

November 16, 2006

Caring

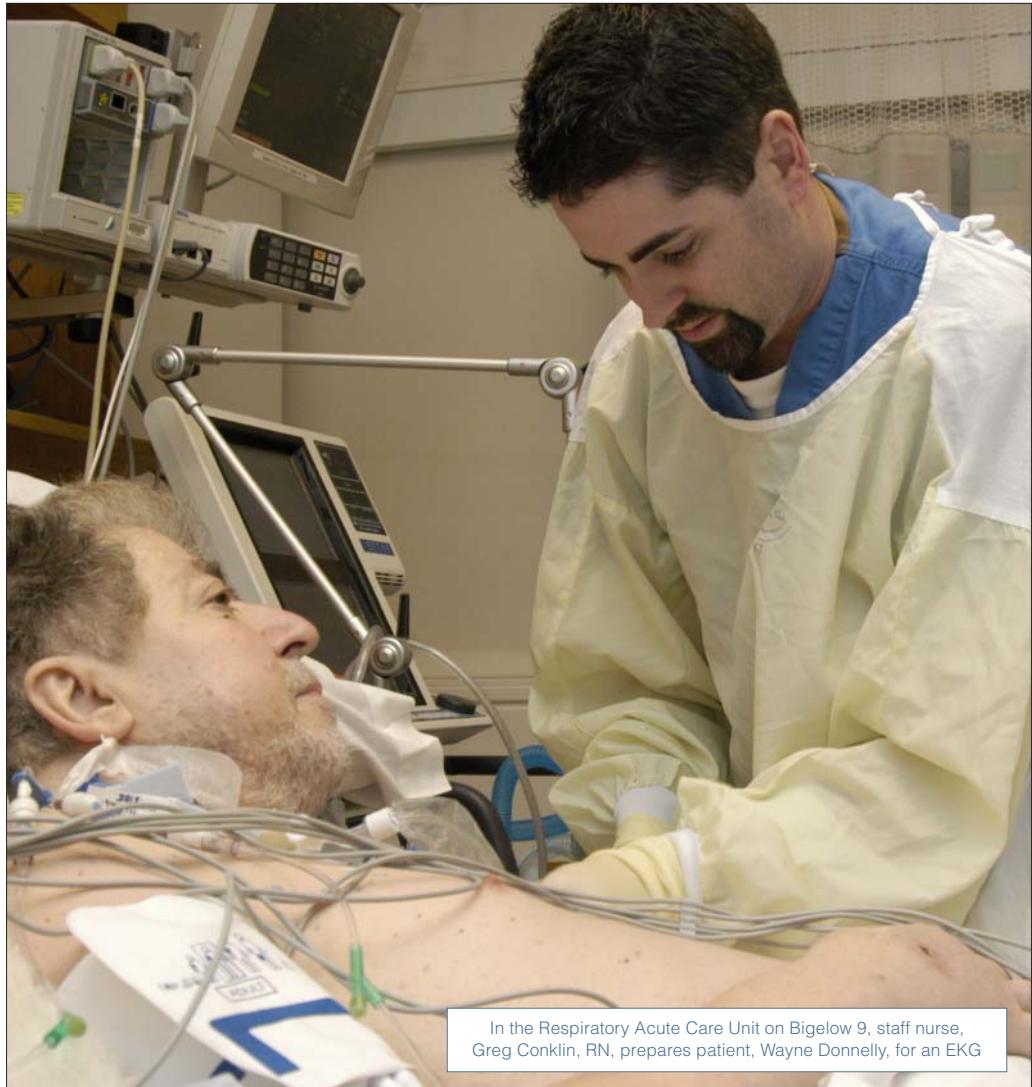
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Medical nursing: a complex and rewarding specialty

(See stories on pages 4, 6, 8)



In the Respiratory Acute Care Unit on Bigelow 9, staff nurse, Greg Conklin, RN, prepares patient, Wayne Donnelly, for an EKG

Medical nursing, Patricia Benner, and clinical narratives

The landmark book, *Novice to Expert*, by Patricia Benner, RN, professor, Thelma Shobe chair in Ethics and Spirituality at the University of California, promotes the use of clinical narratives as a way to uncover knowledge embedded in clinical practice. Benner believes that, "Narrative accounts of practice reveal the clinical reasoning and knowledge that come from experiential learning. Clinical narratives can become a resource to help practitioners understand their own practice, see and share the clinical knowledge of peers, and reveal strengths and impediments of practice." Narratives give clinicians an opportunity to examine what they do and why. They allow clinicians to describe their experiences in a way that includes their concerns, intuition, verbal exchanges, challenges, conflicts, their evolving understanding of events, their desire to take risks, and their feelings of doubt.

As important as it is for clinicians to write stories describing their clinical practice, it's just as important to share those narratives and discuss them with others. When clinicians discuss their narratives with col-

leagues, peers, and clinical experts, they gain new insights, discover cues that weren't known before, and make connections between phenomena that may have been invisible before. Whether sharing their own stories or hearing someone else's, discussion gives clinicians an opportunity to view clinical practice from another perspective, and this process reveals insight, wisdom, and best practices.

Narratives are helpful to clinical leadership not only in helping to deve-

director to seek additional resources to assist staff in identifying and managing ethical situations.

Narratives can help reveal what good, excellent, and not-so-excellent practice looks like. They can reveal systems that support excellence in care, and they can call attention to where systems may need to be improved. It takes courage to tell a story where, despite our best efforts, we fail to achieve a positive outcome for a patient. But these are the stories we must tell. These are

gain a greater depth of understanding, influences not only our present way of thinking but our future interactions. Clinicians who reflect on their practice and gain insight into their motivation,



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

"Narrative accounts of practice reveal the clinical reasoning and knowledge that come from experiential learning. Clinical narratives can become a resource to help practitioners understand their own practice, see and share the clinical knowledge of peers, and reveal strengths and impediments of practice."

—Benner and Benner, 2002

lop individual clinicians but in understanding patterns of concern. Clinical leaders can identify issues and concerns in clinical practice and institutional systems by quantifying the themes that emerge in narratives. An increase in narratives that talk about ethical distress may prompt a manager or

the stories that inform practice and enlighten staff. It's only through honest examination that we can truly achieve excellence.

Narratives are a key tool in the development of reflective practice. Reflection, the ability to carefully consider one's own practice in order to

judgment, and actions go into the next situation more present and aware. This is how a novice becomes an expert; this is how we continuously improve practice and the care we deliver to our patients.

