintained, not cracked, chipped, or scratched.

Gloves are not a substitute for hand hygiene. Cal Stat must be used before and after glove use. Gloves should not be worn while transporting patients unless an assistant is present to open doors, press elevator buttons, or perform other activities that require direct contact with the environment.

The MGH Hand Hygiene Program was developed by the STOP Task Force to promote good hand-hygiene practice. The program is comprised of education, awareness, unit-based champions, compliance surveys, feedback to staff and managers, a poster series featuring MGH staff and physicians, and a rewards program. Promotional efforts have included articles in *Caring Headlines*, the *Hotline*, and *Fruit Street Physician*, a booklet designed for staff and visitors, and special events including a signature poster campaign, handouts, contests, and pins. Compliance goals were established, and units that met them were rewarded with a pizza, ice-cream, or bagel party.

Since the inception of the Hand Hygiene Program, hand-hygiene compliance rates have improved from 8% to 61% before contact, and 47% to 78% after contact. And many units and role groups achieved even higher compliance rates, such as the staff of Blake 6 and Physical and Occupational Therapy, whose rates exceeded 90%. As improvements were made, there was a noticeable decrease in infection rates for MRSA and VRE, underscoring the importance of hand hygiene for everyone who comes into contact with patients: staff, physicians, and visitors.

The Hand Hygiene Program will be expanding to include other departments and ambulatory care practices, and efforts will be made to involve patients and visitors. A video is being developed to teach patients and visitors about the importance of hand hygiene. Staff and physicians are being encouraged to use Cal Stat as they approach every patient and to expect the same from everyone. Higher compliance goals have been set for 2006. Units will be expected to achieve a minimum of 80% compliance, and the rewards goal will be 90%, consistent with JCAHO standards. Units that achieve 90% both before and after contact will be given a pizza party (or equivalent). The ultimate goal is to achieve 100% compliance, a goal that will require the effort and participation of everyone at MGH.

Join us on our journey to be the best. Together, we can make hand hygiene routine at MGH.

For more information on the MGH Hand Hygiene Program or to become a hand hygiene champion on your unit, contact Judy Tarselli in the Infection Control Unit at 6-6330.

GCRC

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stone events on the GCRC since its inception in the 1920s. Karen Hopcia, NP, presented a poster on, "Ergonomics in the research unit," citing optimal configurations of outpatient rooms and blood-sampling methods.

MGH nurses also contributed to the regional GCRC meeting. New England GCRCs crafted a statement on the importance of clinical research nurses describing the unique role and specialized knowledge required by clincal research nurses in safeguarding research participants. Clinical research nurses are actively involved in every aspect of clinical research, from developing a protocol implementation plan, to providing patient care, collecting data, and implementing practice standards based on the findings of clinical research. The position statement was unanimously endorsed by the GCRC nursing group for future distribution.

In addition to attending the annual meeting, GCRC nurses took advantage of being in the nation's capital and visited Massachusetts legislators to discuss the role of clinical research nurses in the new Clinical Translational Science Awards. With the guidance of the MGH department of Nursing, a message was delivered to the offices of Senator Ted Kennedy, Senator John Kerry, Representative Stephen Lynch and Representative Michael Capuano on the importance of nursing in clinical research.

Clinical research nurses build trusting relationships with research participants; they are primary caregivers and advocates in clinical research. Clinical research nurses are key to promoting excellence in clinical research, maintaining patient safety, and providing participants with appropriate resources within and outside the clinical study.

New on-line safety-reporting system

Question: How is safety-reporting (formerly incident-reporting) handled at MGH?

Jeanette: Incident-reporting used to be a manual process, but on March 22, 2006, the new on-line safety-reporting system went live. You can now access the safety-reporting website from Safety Reporting MGH listed under Partners Applications on your Start button.

Question: Why has the safety-reporting system moved from paper to on-line?

