

September 21, 2006

Caring

HEADLINES

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D'Antonio receives Corrao Clanon Award

—by Mary Ellin Smith, RN, professional development coordinator

On Friday, September 8, 2006, Christine D'Antonio, RN, became the 20th recipient of the Ben Corrao Clanon Memorial Scholarship Award. The scholarship was established in 1987 by Regina Corrao and Jeff Clanon in memory of their son, Ben, to recognize Neonatal Intensive Care Unit nurses who demonstrate exemplary practice, a commitment to primary nursing, and advocacy for patients and families.

Nurse manager, Peggy Settle, RN, spoke of the special relationship between parents and primary nurses and the ability of nurses to teach parents to care for their babies in the daunting setting of an intensive care unit. Said Settle, "Christine exemplifies what it means to be a primary nurse."

D'Antonio thanked Corrao and Clanon for supporting the award. Said D'Antonio, "I've only been a nurse for four years, but I've learned so much from my colleagues.

NICU nursing can't be taught in a classroom. It's learned from the experiences we gain every day in a unique work environment. I'm blessed to work with such a talented group of people."

Corrao and Clanon thanked NICU staff for their continued compassion and shared a poem written by Ben's sister, which began:

People do not miss their entrances,
They step into our lives precisely
when they should
And leave them in the same
beautifully scripted manner...



Ben Corrao Clanon Award recipient, Christine D'Antonio, RN (second from left) with (l-r): Peggy Settle, RN, Jeff Clanon, and Regina Corrao

The Institute for Patient Care

advancing clinical excellence through collaboration, education, and research

As the depth and scope of our practice continue to grow amid a changing healthcare landscape, it's essential to maintain a clear and focused vision for the future. It was that future vision that first led me to the idea of creating the Institute for Patient Care at MGH. As you can see by the diagram below, the Institute for Patient Care is comprised of existing (and soon-to-be-created) centers as well as a number

of programs and initiatives geared toward advancing clinical excellence, inter-disciplinary collaboration, education, and research.

My vision for the Institute is that it will be a central entity linking disciplines and professions within Patient Care Services to foster teamwork, share best practices, and bring an informed, inter-disciplinary approach to patient- and family-centered care. Rather than allowing our

good efforts to become scattered and disconnected, the Institute will enable us to integrate competencies, evidence-based practice, quality-improvement, and informatics into the delivery of patient care.

The underlying philosophy of the Institute is rooted in the core competencies articulated by the Institute of Medicine (IOM) in 2002. They are:

- Provide patient- and family-centered care; identify, respect and care about patients'



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

differences, values, preferences, and needs; relieve pain and suffering; coordinate continuous care; listen to,

inform, communicate with, and educate patients; share decision-making; and advocate
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Goals for the Institute:

- Foster an environment of clinical inquiry and experiential learning
- Promote team learning to optimize safe, effective, culturally-competent patient care; create an environment that promotes safety for patients, families, and staff
- Participate in the development and evaluation of organizational initiatives
- Support the development of a diverse current and future workforce

Programs/Initiatives

- Collaborative Governance
- Clinical Recognition Program
- Credentialing
- Organizational Evaluation
- Culturally Competent Care Curriculum
- Leadership Development
- Visitor Program
- Simulation
- Awards/Recognition
- Workforce Development

Goals (continued):

- Enhance the relevance of research as it relates to public health
- Support research that advances care that is safe, effective, and evidenced-based
- Provide leadership for innovations in learning for staff, patients, and families
- Develop, implement, and evaluate programmatic initiatives that impact staff-development and organizational effectiveness
- Make innovations visible through internal and external publications and presentations

New documentation and communication model

Question: What's going on with the Documentation and Communication project?

Jeanette: The Documentation and Communication Project began in February of 2006 when we identified opportunities for improvement as we prepared to automate our documentation systems. The Documentation and Communication Project Team meets regularly and has developed a plan to implement changes on two pilot units, Bigelow 14 and White 8, this month. The plan is to standardize documentation within and across units while shifting expectations about communication within units.

Question: What is driving these changes?