In honor of Medical Nurse Day, Patricia Benner visited MGH on No-

vember 15, 2006, to participate in two educational sessions. The morning session gave Dr. Benner an opportunity to hear narratives written by medical nurses and offer expert commentary. The afternoon session was a multi-disciplinary case presentation exploring the importance of teamwork and collaborative practice. I hope you were able to attend one or both of these sessions and hear the compelling stories of your medical nursing colleagues. Listening to these narratives and the lively discussion that followed, I know you would have been moved to share your own clinical practice. Perhaps we can look forward to reading them in a future issue of *Caring Headlines*.

Update

I'm happy to announce that Maria Rice, RN, has accepted the position of clinical nurse specialist for the Emergency Department, effective November 13, 2006.

Flu vaccine roll-out: are you prepared?

On November 7, 2006, the Provider Order Entry (POE) prompt was activated to cue providers to order flu vaccine for inpatients age 50 and older. Providers can choose the pre-selected order for flu vaccine, decline the order, or defer the decision for up to five days. The flu-vaccine prompt will be active through March 31, 2007.

Question: What is the procedure for administering flu vaccine after an order is received in POE?

Jeanette: Nurses screen patients for eligibility using the Adult Influenza Vaccination Screening and Eligibility Form (#84511) and give patients or family members a copy of the 2006-07 Inactivated Influenza Vaccine Statement (English form #84512; Spanish form #84513) to review. If patients meet the eligibility criteria, nurses administer the vaccine and complete the information at the bottom of the form. The form is filed in the Medication Section of the medical record and a copy is given to the patient or family member.

Question: Do nurses need to obtain consent from a patient prior to administering flu vaccine?

Jeanette: No. But patients and family members have the right to refuse the vaccine after reviewing the Inactivated Influenza Vaccine Statement.

Question: Why does the Screening and Administration Form require so much information?

Jeanette: A patient's eligibility to receive flu vaccine must be determined prior to vaccination (Section 1 of the form). If a patient is eligible for the vaccine and the vaccine is administered, the Department of Public Health requires documentation, including date, lot number, manufacturer, expiration date, injection site, and the signature of the nurse administering the vaccine (Section 2 of the form).

Question: Are there any contra-indications to the flu vaccine?

Jeanette: Yes. Patients should not receive the flu vaccine if they have already received a flu vaccine this season, or if they have any of the following contra-indications: previous severe reaction to flu vaccine; an allergy to eggs, thimerosal, or latex; a history of Guillain-Barré syndrome; or fever greater than 100°F or 38°C at the time of vaccination.

Question: Do I have to wait until the day of discharge to administer the vaccine?

Jeanette: No. But if the vaccine is given on the

day of discharge, it must be given at least 20 minutes prior to discharge so the patient can be observed for a reaction. The risk of flu vaccine causing serious side-effects is small. Severe reactions, such as hives, shock, or difficulty breathing occur rarely and should be reported immediately to the patient's physician.

Question: Do I need to document vaccine information in the Nursing Discharge Module?

Jeanette: Yes. The nurse discharging the patient needs to document the date the patient received the flu vaccine or the reason the patient didn't receive it. The prompt in POE will not appear during subsequent admissions during the same flu season if it has been documented that the patient received the vaccine or a contra-indication was indicated.

Question: Some of my patients have an order for flu vaccine and the pneumovax at the same time. Why is that? Can I administer both vaccines at the same time?

Jeanette: Providers now see a combined flu and pneumovax screen in

POE for patients 65 years old and older who are eligible to receive both vaccines. Eligible patients have no documentation of receiving the pneumovax since turning 65 and no documentation of receiving the flu vaccine this season. Providers have the option of ordering, declining, or deferring one or both vaccines. If both vaccines are ordered, it's safe to administer them at the same time. Screening and documentation for the flu vaccine is outlined above. Patients

must be screened for pneumovax eligibility using the Pneumococcal Vaccination Screening and Eligibility Form (#84502) and the patient or a family member is given a copy of the Pneumococcal Polysaccharide Vaccine Statement (English form #84492; Spanish form #84493). All other documentation remains the same.

For more information about the flu and pneumovax programs call Janet Madigan, RN, project manager at 6-3109.

The MGH Tobacco Treatment Service

Under the current standard, all patients should be asked if they've used tobacco products in the past 12 months. If they have, the Tobacco Treatment Service should be notified (6-7443) for a consult

In the smoke-free environment of the hospital, The Tobacco Treatment Service can help patients avoid nicotine withdrawal

Every patient who has smoked in the past 12 months should be given a copy of the *Guide for Hospital Patients Who Smoke* (Standard Register form #84772). A copy of the guide is placed at every patient's bedside when the room is cleaned

Helping patients to quit smoking is part of the excellent care all clinicians provide at MGH.

**Make your practice visible
Document your work**

For more information, or to request a quit-smoking consult, call 6-7443

The Medical Nursing Practice Committee

—by Cynthia LaSala, RN
clinical nurse specialist

Medical Nursing is an area of specialty practice that more often than not deals with the unexpected. Medical patients present with complex, diverse, physical and psychosocial needs that challenge both novice and experienced nurses in a dynamic, ever-changing environment. Team-building, collaboration, and consultation among staff and unit leadership are critical to daily operations and effecting quality patient-care outcomes.

The Medical Nursing Practice Committee was formed in March of 2005 by the nurse managers and clinical nurse specialists of the general medical units, the Medical Intensive Care Unit (MICU), and the Respiratory Acute Care Unit (RACU) to provide a forum for collectively identifying, discussing, and resolving practice issues of mutual concern. After weeks of brainstorming, it became clear that the interests and issues raised by the group were related not only to professional practice but to performance-improvement, and professional development, as well. Unit leadership was committed to including staff nurses from each medical unit as active participants.

Using the collaborative governance model, a nurse manager and clinical nurse specialist assumed co-chair responsibilities with the intention of staff nurses assuming those roles later on with a nurse manager or clinical nurse specialist as coach. Within the first few months, the Medical Nursing Practice Committee agreed on the fol-

lowing vision statement to guide its work: "To create a professional practice environment that promotes medical nursing as a specialty through clinical excellence, research-based practice, a spirit of inquiry, and a commitment to lifelong professional development."