Jeanette: Having a safety-reporting system on-line makes it easier and more efficient for staff. The hope is that more staff will report safety concerns now that access is so convenient. Web-based reporting is less time-consuming, and information is easier to analyze, so communication and feedback are more timely.

Question: Why is it important to report events?

Jeanette: Reporting 'out of the ordinary' events is critical in identifying and addressing systems issues. Reporting 'near misses' and close calls helps identify potential risks and hazards before something serious happens. Event-reporting allows us to explore the causes of errors and weaknesses in the system and understand why an error happened. If we know why an error happened, we're better equipped to prevent it and develop new systems to reduce the risk of it happening again.

Question: Won't there be negative consequences if I make an error and then report it?

Jeanette: No. We're working hard to establish a culture of safety, and safety-reporting is critical to any effective safety initiative. MGH promotes a 'no-blame' environment. We want to know about errors so we can discover contributing factors and prevent future harm to patients and staff. Error-reporting is essential in assessing system performance, *not* staff performance.

Question: People are ashamed when they make a mistake. Why would they want to admit to it?

Jeanette: The culture is changing. We don't want people to feel ashamed. We want people to feel good about the fact that reporting errors contributes to a safer environment. Disclosure of adverse events prevents errors in the future and ensure that systems are working the way they were intended.

Question: How many reports have been submitted on-line?

Jeanette: Almost 300 reports have been filed since March 22nd. An average of 16 reports are received on-line every day. The manual system will remain active until staff has been trained in the new system.

Question: What category do most incident reports fall into?

Jeanette: Since March 22nd, the most frequently reported events are related to: medication/IV safety; falls; general employee incidents; ID/documentation/consent; and safety/security/conduct.

Question: How can I arrange to be trained on the new safety-reporting system?

Jeanette: Staff from the Office of Quality & Safety offer training sessions in large, multi-disciplinary forums or in small groups on units or in individual departments. Training takes about 30 minutes. As of April 13, 2006, more than 2,000 staff and 50% of department leadership and quality chairs had been trained.

If you would like to set up a training session, contact Deb Mulloy in the Office of Quality & Safety at 6-0167.

Be prepared for your patients' questions

Learn more about HPV and genetic testing for women's cancers

Topics:

- What's new in genetic testing: understanding the implications for breast and ovarian cancer
- Cervical cancer screening: what's the message behind HPV?

Thursday, May 18, 2006
11:00am–1:30 pm
Yawkey 10-660

sponsored by: Dana Farber/Partners Breast and Cervical Screening Collaborative and the MGH Women's Health Coordinating Council

Pre-registration is required. To register, call 617-726-3111
Contact hours will be awarded

MESAC Update

Did you know you can link directly to the IV Push Policy from the MESAC website?

Click your 'Start' button and scroll up to 'Partners Applications.' Highlight 'Clinical References' and click MESAC. From the MESAC website you can link directly to a variety of resources to help you provide safe and effective care to your patients. When you check out the MESAC website, use the 'Feedback' option to let us know how we can make the site more helpful to you.

Clinical Pastoral Education fellowships for healthcare providers

The Kenneth B. Schwartz Center and the department of Nursing are offering fellowships for the 2007 Clinical Pastoral Education Program for Healthcare Providers

Clinicians from any discipline who work with patients and families may apply

The program is part-time with group sessions held Mondays from 8:30am–5:00pm
Additional hours are negotiated for the clinical component

Deadline for application: September 1, 2006

For more information call 6-4774 or 4-3227

Kindman certified

Mary Kindman, RN, staff nurse, Ellison 11, became certified as a cardiovascular nurse in March, 2006.

Pessina active in community

Monica Pessina, OTR/L, occupational therapist, is a member of the Americans with Disabilities Committee of West Newbury, Massachusetts.

Moran, president-elect

Peter Moran, RN, case manager, is the new president-elect of the Case Management Society of America, 2006–2007.