Jeanette: As we standardize practice in preparation for an automated documentation system, it is important to retain our ability to hear the patient and family's perspectives and be able to use this knowledge to optimize outcomes. Patient care and nursing practice need to drive the design, so the goal is to enhance practice before moving to automation.

Question: What will be different?

Jeanette: A care-delivery model comprised of a care team and care leader will ensure continuity of care for patients over the course of their hospitalization. The care team is accountable for achieving optimal patient outcomes and enhancing the

patient and family experience.

We value documentation that reflects nursing's contributions to outcomes of care. Currently, valuable information is communicated verbally but not documented in the patient's record. New strategies include changing the nursing assessment to the nursing data set, eliminating admission notes, and writing goal-oriented progress notes that reflect the synthesis of care provided.

Question: Will shift report change?

Jeanette: Report will be a transfer of written information (progress notes, the data set, the patient problem/intervention/outcome sheet, treatment

record, and flow sheet). After the in-coming nurse reviews the documentation, there will be an opportunity for dialogue between the nurse coming on duty and the nurse going off duty to clarify any questions. Both nurses will meet with the patient to ensure a seamless transition of care.

Question: How will the Documentation and Communication Project be rolled out to the rest of the hospital?

Jeanette: Once initial feedback is obtained from the pilot units, adjustments will be made, and four more units will adopt the program in November. More units will be added periodically until all units are using the new documentation and communication model.

Prior to implementation, unit leadership will receive information to help staff prepare for the

change. Members of the project team will meet with staff prior to roll-out to review documentation changes. During the first week of implementation members of the team will be on hand to support staff.

Question: How do we know the new system is better than the old one?

Jeanette: A research protocol was developed to look at pre- and post-implementation responses of staff and patients. And staff on the pilot units will participate in focus groups to give feedback about the changes and the implementation process.

If you'd like more information about the new documentation and communication model, contact project managers, Rosemary O'Malley, RN, (6-9663); Miriam Greenspan, RN (4-3506); or Mandi Coakley, RN (6-5334).

Jeanette Ives Erickson

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for disease-prevention, wellness, and healthy lifestyles

- Work in inter-disciplinary teams; cooperate, collaborate, communicate, and integrate care
- Employ evidence-based practice; integrate research into clinical expertise and patients' values for optimum care
- Employ quality-improvement measures; identify errors and

hazards; understand and implement basic safety principles; continually understand and measure quality of care; and design and test interventions to change systems with the objective of improving quality

- Use informatics; communicate, manage knowledge, mitigate error, and support decision-making using information technology

Education, innovation, and influence don't happen in a vacuum; much of our work will rely on new and existing partnerships. It will be important as we move forward to forge relationships with businesses and educational organizations that support free thinking and interdisciplinary learning.

We're still in the early stages of designing and creating the Institute for Patient Care, but I can tell you it will continue to evolve and develop over time as we obtain

more funding, implement more programs, and identify more areas for research.

It's good that our practice and sphere of influence continue to grow, mirroring the dynamic nature of health care itself. The Institute for Patient Care will help us harness the knowledge, imagination, and spirit of inquiry that have made us a world-class institution and keep our talents and energies focused on the areas where they're needed most. I'll keep you informed as we

move forward with this important work.

Update

I'm pleased to announce that Mary Sylvia, RN, has accepted the position of nurse manager for the Jean M. Nardini, RN, Hemodialysis Unit. I'd like to thank Tony DiGiovine, RN, for providing interim leadership, and I want to acknowledge the invaluable contributions of unit-based leadership and staff during the difficult months following Jean Nardini's death. I know Mary will appreciate your support as she assumes her new position.

Lean Equipment Management: a utilization success story

—by Dan Kerls, OTR/L, senior project specialist,
and Ed Raeke, director, Materials Management

For the past year, staff from Patient Care Services, Materials Management, and Biomedical Engineering have worked to improve the systems driving the care, management, and distribution of centrally-stored equipment. During a three-day seminar to kick off this effort, the group looked at current equipment-management systems to identify opportunities for improvement. They discovered a number of practices that contributed to delays, duplication of efforts, and inefficient circulation of equipment. The multi-disciplinary team concluded they needed a system that would address both the functionality and accessibility of equipment to ensure optimal patient care.