The committee identified a mission statement

and guiding principles to support their vision. Its mission is to provide a forum to identify, discuss, and resolve issues related to nursing practice, quality improvement, and professional development.

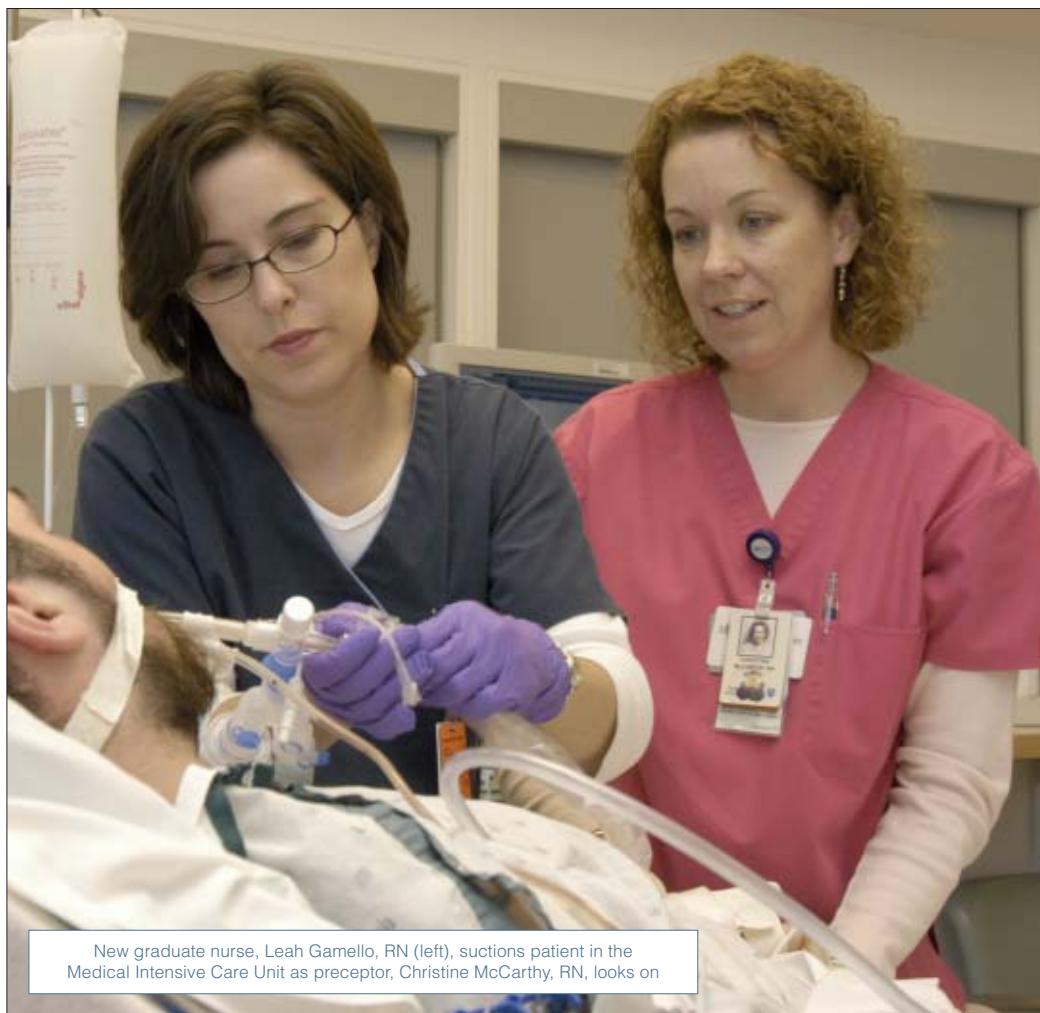
Guiding principles are:

- *We believe...* that trust, mutual respect, integrity, and a shared commitment to a unified team approach are the foundation for all we do
- *We believe...* that 'knowing the patient' is cen-

tral to establishing therapeutic relationships with patients and the provision of quality patient care

- *We believe...* that an interdisciplinary approach individualized to the patient's physical, emotional, cultural, and spiritual needs promotes better patient-care outcomes
- *We believe...* in the healing power of nursing and caring through service to patients, families, and one another

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Medical Nursing Practice Committee

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- *We believe...* in life-long learning and fostering an environment that encourages clinical inquiry, creativity, mentorship, and career development
- *We believe...* that professionalism means being personally accountable and responsible for one's practice, on-going professional growth, and the advancement of professional nursing
- *We believe...* in the nurse as patient advocate and the critical role the nurse plays in empowering patients to take an active role as possible in their care to

achieve optimal wellness and quality of life

- *We believe...* in maintaining a safe environment for patients, families, and staff by minimizing the potential for injury through collaborative problem-solving, performance-improvement, and promoting a blame-free environment
- *We believe...* in the importance of celebrating our successes and promoting medical nursing as a specialty practice area

Since its inception, some of the committee's activities and projects have included the development and implementation of a template for giving nurse-to-nurse report between the ICU and general medical units; establishing a workgroup to evaluate the use of patient observers; proposed guidelines related to smoking privileges and behavioral management of patients with psychiatric and/or substance-abuse problems; development and implementation of transcription guidelines for the treatment record; unit-based best practices related to minimizing the risk of patient falls; care of mechanically ventilated patients and staff train-

ing needs; initial assessment and triaging of front-door admissions; the development and implementation of plans to celebrate Medical Nursing 2006; and a one-day Medical-Surgical Certification Exam Review Course for staff nurses.

Interdisciplinary collaboration related to these projects and activities has included the Office of Quality & Safety; the Admitting Office; Respiratory Care; physicians on the Medical Service; the Cardiac Nursing Practice Group; Police, Security & Outside Services; staff specialists; the Nursing Practice Committee; Human Resources; nursing supervisors; and the Psychiatric Clinical Nurse Spe-

cialist Consultation Liaison Service.

The Medical Nursing Practice Committee is preparing for a transition in leadership this month. Two staff nurses are taking over co-chair responsibilities, giving them and others to follow a wonderful opportunity for personal and professional development as nurse leaders. Nurse managers, clinical nurse specialists, and staff nurses look forward to another exciting and challenging year of collaboration, problem-solving, and teamwork in advancing the specialty of medical nursing and promoting an environment of clinical inquiry and life-long learning that ensures the highest quality care to patients and their families.