Macauley elected secretary

Kelly Macauley, PT, physical therapist, was elected secretary of Geriatric Special Interest Groups for the Massachusetts Chapter of the American Physical Therapy Association, from 2006–2009.

Quinn on Nominating Committee

Thomas Quinn, RN, project director, MGH Cares About Pain Relief, was elected to the Nominating Committee for the American Society for Pain Management Nursing in March, 2006.

Mylott receives award

Laura Mylott, RN, clinical nurse specialist in The Knight Nursing Center for Clinical & Professional Development, received the Academic Nursing Early Career Award from the Massachusetts Association of Colleges of Nursing, in March, 2006.

French receives NNSDO award

Brian French, RN, professional development coordinator, The Knight Nursing Center for Clinical & Professional Development, received the 2006 Excellence in the Role of Professional Development Facilitator, Change Agent, and Consultant Award, from the National Nursing Staff Development Organization (NNSDO), in March, 2006.

Lavieri presents

Mary Lavieri, RN, clinical nurse specialist, presented, "Pulmonary Critical Care," at the Critical Care Registered Nurses Review in Manchester, New Hampshire, March 30 and 31, 2006.

Lowe presents

Colleen Lowe, OTR/L, occupational therapist, presented, "Sensation and Sensibility," at the Tufts University, Fellowship Program March 27, 2006.

Akladiss presents

Joanne Akladiss, OTR/L, occupational therapist, presented, "Introduction to UE Evaluation and Intervention," "Splinting Applications and Principles," and "Introduction to Physical Agent Modalities," at the University of New Hampshire in March, 2006.

Fitzgerald presents

Karen A. Fitzgerald, RN, clinical nurse specialist, Post Anesthesia Care Unit, presented, "Heart Failure and the Surgical Patient: Implications for Peri-Anesthesia Nursing," at the Massachusetts Society of Peri-Anesthesia Nurses Spring Conference, March 12, 2006.

Jeffries presents

Marian Jeffries, RN, clinical nurse specialist, Thoracic Surgery, presented, "Comparison of CNS Responses to a National Survey on Common Patient Problems with Responses from Staff Nurses and CNSs in a Large Boston Medical Center," at the National Association of Clinical Nurse Specialists Convention in Salt Lake City, March 17, 2006.

Madigan featured

Janet Madigan, RN, project manager, was featured in the March, 2006, *Nursing Spectrum*, in the articles, "A Toolbox for Survival: The Future of Nurse Leadership Depends Upon an Intelligent Combination of Mentoring and True-to-Life Classroom Experiences," and, "Massachusetts Hospitals Go Public: Staffing Stats Now Public Domain Throughout the State."

Pazola presents

Kathy Pazola, RN, staff nurse, clinical scholar, presented her clinical narrative to nursing students at the Massachusetts College of Pharmacy in Worcester, April 3, 2006.

Pessina presents

Monica Pessina, OTR/L, occupational therapist, presented, "Primate and Human Research Related to Upper Extremity Function," at Tufts University School of Occupational Therapy, February 25, 2006.

Quinn presents

Thomas Quinn, RN, project director, MGH Cares About Pain Relief, presented, "Respiratory Depression: Do We Really Need to be so Nervous?" and, "Palliative Sedation by Any Other Name," at the annual meeting of the American Society for Pain Management Nursing in Orlando, Florida, March 31, 2006.

Snydeman presents

Colleen Snydeman, RN, nurse manager, RACU and CCU, presented, "Intercepting Near-Miss Adverse Events: the Critical Care Nursing Safety Net," at the Institute for Nursing Healthcare Leadership at Brigham and Women's Hospital March 28, 2006.

Coglianese reviews

Debra Coglianese, PT, physical therapist, reviewed the book, *Muscles: Testing and Function with Posture and Pain*, by Florence Peterson Kendall, Elizabeth Kendall McCreary, and Patricia Guise Provance, for *Physical Therapy*, February, 2006.