The group met with a team of consultants to learn more about the Lean Equipment Management system. The Lean system is derived from the Toyota manufacturing philosophy that eliminates waste at every opportunity to ensure the 'leanest' possible process. The group looked at what wasn't working in the current system and soon presented a new design for equipment flow at MGH. The design was piloted on four patient-care units in January,

2006, and two more units were added in April.

The pilot programs gave the team an opportunity to look at the overall process, study staffing issues, and refine supply levels needed to support the demand for equipment on each unit. It also allowed the implementation team to spend time with staff hearing feedback and promoting best practices. In August, the Lean Equipment Management system was rolled out on five more units, allowing the team to factor in elevator wait time.

What does the new Lean equipment flow look like? Each unit has a cart containing the most commonly used equipment (Propaq monitors, 3M pumps, PCA pumps, Sigma pumps and feeding pumps). Equipment on carts is visible, so the likelihood of not having equipment when needed is minimized. This has resulted in fewer calls to Customer Service.

Prior to implementing the Lean management system, equipment frequently spent more time in transit than being used for patient care. It was decided that the best solution was to have equipment remain on units at all times. Now, equipment is cleaned in the Soiled Utility Room by a Materials Management Lean associate. After

being cleaned, it's returned to the Lean cart, ready to use. Each Lean associate handles five or six units, visiting each unit every two hours. So the maximum amount of time any piece of equipment is out of service waiting to be cleaned is two hours. Units are covered by Lean associates seven days a week, from 7:00am–11:00pm.

To enhance the Lean system even more, Biomedical Engineering has made some changes to the way certain equipment is repaired to re-

duce turn-around time. Lean associates have been trained to perform quick repairs on the unit to minimize the amount of time equipment is out of service.

Staff on units where the Lean program has been implemented are extremely satisfied. One clinician wrote, "I love this plan. It's terrific to be able to go in the back room and get clean, functional equipment... whatever we need. I hope we continue this." The Lean Equipment Management system is a rewarding solution for patients, staff, Biomedical Engineering, Materials Management, and Patient Care Services.

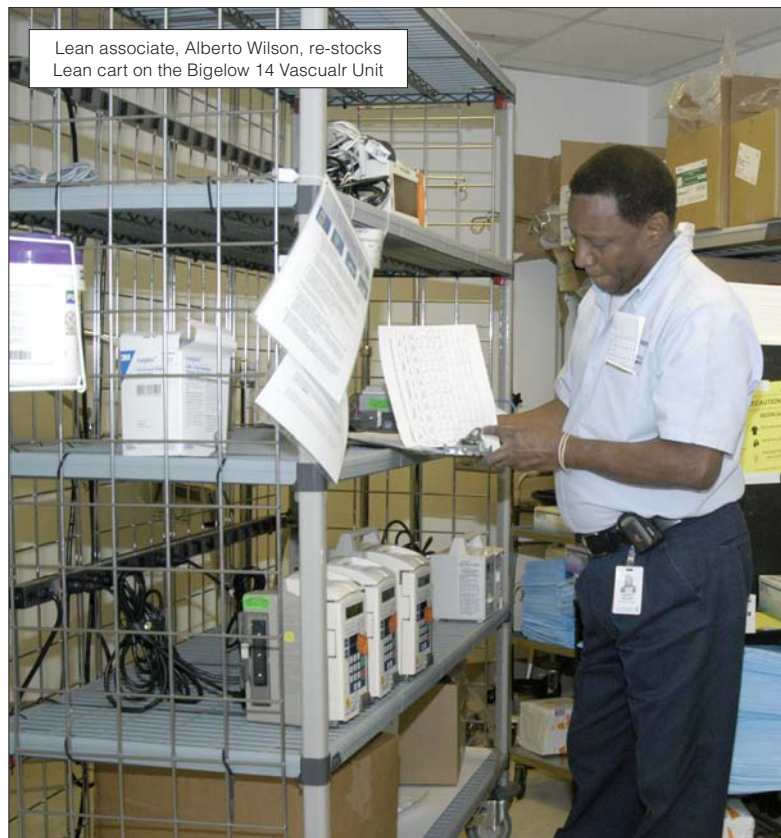
The Lean Equipment Management system

offers:

- equipment carts on units
- Lean associates assigned to monitor/re-stock units
- Lean associates can be requested via pager
- cleaning and par level stocking done on site

Plans are currently under way to bring the remaining inpatient units into the Lean program, a few units at a time. This fall, senior project specialist, Dan Kerls, and director of Materials Management, Ed Raeke, will begin to assess equipment demand and staffing issues in preparation for implementation.