Ushering new graduate nurses into the complex specialty of medical nursing

—by Kate Barba, RN, and Patricia Fitzgerald, RN

Many new graduate nurses opt to work on a general medical unit after graduation to gain experience caring for patients with a variety of medical, psychological, and social issues. This multi-faceted patient population provides new graduates with a multitude of learning opportunities. Due to the complex needs of these patients, nurses must have highly developed critical-thinking and physical-assessment skills and the ability to effectively collaborate and communicate across disciplines.

Bigelow 11 is a 25-bed general medical unit that hires an average of five to seven new graduate nurses a year. The clinical nurse specialist (CNS) role is shared by Kate Barba, RN, and Patti Fitzgerald, RN. In response to the increasing complexity of the general medical population, CNSs, with staff input, have implemented several strategies to assist new graduate nurses throughout their first year of practice.

New nurses on Bigelow 11 participate in an eight-week orientation period with an experienced preceptor. During this time, new graduate nurses slowly increase their

responsibility and patient assignments, until they're able to function independently. The CNS acts as a resource to the new graduate and the preceptor during the orientation period. The CNS meets frequently with the preceptor and new graduate nurse to evaluate the orientation process and to identify areas where additional support is needed. Support can be as simple as providing research about certain

clinical conditions, or as complex as developing an in-depth learning plan to ensure the new graduate's successful completion of orientation. During orientation, the new graduate nurse spends a day working with the CNS to review clinical issues and competencies necessary for completion of orientation. This is a casual, low-stress day that focuses not only on clinical issues but on the new graduate's psycho-

social and emotional adjustment to his/her new situation.

After the eight-week orientation period ends, the CNS and all nurses on Bigelow 11 continue to provide support to the new graduate. Bigelow 11 has a strong culture of learning, where questions are encouraged, and no issue is too small. Everyone is expected to participate in helping the new graduate nurse develop.

The CNS checks in with the new nurse daily, discussing patient assignments and helping the new graduate analyze clinical data and create a plan of care. The resource nurse checks in with the new nurse several times

throughout the shift to ensure he/she doesn't become overwhelmed by his/her patient assignment.

Working the night shift can be challenging for new nurses. A helpful strategy we've used to assist nurses to transition to the night shift is to have an experienced night nurse act as a mentor to new nurses over the course of a few nights. The experienced nurse doesn't take a direct patient-care assignment, but focuses on helping new nurses organize their work and adjust to the different pace and responsibilities of the night shift.

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New nurse, Melissa Donovan, RN (right), with the aid of preceptor, Christina Dhimtri, RN, administers antibiotic via Sigma pump to patient, George Flynn

New Graduate Medical Nurses

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New graduate nurses are encouraged to select a mentor. It can be the nurse's preceptor or another experienced nurse with whom the new graduate has developed a relationship and whose practice he/she admires. The new graduate and mentor attend the New Graduate Nurse Development Program together, and mentors become a supportive resource to new graduates thereafter.

Research shows that the six-month milestone is an important one in the

development of a new nurse. This is when new graduates' competence and proficiency increase as they simultaneously experience a decline in morale and confidence. On Bigelow 11 we employ a couple of strategies to help new graduates over this developmental hurdle. On the new graduate's first day on Bigelow 11, he/she is encouraged to plan a vacation to coincide with their six-month anniversary. We've observed that nurses need to re-energize

at this pivotal point, and time away from the unit is a good way to achieve that. Last year's new graduates took this advice to heart and planned a group trip to the Dominican Republic. With support from veteran staff members and some creative scheduling, we were able to make this happen. They returned to the unit well rested, tan, and eager to take on new challenges.

Another strategy we use to help new graduates get over that six-month hurdle is what we call, "New Graduate Day." This is a time when new graduate nurses spend

time away from the unit with the CNS and other experienced nurses to address any clinical, emotional, or psychosocial issues they may have. The content of the day is driven by the needs of the new graduates with experienced nurses developing and presenting classes. A highlight of this day is the discussion session with new graduates and senior staff.

These open discussions give both groups a better understanding of perceptions and needs and strengthens relationships between staff.

New graduates attend other, structured programs

during their first year, such as Basic Nursing Respiratory Care and Simulated Bedside Emergencies for New Nurses. These classes provide important clinical content and an important change of pace from the clinical setting. We encourage new graduates to identify other educational experiences they'd like to try such as observing on different units.

At the one-year mark, most new graduates are much more comfortable with the routine of the unit and can easily handle their patient assignments. It's at this point that our focus on their development changes. We begin to encourage them to participate in unit projects, orient to the resource role, and begin to think about participating in collaborative governance. We begin to have discussions about their interests and career goals and challenge them to become more involved in unit and hospital-wide activities.

The increasing acuity of our inpatient population impacts everyone, but none more than new graduates. It truly does "take a village" to help them develop strong clinical skills and the values and philosophies that they'll carry with them throughout their entire careers. By using a combination of strategies, we improve their competence and confidence, and set the stage for a happy and successful nursing career.



Medical nurse brings empathy, compassion, and advocacy to end-of-life care

Brittany Kupferberg is a clinician in the PCS Clinical Recognition Program

My name is Brittany Kupferberg, and I am a staff nurse on the White 9 Medical Unit. I started this particular day the way I start most days. When I got into work, I prepared to accept report from the night nurse. We were 'trading assignments,' which means I was taking all her patients for the day shift. She told me that the patient in room 42 was going to break my heart. I listened to his story. A 45-year-old man, who had come to MGH for an evaluation of a questionable mass on his liver, had presented with complaints that his belly 'just kept getting bigger' despite the fact that he'd been losing weight. He had a new, sharp flank pain, and he had been admitted for a work-up of these complaints.

Mr. D had a known history of hepatitis C, and was found to be in liver failure upon admission. A biopsy of his liver was performed, and we were awaiting the results. After report, I knew I had to see Mr. D first.

I went into his room and saw a man whose belly looked like it belonged on someone else's body. He was thin and jaundiced and had that all-too-familiar look of fear in his eyes. I tried to

engage him in conversation but could tell he was in no mood for talking. I told him how to call me if he needed anything, and assured him I'd be there with him throughout the day.