Nurses present

Colleen Snydeman, RN; Bessie Manley, RN; Brenda Miller, RN; John Murphy, RN; Marita Prater, RN; Aileen Tubridy, RN; Donna Perry, RN; and, Trish Gibbons, RN, presented the poster, "Creating a Culture of Leadership: the MGH Nurse Manager Leadership Development Program," at the Massachusetts Organization of Nurse Executives, March 10, 2006.

A message from Infection Control: diagnosing and managing patients with mumps

—by David Hooper, MD, chief, Infection Control Unit, and Stephen Calderwood, MD, chief, Division of Infectious Diseases

As you may be aware, a large outbreak of mumps has been reported in Iowa and adjacent states, with a smaller number of cases identified in several other more distant states. On April 26, 2006, the Boston Public Health Commission issued an alert stating that three cases of mumps had been reported in Boston since April 18th. Investigations are on-going, and it is anticipated that additional cases will occur.

With that in mind, we want to provide the following information:

Diagnosing and managing patients with mumps

Mumps should be suspected in any patient who presents with unilateral or bilateral pain and swelling of the parotid salivary gland (parotitis). Other symptoms, including low-grade fever, malaise, headache, and muscle-aching, may also occur.

For patients suspected of having mumps:

- Put the patient on Droplet Precautions (move patient to a private room, which doesn't need to have negative pressure; healthcare workers wear a surgical mask within three feet of the patient; and patients should wear a mask when outside the room)
- Notify Infection Control at 726-2036
- Inquire about contact with other people known or suspected of having mumps
- Inquire about a prior history of mumps, prior mumps or measles mumps rubella (MMR) vaccination (how many doses and when), and any prior tests for mumps immunity (positive answers to these questions do *not* exclude a diagnosis of mumps)
- Draw one red-top tube of blood for mumps virus antibody (IgM and IgG) and send to Clinical Microbiology Laboratory
- Promptly collect a clean-catch urine sample 5-10ml in a screw-top sterile container and send to the Clinical Microbiology Laboratory on ice for mumps culture/PCR
- Collect a sterile dacron swab from the buccal mucosa of the upper rear molars 30 seconds after massage of the parotid gland on the same side. Promptly place the swab in viral transport and send on ice to the Clinical Microbiology Laboratory for mumps culture/PCR

Protection from mumps

The Boston Public Health Commission and the Massachusetts Department of Public Health recommend documentation of immunity for healthcare workers involved in patient contact and at risk for exposure to patients with mumps by either:

- a positive test for antibody (IgG) to mumps virus
- or documented receipt of two doses of MMR vaccine

Unprotected exposure (without droplet precautions) to a patient with mumps by a healthcare worker without documented immunity could result in a furlough from work from day 12 to day 25 after exposure (the incubation period between exposure and onset of clinical symptoms).

To ensure immunity for at-risk healthcare workers, Occupational Health will provide mumps antibody testing. MMR vaccine will be offered to staff who have no contra-indications, whose tests are negative, or who have received one or fewer prior doses of MMR vaccine.

Staff in ambulatory and emergency areas, those most likely to encounter mumps cases, will be a priority for testing and vaccination if needed and not contra-indicated. Information about this process will be/has been provided to ambulatory and emergency managers.

For more information about mumps or managing patients with mumps, contact the Infection Control Unit at 6-2036.

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

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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:
May 25, 2006

Medication-reconciliation initiative: 'Be Med Smart'

—by Janet Madigan, RN, project manager

To help reduce the risk of medication errors and comply with JCAHO's National Patient Safety Goal to, "accurately and completely reconcile medications across the continuum of care," MGH is launching an electronic medication-reconciliation initiative to help clinicians track the medications being taken by inpatients and outpatients. Medication reconciliation involves obtaining a complete list of the medications a patient is currently taking (including the name, dosage, frequency, and route) and comparing it to admission, transfer, and discharge medication orders. The goal is to reduce the risk of omissions, dosage errors, duplication of drug classes, or other types of discrepancies as patients travel through what can be a complex path of care.