For more information about the Lean program, please contact Ed Raeke at 6-3686, or Dan Kerls at 4-3085.



MGH-Timilty SummerWorks interns gain life-saving skills

—by Roytel M, MGH-Timilty SummerWorks intern

With informational pamphlets at their sides and hands-on experience under their belts, 15 MGH-Timilty SummerWorks interns left the Family and Friends CPR training sessions with enough information to save a life. With the help of clinical educators, Roberta Raskin Feldman, RN, and Laura Sumner, RN, of the Knight Nursing Center for Clinical & Professional Development, interns had an opportunity to perform CPR on simulation mannequins. Other MGH employees certified as CPR instructors volunteered to help. They were: Tom Hennessey of Police, Security & Outside Services; Karla Leegard, RN; Denise Lozowski, RN; Suzanne Newton, RN; and Richard Pino, MD.

On the first day of training, interns learned adult CPR procedures, which consisted of precise chest compressions and breaths. Many participants commented on how exhausting the process can be as they practiced on life-sized mannequins.

On the second day of training, participants learned other safety interventions, including the Heimlich maneuver (on adults and infants), and CPR for babies and small children. The seriousness

of the class registered with students as they began to understand the importance and consequences of being unprepared in an emergency situation.

Says Dan Correia, SummerWorks coordinator, “This is just one example of the kind of transferable skills we provide as interns continue to ‘learn and earn’ throughout the summer.”

At times, training was challenging, but the impor-

tance of the information kept everyone focused and on track. Some interns commented that they felt a sense of relief in knowing they possessed life-saving knowledge and techniques. Upon completing their training, they felt better informed

about the real practice of CPR as compared to the glamorized version they had seen on television.

Said one intern, “The information we got will be useful in any situation where someone needs help.”

The MGH-Timilty SummerWorks Program is a career-exploration/summer em-

ployment program that offers eighth graders graduating from Timilty Middle School paid internships at MGH during the summer.

For more information about the MGH-Timilty SummerWorks Program, contact Dan Correia at 4-6424.



Photos clockwise from top left: Laura Sumner, RN, guides SummerWorks intern, Nateaha, through exercise in infant CPR; Roberta Raskin Feldman, RN, coaches intern, Yeriseli, in adult CPR; Sumner and Raskin Feldman with interns (l-r): Yeriseli, Nateaha, Roytel, and Crystal (seated)



(Photos by Daniel Correia)

A service of remembrance: five years later

—by Mike McElhinny, MDiv, director, MGH Chaplaincy

On Monday, September 11, 2006, the MGH Chaplaincy and hospital administration offered a service of remembrance commemorating the events of September 11, 2001. The service incorporated readings, music, prayer, and reflective thinking to acknowledge the continuing despair and world changes that have occurred since that day five years ago.

The days after September 11, 2001, taught us that we need each other more than ever. Just

as our International Medical and Surgical Response Team (IMSuRT) traveled to Ground Zero, following the attacks on the World Trade Center, the MGH community continues its ongoing mission of delivering compassionate care.

Speaking to the gathering, Mike McElhinny, MDiv, director of the Chaplaincy, said, “We the survivors of September 11th have an obligation to those who died to use our talents to restore a sense of hope.”