An hour later, I noticed that Mr. D had a visitor. I was caring for the other patient in the room when I heard him tell the visitor that I was his nurse. I walked over and introduced myself to the woman whom I learned was Mr. D's wife. Mrs. D was immediately engaging, asking questions, wanting to learn everything she could about what was going on with her husband's care and hospital course. I sat with them and told them both everything I knew about Mr. D's care. In his wife's presence, Mr. D opened up more and more. I enjoyed having Mr. D as a patient, and I was moved by how caring his wife was. The rest of our first day together was uneventful—Mr. D was being monitored and awaiting the final results of his liver pathology.

The next morning when I returned to work, I was rounding with the team when I heard the news for the first time. Mr. D's pathology results were back, and they were very poor. He had been diagnosed with hepato-

cellular carcinoma, and the lesion was so large it had spread almost across his entire liver. The team consulted Oncology, and the junior resident and the attending physician planned to talk with Mr.

and Mrs. D at noon. When rounds were over, the operations associate paged me to Mr. D's room. I went to see what he needed. Mrs. D said she was sorry to bother me; they just wanted to know what the doctors were going to talk with them about at the noon meeting. I told them the doctors wanted to go over Mr. D's test results. Later, Mrs. D told me she knew something was wrong in that moment. She saw in my eyes that everything wasn't as they'd been hoping.

A little while later, I saw the junior resident and attending physician go into Mr. D's room and close the door. As I tended to my other patients, I kept a close eye on Mr. D's door so I'd know when their meeting was over. A short while later, the doctors left the room. I wanted to go in, but I thought they might need time to digest what they'd just heard. I waited a few minutes and then went in to see them. Their eyes were red and watery. They were both lying in the small twin bed hold-

ing each other. I quietly told them I was there for them, but recognized their need to just be with each other.

That evening, Mr. D called me and said he was starting to feel short of breath. I checked his lung sounds and oxygen saturations and heard he was wheezing with bibasilar crackles. His saturation was only 87%. I called the doctor, and we began to give Mr. D a nebulizer treatment and some intravenous lasix. He immediately regained control of his breathing. Medically, this episode had been easy to diagnose and resolve, but it carried a lot of meaning. This was the first time Mr. D had had an acute episode. Up until now, his pain and fatigue had been chronic. This shortness of breath was another indication that Mr. D was more than just a little ill.

The next morning, Mr. D was already awake and waiting for me when I came in to see him. Mrs. D was there, too.

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**Brittany Kupferberg, RN
staff nurse, White 9**

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

Clinical Narrative

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had tears in my eyes. We heard Mr. D finishing up in the bathroom and quickly wiped our faces—we didn't want him to see how sad we were.

Later that day, Mr. D's friends came to visit him, and he truly came alive. This man who'd been so flat, so scared, suddenly became a vivacious character, telling stories, making a room full of people laugh. Mrs. D came out and asked if they were being too loud. I smiled and told her Mr. D looked so happy with his friends, I wouldn't dare try to quiet them down.

Later that night, Mr. and Mrs. D began to talk

about being discharged. They had decided they needed to go home. Given Mr. D's grave diagnosis, they wanted to spend as much time as possible at home. I shared this information with the junior resident, and we talked about preparing Mr. D to leave the following day.

That night, as I was leaving, I saw Mrs. D as I was walking past the parking garage. She was talking on her cell phone, and I waved to her as I walked by. She hung up abruptly and came over to me. She hugged me and thanked me for being there with them at this difficult time. She told

me how much it meant to her that I had taken the time to ask her how she was. She appreciated that I had asked her when Mr. D wasn't in the room. She was so worried for him, but of course, she didn't want him to know how scared she was. I hugged her and told her what a pleasure it had been to take care of Mr. D.

I don't think either of them realized what an impact they had on me. Mr. D was not a medically complex patient. His vital signs were stable, he was able to do a lot for himself, and he had a great support system. Mr. D needed the kind of care that can't be learned from a book or by sitting in a classroom. He needed someone to listen to him,

to sit and talk with his wife, to make him feel comfortable with his diagnosis—to the extent that that was possible.

The next morning, I began to prepare Mr. and Mrs. D for discharge. During his hospitalization, Mr. D had some serious declines in his health. He was becoming weaker and weaker every day. His pain had increased, and as we increased his pain medication, his mental status became foggy. He needed more diuretics and had a new oxygen requirement. I had spoken with the junior resident about his discharge. We were both apprehensive about his leaving, but we understood Mr. D's desire to be home. We both wanted to give him that chance.

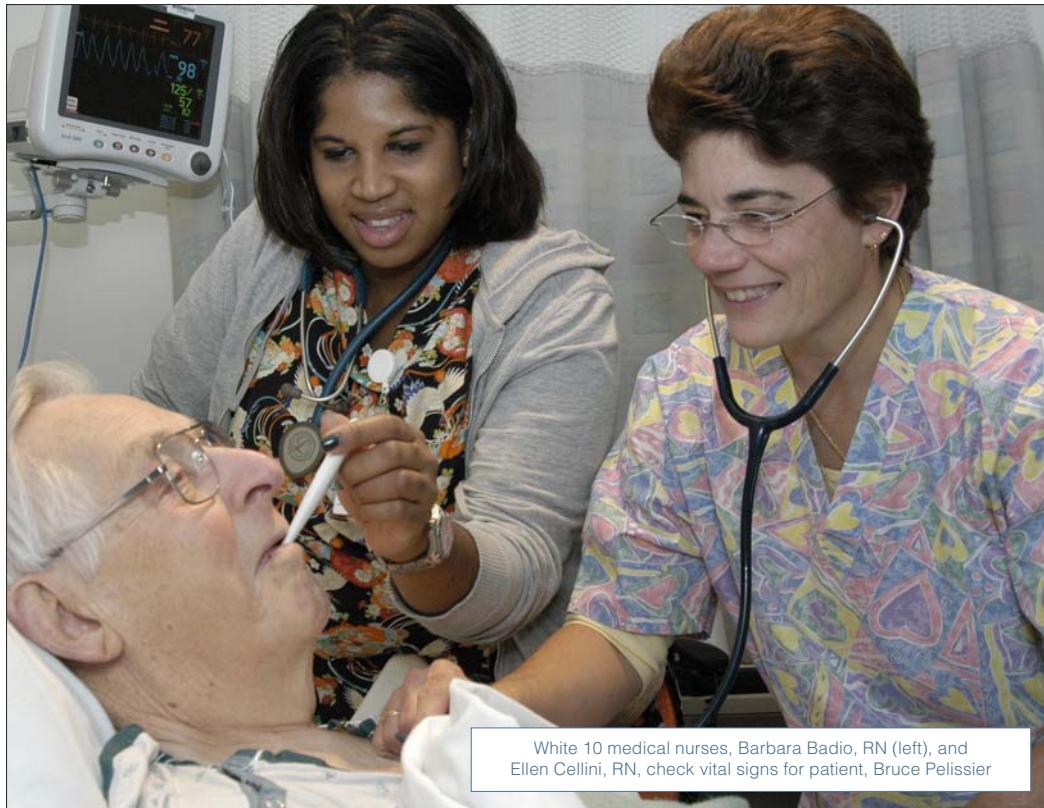
I prepared Mr. and Mrs. D for the possibility that they might have to return to the Emergency Room. I knew they'd both think of it as a setback, but I wanted them to know the signs to look for. And I didn't want them to be surprised if Mr. D continued to decline. I searched for the right words to tell them without being discouraging.