The electronic medication-reconciliation initiative began on some units on April 25, 2006, when a new module was introduced in Provider Order Entry (POE) to support the new process. The new module is called the Pre-Admission Medication List (PAML).

The list, which includes all prescription, over-the-counter, and herbal medications, can be accessed in an outpatient setting, such as a physician's office, and must be reconciled at time of admission and discharge. The admitting clinician (physician, physician assistant, or nurse practitioner) is responsible for documenting pre-admission medications in PAML, indicating the planned action for each pre-admission medication on admission, accurately entering medication orders into POE, and collaborating with members of Pharmacy and/or Nursing within 24 hours of admission to resolve uncertainties.

Key components of the initiative:

- The nurse is responsible for reviewing and verifying the PAML at admission when the PAML icon appears on the Unit Census Monitor
- The PAML should be printed and used as a worksheet to review with the patient, family and/or the patient's caregiver
- If discrepancies are identified, the nurse is responsible for communicating discrepancies to the admitting clinician and updating the information in PAML so that the physician can update POE orders if appropriate
- If medication information cannot be confirmed with the patient, family, and/or caregiver, the nurse must make a notation in the Comment section of PAML
- The nurse must electronically sign the modified PAML as the PAML reviewer and discard the paper PAML in the recycle bin
- The pharmacist then reconciles the admission POE orders with the PAML based on the admitting clinician's planned action for each medication. If there are discrepancies, the pharmacist contacts the physician to resolve the discrepancies

If the patient is transferred within the hospital:

- At transfer, the physician enters medication orders in POE by also referring to the PAML
- The nurse must review the PAML to ensure that medication orders written on transfer are consistent with the PAML
- The pharmacist reconciles orders against the PAML

Upon discharge, the discharging prescriber (MD, NP, PA) is responsible for reconciling the discharge medications with the PAML. The nurse must compare the discharge medications with the PAML and notify the provider who discharged the patient of any discrepancies so discharge medications can be adjusted by the provider if appropriate.

- Once the PAML and discharge medications have been reviewed, the nurse clicks the, 'Check here if PAML has been reviewed' button in the Nursing Discharge Note section
- Discharge medications must be reviewed with the patient, family and/or caregiver, and the patient must receive a copy of the completed discharge medications from the Post-Hospital Care Plan. The patient should not be given a copy of the PAML

Says senior vice president for Patient Care, Jeanette Ives Erickson, RN, "This initiative represents a vital partnership between our patients and caregivers. It is essential that every member of the care team works together to keep the PAML accurate. We're confident this new system will streamline the process making it easier for all clinicians to keep our patients safe."

A patient awareness campaign called, 'Be Med Smart,' is being launched along with the medication-reconciliation initiative encouraging patients and families to maintain an accurate list of medications and bring that list with them to all appointments, hospitals admissions, and ED visits.

The Medication Reconciliation Committee is chaired by Chris Coley, MD; Sally Millar, RN; and Meg Clapp, RPh. For more information about the medication-reconciliation initiative, contact Joanne Empoliti at 6-3254 or Rosemary O'Malley at 6-9663.

Medication-Reconciliation Roll-Out

General Medicine: White 8, 9, and 10, Ellison 16	April 25
General Medicine, Oncology: Bigelow 9, Blake 7, Ellison 14	May 1
Pediatrics: Ellison 17, 18 and PICU	May 8
Cardiology and Psychiatry: Ellison 9, 10, 11, Blake 11	May 15
Neurology and Burn Unit: Bigelow 12, White 12, Ellison 12, Bigelow 13	May 29
General Surgery, Vascular Surgery: SICU, Ellison 7, White 7, SICU, Bigelow 14	June 5
Orthopaedics, Gynecology and Transplant: Ellison 6, White 6, Bigelow 7, Blake 6	June 12
Medicine: Phillips 20, 21, Bigelow 11, White 11	June 19
General Surgery, Cardiac Surgery: Ellison 8, 19, 22 and Blake 8	June 26
Obstetrics: Ellison 13, Blake 13, 14, and NICU	July 10