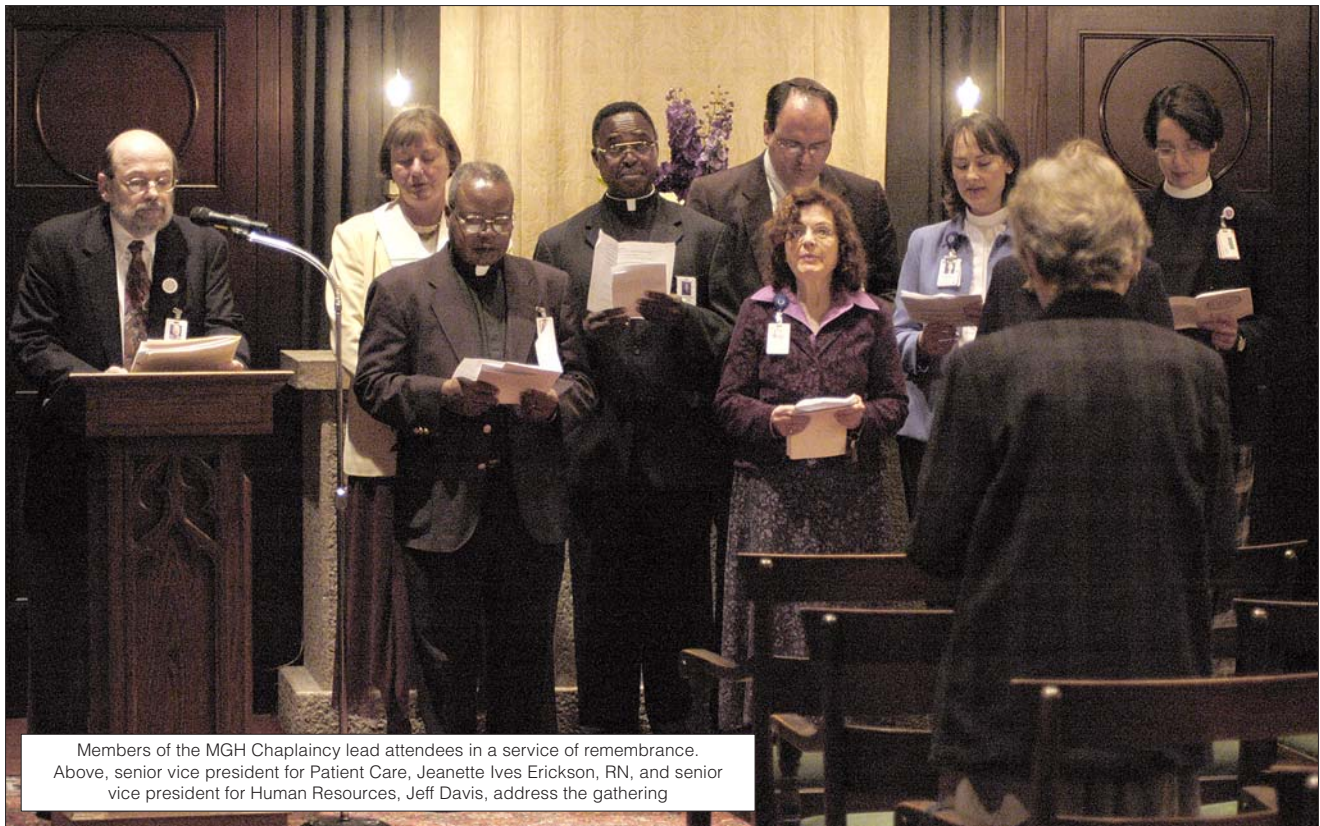
Senior vice president for Patient Care, Jeanette

Ives Erickson, RN, and senior vice president for Human Resources, Jeff Davis, participated in the service. Said Ives Erickson, “It was just five years ago that we shared the sadness that engulfed our world. We reached out to our colleagues in New York and to those with whom we work at MGH. We cared for those who lost their loved ones and in so doing, became a different institution, a different commu-

nity—a community with a global mission.

“Today, our hearts are one. We have re-affirmed our commitment to improve the lives of those seeking our care and to work toward a better world. In the face of adversity, we are a united team, caring for all who

need our knowledge, skill, and services. Five years later, our spirit and commitment are strong. As we honor those who died and suffered loss on this day in 2001, I wish you all peace and personal happiness. Thank-you for all you do... for people and for MGH.”



Members of the MGH Chaplaincy lead attendees in a service of remembrance. Above, senior vice president for Patient Care, Jeanette Ives Erickson, RN, and senior vice president for Human Resources, Jeff Davis, address the gathering

(Photos by Paul Batista)

Burke, new director, MGH Center for Global Health & Disaster Response

Thomas Burke, MD, has accepted the position of director of the MGH Center for Global Health & Disaster Response.