Even though it's been months since Mr. D's admission, I still think of him all the time. He was one of those patients who makes you remember why you wanted to be a nurse. I know I made a difference in his end-of-life care, and that is something I will always treasure.

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

This narrative beautifully showcases Brittany's clinical skills and caring practice. She knew intuitively when Mr. and Mrs. D needed to be alone and when they needed her presence. She reached out to Mrs. D knowing the entire family was affected by Mr. D's illness. Transitioning home so close to the end of life is a tremendous stress for anyone. Brittany prepared Mr. and Mrs. D for what to expect and how to manage once they were home. She empowered them to 'normalize' a very out-of-the-ordinary situation.

Thank-you, Brittany.



Comfort and Support After Loss Memorial Service

—by Leslie S. Kerzner, MD, associate medical director, Special Care Nursery

Con November 5, 2006, the Comfort and Support After Loss Committee held its 15th annual Pediatric, Neonatal, and Obstetric Bereavement Service. This memorial program is dedicated to families who have experienced the death of an infant, child, or adolescent, or who have lost a child through miscarriage or still-birth.

Fredda Zuckerman, LICSW, obstetric social worker, moderated the service. Ron Kleinman, MD, acting chief of Pe-

diatrics; Howard Weinstein, MD, chief of Pediatric Oncology; and Judy Newell, RN, nurse manager of the pediatric inpatient units participated in the program; Reverend Ann Haywood-Baxter, pediatric chaplain, shared a non-denominational reading; and several family members read stories and poems reflective of their journeys through grief and bereavement.

Music was provided by Lora, Lisa, and Patricia Tamagini whose voices echoed poignantly throughout the service. Parents, families, and

friends were invited to take part in the traditional naming ceremony; they received tulip bulbs and a pewter heart in memory of their children.

Family members and caregivers hung memorials on a remembrance board; the memorials will be added to a quilt in the future. A slide show capturing 15 years of memories was presented.

Following the service, a reception was held in the East Garden Room. The memorial quilts from 1998–2002 were on display outside the General Store, and



several scrapbooks from years past were available for viewing.

Members of the Comfort and Support After Loss Team include:

- Fredda Zuckerman, LICSW
- Kathryn Beauchamp, RN
- Ann Haywood-Baxter, MDiv
- Genevieve Gonzales, LICSW
- Heidi Jupp, RN
- Leslie Kerzner, MD
- Elyse Levin-Russman, LICSW
- Janet Madden, RN
- Joyce McIntyre, RN
- Brenda Miller, RN
- Kristen Nuttall, RN
- Heather Peach, CCLS
- Eileen White

MGH Institute of Health Professions Information Sessions

Thursday, December 14, 2006, 6:00–8:00pm

Saturday, February 24, 2007, 10:00am–12:00pm

Thursday, May 17, 2007, 6:00–8:00pm

For more information, visit: www.mghihp.edu/admissions/infosessions.html

Call for Proposals

The Yvonne L. Munn, RN, Nursing Research Awards

Submit research proposals for the annual Yvonne L. Munn, RN, Nursing Research Awards to be presented during Nurse Recognition Week, May 6–11, 2007

Proposals are due January 16, 2007

Guidelines are available at: www.mghnursingresearchcommittee.org For more information, call 617-726-3836

Call for Abstracts

Nursing Research Day 2007

Categories:

- Encore presentations (posters presented at conferences since May, 2006)
- Original research
- Research utilization
- Performance improvement

Some restrictions apply

For more information, go to the Nursing Research Committee website at: www.mghnursingresearchcommittee.org

Abstracts must be received by January 31, 2007

Magnet ambassadors attend Denver conference

—by Sheila Golden-Baker, RN; Gayle Peterson, RN; and Madeleine McGarry, RN

Seventeen MGH nurses led by Keith Perleberg, RN, nurse manager and co-chair of the Magnet Re-designation Team, and Sheila Golden-Baker, RN, clinical educator in The Knight Nursing Center for Clinical & Professional Development, attended the 10th national Magnet Conference, October 4–6, 2006, in Denver, Colorado. The conference was sponsored by the American Nurses Credentialing Center, a division of the American Nurses Association that awards Magnet status to qualified institutions.

In 2003, MGH was the first hospital in Massachusetts to receive Magnet status, a designation that must be re-earned

every four years. The conference coincided with the kick-off of the hospital's Magnet redesignation initiative.

well as a clinical nurse supervisor, and a Magnet ambassador assisting with Magnet champion education.

"From a distance we look a little fuzzy, but up close, it's clear to see we share: Strength, Unity, Pride, Expertise, and Respect."

—Jim Barone, RN, Magnet ambassador,
Main Operating Room

Sixteen Magnet ambassadors attended the conference; that's a new role created for the re-designation process based on feedback from Magnet champions who participated in the 2003 preparations. Four staff nurses attended, selected by associate chief nurses and nurse managers, as

Ambassadors will serve as a communication link between Magnet teams and unit-based Magnet champions. They'll help sustain momentum with on-going, reliable communication and informed coaching.

The 'mile-high' conference offered many strategies for reaching

and maintaining Magnet status. There were opportunities to network with colleagues from other institutions, which was helpful to ambassadors who were exploring creative strategies for our own re-designation efforts. Two nationally known speakers, Curt Coffman, author of *First,*

together away from the hospital and get to know each other. Said one ambassador, "We started out as eighteen strangers exploring a new role, and over three days, we quickly became a cohesive team." On the last evening, laughter and lively discussion were shared over a sumptuous dinner made possible by Jeanette Ives Erickson, RN, senior vice president for Patient Care.