When/Where	Description	Contact Hours
May 10 8:00am–2:00pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
May 12 and 22 8:00am–5:00pm	**Advanced Cardiac Life Support (ACLS)—Provider Course** Day 1: O'Keeffe Auditorium. Day 2: Thier Conference Room	- - -
May 15 8:00am–4:30pm	**Post-Operative Care: the Challenge of the First 24 Hours** Thier Conference Room	TBA
May 16 11:00am–12:00pm	**Chaplaincy Grand Rounds** "Providing Spiritual Care for Kids and Families." Sweet Conference Room	- - -
May 17 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
May 18 11:00am–1:30pm	**Be Prepared to Answer your Patients' Questions: HPV and Genetic Testing for Women's Cancers** Yawkey 10-660	TBA
May 22 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)	- - -
May 23 8:00am–2:00pm	**BLS Certification for Healthcare Providers** VBK601	- - -
May 24 8:00am–4:00pm	**Psychological Type & Personal Style: Maximizing Your Effectiveness** Training Department, Charles River Plaza	8.1
May 24 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (for mentors only)
May 25 12:00–3:30pm	**Basic Respiratory Nursing Care** Sweet Conference Room	- - -
May 25 1:30–2:30pm	**Nursing Grand Rounds** "PICC Your Lines: the Inside Story." O'Keeffe Auditorium	1.2
May 31 8:00am–12:30pm	**Pediatric Advanced Life Support (PALS) Re-Certification Program** Training Department, Charles River Plaza	- - -
June 1 7:30–11:00am/12:00–3:30pm	**CPR—American Heart Association BLS Re-Certification** VBK401	- - -
June 2 8:00am–4:30pm	**Intermediate Respiratory Care** O'Keeffe Auditorium	TBA
June 7 8:00–11:30am	**Intermediate Arrhythmias** Haber Conference Room	3.9
June 7 12:15–4:30pm	**Pacing Concepts** Haber Conference Room	4.5
June 7 and 14 8:00am–4:30pm	**Wound Care Education: Phase II** Training Department, Charles River Plaza	TBA
June 13 11:00am–12:00pm	**Chaplaincy Grand Rounds** "Providing Care to Jehovah's Witnesses." Sweet Conference Room	- - -
June 14 8:00am–2:00pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (for mentors only)
June 14 11:00am–12:00pm	**Nursing Grand Rounds** Haber Conference Room	1.2

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.

What's a little friendly competition among colleagues?

Nurses and physicians in the MGH Medical Service are engaging in a friendly competition during the month of May. To encourage donations to the MGH Blood Donor Center, doctors (interns, junior and senior residents, and attending physicians), have challenged nurses from the medical units (White 8, 9, 10, and 11, Bigelow 9 and 11, Ellison 16, Phillips 20 and 21, and the Medical Intensive Care Unit) to see who can donate the most blood. All donors will receive a T-shirt; the winning team will enjoy a pizza party to celebrate their victory.

Nurse manager, Susan Morash, RN, and resident, Allan Moore, MD, kick off the Medical Service Blood Donor Challenge with the first donation. Gail Fennessy, LPN, performs the blood-draw.

Some people think blood shortages only occur during the winter holidays. That's not the case. Every summer there is a state-wide shortage of blood due to donors going on vacation, companies shutting down, and a lack of donorship from schools and colleges that are closed for the season.

Blood drives like the one the Medical Service is holding help increase the amount of blood we have on hand and urgently need for our patients. You can help. Blood donors make many life-saving treatments possible. All blood given to our patients is donated by generous strangers like you.

Got an idea for a blood-donor challenge? It could save a life. For more information, call Kathryn DeCoste, marketing specialist, in the Blood Donor Center at 4-9699.

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