The Center for Global Health & Disaster Response was established earlier this year to build on our long history of providing humanitarian care to victims of disease and disaster around the world. That history and a growing demand for expertise in global health prompted MGH to create a formal center to support this important work.

In his role as director, Burke will position the Center for Global Health & Disaster Response to be able to respond to international disasters, provide knowledgeable care for widely varied populations, and maintain strong alliances with government, non-government, and academic agencies to bring aid to victims of disease and disaster in the United States and internationally.

The work of the Center for Global Health & Disaster Response will focus on five key areas: global health care (delivery and education), disaster response, training and education, worldwide medical consultation, and research.



(Photo provided by staff)

Thomas Burke, MD
director, MGH Center for Global
Health & Disaster Response

Burke most recently served as attending physician and associate clinical director of Emergency Medicine at Brigham and Women's Hospital. He also served as faculty in the division of International Health and Humanitarian Programs. He is a member of the faculty at Children's Hospital and an instructor at Harvard Medical School. Burke has served in leadership positions at several hospitals and health-care organizations, including the International Trauma Treatment Program in Olympia, Washington, and the Harvard Humanitarian Initiative at the Harvard School of Public Health. Burke has worked with the Third Battalion/9th Infantry,

and as a tactical physician with the FBI supporting various missions including deployments at Ruby Ridge, Idaho, and Waco, Texas. In the mid-1990s, Burke established a foundation to develop medical systems in Eastern Europe and founded three com-

panies. He has published extensively and lectured throughout the world regarding humanitarian issues.

Burke earned a medical degree from Albany Medical College, and bachelors' degrees in Mathematics and Neuroscience from the University of Massachusetts in Amherst. He was born in Göttingen, Germany, and today resides in Newton.

Said MGH president, Peter Slavin, MD, "As we continue to advance our global mission, Tom will play a key role in organizing and mobilizing our international efforts to serve a variety of populations. Please join me in welcoming Dr. Burke to MGH and to his new role."

Staff Perceptions of the Professional Practice Environment

Your opinion counts!

Staff Perceptions of the Professional Practice Environment surveys will be distributed this month

Clinicians will receive a hard copy and an on-line version and may choose which they'd prefer to complete

Clinicians who complete the survey (by hard copy or on-line) will be eligible to receive one of 40 gift certificates worth \$25 to The MGH General Store & Flower Shop

For more information, contact Eric Campbell at 726-5213

Caring HEADLINES

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

Jewish High Holy Days

Schedule of Services

- Friday, September 22, 2006, 11:00am
Erev Rosh Hashanah: the Eve of the New Year
Hayom Harat Olam: Today the World Was and Is Created
- Sunday, October 1, 2006, 3:00pm
Erev Yom Kippur: the Eve of the Day of Atonement
Minchah: Afternoon Service, Kol Nidre Recitation
- Friday, October 6, 2006, 11:00am
Erev Sukkot: The Eve of the Festival of Booths
The Waving of the Lulav and the Etrog (palm branch and citron)
- Friday, October 13, 2006, 11:00am
Erev Erev Simchat Torah: The Eve of the Celebration of the Law
The Parade of the Copies of the Torah

Entry-level physical therapist gains insight from expert colleagues

Sheila Pallotta is an entry-level clinician

My name is Sheila Pallotta, and I have worked at MGH as an inpatient physical therapist for the past year. During the first nine months, I was the primary therapist working on the Cardiac Surgical Service treating patients who had undergone valve replacements and coronary by-pass surgery.

Toward the end of my first rotation as primary therapist on the Cardiac Surgical Step-Down Unit, I was asked to consult on a pre-operative patient. Mr. P was a 68-year-old man from out of state who had experienced progressive fatigue over the past 18 months. He struggled with re-accumulating pleural effusions (fluid accumulating around the lungs) and had bacterial endocarditis (inflammation of the lining of the heart), which required valve-replacement surgery.