A group of weary but energized MGH nurses arrived at the Denver airport, reflecting on their memorable experience and crediting Perleberg with facilitating this exhilarating excursion.

Magnet ambassadors and others participating in the re-designation effort include:

- Amie Stone, RN
- Heather Parker, RN
- Madeleine McGarry, RN
- Joanne Parhiala, RN
- Gayle Peterson, RN
- Dawn McLaughlin, RN
- Courtney Wells, RN
- Diane Lyon, RN
- Suzanne Algeri, RN
- Erin Salisbury, RN
- Jim Barone, RN
- Kelley Sweeney, RN
- Keith Perleberg, RN (co-chair)
- Kate Boyle, RN
- Sheila Golden-Baker, RN (support staff)
- Ann Morrill, RN;
- Mary McAuley, RN
- Denise Young, RN
- Maureen Mullaney, RN
- Diane Grobman, RN
- Joan Braccio, RN
- David Reisman (support staff)

For more information about our Magnet re-designation initiative, contact Sheila Golden-Baker, RN, at 6-1343.



(Photo provided by staff)

Safety reporting: a key component of performance-improvement

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

*S*afety reports are the foundation on which many performance improvements are based. Performance-improvement initiatives are created because of events reported by staff and employees. Medical errors and patient safety have received a lot of attention of late, and patient safety is now recognized as a separate

discipline within quality assurance. Because nurses are ‘front-line’ caregivers, their participation in safety reporting is even more crucial to safe and effective patient care.

Near misses, or adverse events that don’t result in harm, represent opportunities to improve practice and put mechanisms in place to ensure that future adverse events don’t occur. If the under-

lying conditions that contribute to near misses are quickly identified, remedied, and widely communicated, the likelihood of adverse events recurring is greatly reduced or eliminated. The goal of safety reporting is to gain a better understanding of potential problems as they relate to safety. Accurate information in safety reports leads to effective root-

cause analyses and potential solutions to avoid a recurrence of the event.

MGH fosters a blame-free culture for the reporting of errors. Clinicians should not feel that completing a safety report would put them at risk for disciplinary action. A blame-free culture recognizes that it’s rare for a single individual to be the cause of an incident; rather, multiple systematic factors usually contribute to circumstances wherein adverse events occur. A blame-free culture eliminates punishment for adverse events unless the employee is found to have

engaged in malicious, reckless, or illegal behavior. Accidents do not constitute malicious, reckless, or illegal behavior.

Rather than blaming, MGH looks ‘behind’ the incident to determine what factors were present that allowed the adverse event to occur. MGH values the support of all employees in ensuring optimal patient safety and performance-improvement. Nurses play an integral role in patient safety, performance-improvement, and quality care.

For more information on safety reporting, call Katie Farraher, at 6-4709.

MGH is committed to improving hand hygiene

Frequently asked questions about hand hygiene:

- Why does hand hygiene need to be performed *before* contact with patients or their environment?

We all have germs living on our skin. We can’t see them, but they’re there. We can pick up germs simply by touching other people or contaminated surfaces.

The germs we carry can cause infection or illness when conditions are right or our resistance is low. They can be spread to other people and surfaces by direct contact, a simple touch.

Fortunately, germs on our hands can usually be removed with good hand hygiene. This is important to remember, especially when caring for patients at greater risk for infection.

Hand hygiene *before contact* prevents the spread of germs to patients and their environment.

- Can gloves be used as a substitute for hand hygiene?

No. Gloves do *not* eliminate the need for hand hygiene, and hand hygiene does not eliminate the need for gloves when recommended or required.

Hands must be disinfected: *before* gloves are worn and *after* gloves are removed

- Why?

- Gloves are not 100% effective in preventing hand contamination
- Glove materials may contain imperfections that are invisible to the naked eye
- Warm temperatures inside gloves can promote the growth of germs already present on your skin
- Hands can become contaminated as gloves are removed
- Cal Stat must be used to reduce the levels of bacteria on your skin *before and after* glove use.

- What are the benefits of Cal Stat?

- More effective than soap and water
- Faster than hand-washing
- Better for your skin than alcohol-based hand cleaners
- Safe and environmentally friendly



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

Holiday survival strategies

—by Melanie Pearsall, RD, registered dietitian

It starts subtly: an invitation to a Halloween party; hosting Thanksgiving for family and friends; a Christmas catalog; the annual e-mail asking you to hold the date for the office holiday party. The holiday season is upon us. This time of year can be a challenging time to maintain a healthy diet and exercise program. The month between Thanksgiving and New Year's is a concentrated period of time filled with parties, travel, shopping, and visiting, all of which disrupt our normal routine.

Family, friends, and food are integral parts of almost every holiday tradition.

People often report gaining weight during the holidays. This weight gain is typically small, but it almost never goes completely away. And that gradual weight-gain over a number of years can significantly increase your risk for heart disease and diabetes. It's appropriate at this time of year to focus on maintenance strategies that can give you some flexibility in your eating and activity regimens while still getting lots of enjoyment out of every gathering. Below are Nutrition & Food Services' top ten holiday survival strategies:

- 1) Plan ahead. Decide what *your* plan is for managing your eating and drinking in every situation. Be specific and realistic.
- 2) Don't go hungry. Avoid 'saving up' your calories. Have a small snack to curb your appetite. Make sure to eat breakfast and lunch.
- 3) Keep your alcohol intake



low. Alcohol is high in calories and increases appetite. Stick to sparkling water and diet drinks.

- 4) Practice portion control. Use small plates, small cups, and take small servings of everything.
- 5) Don't be the 'hostess with the mostess.' Freeze those leftovers for another day, or give them to guests as they leave.
- 6) Modify recipes. Re-create some family favorites with lower-calorie ingredients, or try something new altogether. Monthly magazines like *Cooking Light* and *Real Simple* offer great holiday food ideas.

- 7) Make grocery shopping 'extra' healthy. Make your weekly shopping run extra healthy with lots of fruits, vegetables, and low-calorie snacks to help offset those calories eaten at parties.
- 8) Don't forget to exercise. Try to maintain your usual exercise routine, or even better, kick it up a notch. Even small increases in exertion and time help burn off those extra calories.
- 9) Eat mindfully. Focus on quality, not quantity.
- 10) Get support. Enlist the aid of family, friends, or a registered dietitian to help you stay on track.

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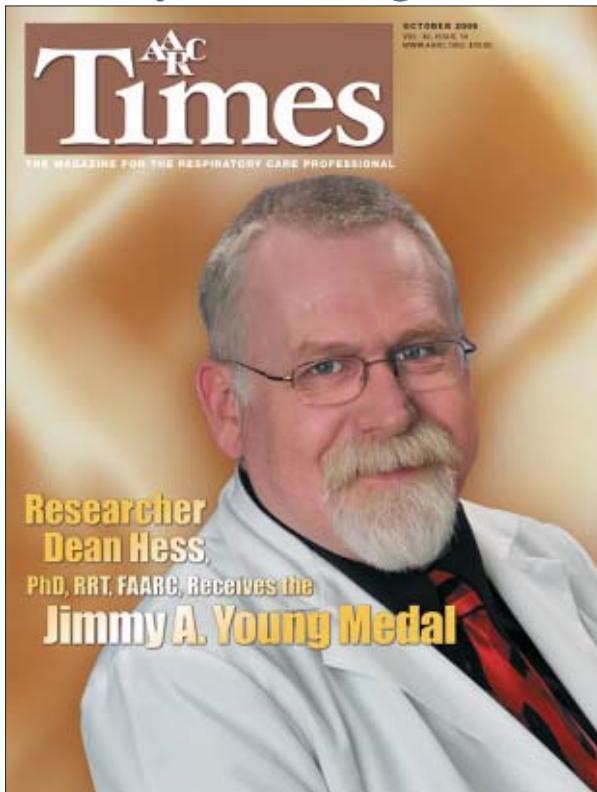
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Hess receives prestigious Jimmy A. Young Medal



Assistant director of Respiratory Care, Dean Hess, RRT, has been named the 2006 recipient of the American Association of Respiratory Care's highest honor, the Jimmy A. Young Medal. He will accept the award at the national meeting of the AARC in Las Vegas in December.

The Jimmy A. Young Medal is given to a member of the respiratory care profession who exceeds all expectations for meritorious service and who has made a significant contribution to the advancement of the profession. The

award was created in 1976 to honor the memory of Jimmy Young, a rising star in the respiratory care profession who was widely recognized for his work in respiratory care education and management. Young was the first director of the Inhalation Therapy Department at MGH and co-wrote one of the first textbooks on respiratory care, *Principles and Practice of Inhalation Therapy*, published in 1970.

In the October issue of *AARC Times*, David Peirson, MD, professor of Medicine, Pulmonary, and Critical Care

Medicine at the University of Washington, said of Hess, "Dean is a peerless teacher who has brought a scientifically sound, physiologically based approach to addressing bedside problems to a generation of physicians, nurses, and fellow respiratory therapists. He is perhaps the very best writer in his profession, worldwide."

Says Robert Kacmarek, RRT, director of Respiratory Care at MGH, "Dean's original research on aerosol therapy has to be considered one of the most significant academic contributions to the profession."

Blood donors needed during the holidays

Every year around the holidays, blood supplies dwindle as people become distracted with seemingly more pressing matters. During the busy weeks of Thanksgiving and Christmas, blood donors are needed more than ever.

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

Do you really have something more important to do...?

Educational Offerings

November 16, 2006

When

November 29
8:00am–4:30pm

November 30
8:00am–4:00pm

December 1
8:00am–4:30pm

December 7
7:30–11:00am/12:00–3:30pm

December 7
7:00am–12:00pm

December 7 and 14
8:00am–4:00pm

December 18
8:00am–2:00pm

December 13
8:00am–2:30pm

December 13
12:15–4:30pm

December 13
7:30–11:00am/12:00–3:30pm

December 13
1:30–2:30pm

December 13
8:00am–4:30pm

December 18
8:00am and 12:00pm (Adult)
10:00am and 2:00pm (Pediatric)

December 21
1:30–2:30pm

December 27
8:00am–2:30pm

January 8
7:30–11:00am/12:00–3:30pm

January 9
8:00am–2:00pm

January 10
8:00am–2:00pm

January 10
11:00am–12:00pm

January 10
1:30–2:30pm

January 11
8:00am–4:30pm

Description

**Building Relationships in the Diverse Hospital Community:
Understanding Our Patients, Ourselves, and Each Other**
Training Department, Charles River Plaza

Assessment and Management of Patients at Risk for Injury
Yawkey 2230

Intermediate Respiratory Care
O'Keeffe Auditorium

CPR—American Heart Association BLS Re-Certification
VBK401

CVVH Core Program
Training Department, Charles River Plaza

Oncology Nursing Society Chemotherapy-Biotherapy Course
Yawkey 2220

BLS Certification for Healthcare Providers
VBK601

New Graduate Nurse Development Seminar I
Training Department, Charles River Plaza

Pacing Concepts
Haber Conference Room

CPR—American Heart Association BLS Re-Certification
VBK401

OA/PCA/USA Connections
Bigelow 4 Amphitheater

Preceptor Development Program
Training Department, Charles River Plaza

CPR—Age-Specific Mannequin Demonstration of BLS Skills
VBK401 (No BLS card given)

Nursing Grand Rounds
“Anaphylaxis.” O'Keeffe Auditorium

New Graduate Nurse Development Seminar II
Training Department, Charles River Plaza

CPR—American Heart Association BLS Re-Certification
FND325

BLS Certification for Healthcare Providers
FND325

New Graduate Nurse Development Seminar I
Training Department, Charles River Plaza

Nursing Grand Rounds
Haber Conference Room

OA/PCA/USA Connections
Bigelow 4 Amphitheater

**Psychological Type & Personal Style: Maximizing Your
Effectiveness**
Training Department, Charles River Plaza

Contact Hours

7.2

TBA

TBA

6.3

16.8
for completing both days

6.0
(for mentors only)

4.5

7

1.2

5.4 (for mentors only)

6.0

(for mentors only)

1.2

8.1

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>.

White 9 bids farewell to 'grande dame' McLeod after 35 years

The White 9 Medical Unit recently bid farewell to unit service associate, Udell McLeod, who retired after 35 years of service to MGH. McLeod, the unit's 'grande dame,' had been the longest serving employee on White 9 until the day she retired. Friends, co-workers, and administrators gathered for a special reception

in her honor and to wish her well as she embarks on a new chapter of her life in Jamaica. (McLeod is wearing a corsage.)



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