When I first met Mr. P, I was struck by his impaired posture and how short of breath he was lying in bed at rest. His respiratory system was compromised due to the pleural effusions compressing his lungs and impacting his ability to catch his breath. With the

help of a walker to ease the exertion of ambulating to the bathroom, Mr. P remained fairly functional. He did rely on the assistance of his nurses to maneuver his lines and tubes as he moved about the unit.

I decided my skills would be best focused on Mr. P's impaired posture. The first day, when he sat on the edge of the bed, I realized his spine was flexed so forward that he was unable to look me in the eye. Mrs. P explained that as Mr. P had become more ill, he spent most of the day sitting in a recliner and frequently fell asleep with his chin on his chest for hours at a time. Due to severe neck pain, he had gone from sleeping with one pillow behind his head to three pillows in the past three months. In the hospital, Mr. P slept with the head of his bed elevated and two pillows behind his neck. An MRI earlier in the week had to be terminated because Mr. P was unable to lie flat on the exam table.

Knowing that Mr. P was awaiting cardiac surgery, I was concerned that he was unable to lie flat, because he'd need to be intubated for surgery. Looking at Mr. P's neck,

it was hard to imagine they'd be able to fit a tube down his airway with the amount of flexion he needed in order to be comfortable. I also thought that if Mr. P was forced to lie down after being anesthetized, he could wake up in even more excruciating pain than he was already experiencing.

I spoke with my inpatient clinical specialist and together we decided Mr. P should be treated for his cervical spine issues the same as patients we see in the outpatient setting. I went home that night and reviewed the literature on cervical spine exams. The next day, I collected all the data I needed to determine the cause of Mr. P's neck pain. Although it was a chronic condition that had started more than three months ago, he was in the acute phase of pain. He had impaired posture, limited range of motion, muscle tightness, and muscle tenderness with minimal palpation. I also found that Mr. P was in a phase of 'muscle guarding' that made any more than five degrees movement to his neck intolerable.

Not knowing the best way to treat Mr. P, I con-

sulted with a clinical specialist in the outpatient Physical Therapy setting, who specializes in treating spinal conditions. Together we reviewed the data I had collected about Mr. P's cervical impairments, and we went to see him to determine the best treatment plan. We surmised that Mr. P's pain was being caused by muscle guarding. If we could relax his muscles he might feel some relief, and it would allow us to improve his postural alignment.

The clinical specialist expertly performed manual therapy, and after 20 minutes, Mr. P was comfortable enough to lie with the head of his bed flat and with only one pillow. This change in position was a huge improvement, and if he was able to tolerate it, he'd be able to comfortably make it through surgery without increased neck pain. The clinical specialist worked with me to devel-

op my manual therapy skills, and with my new hands-on joint-mobilization and stretching techniques, I was able to treat Mr. P effectively. Mr. P didn't experience any negative changes in his posture or neck positioning during the night, and with daily manual therapy, he continued to see improvement in his alignment, ability to sleep, and level of comfort.

I was able to educate Mrs. P in some of the soft-tissue techniques to help alleviate Mr. P's pain during evenings and weekends. In the end, Mr. P underwent successful valve-replacement surgery without aggravating his cervical spine.

Mr. P's case was an eye-opening experience for me during my last month on the Cardiac Surgery Service. I had gotten into a routine of seeing the same patient problems over and over, and Mr. P helped me

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Sheila Pallotta, PT
physical therapist

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

Clinical Narrative

continued from previous page

challenge myself to learn more. Also, I realized how important it is to treat the patient as a whole person, not just a medical diagnosis. Although Mr. P had many other impairments, alleviating his neck pain allowed me to improve his quality of life.

This case made me realize the advantages I have as a physical therapist working at MGH. Physical therapists are trained to treat the whole body, and as a new therapist I saw how important it was to be thorough in my initial examination regardless of the reason for the consult.

It made me appreciate what it means to work at a world-class teaching hospital with so many resources available to me and my patients. I was able to consult a physical therapy spine specialist to assist me in treating a patient when I was unsure of the best treatment myself. The environment at MGH is one of the most challenging I have ever encountered, and one of the most rewarding. I'm overwhelmed at the new skills and knowledge I acquire here.

I wish I had come to this realization on my own, however, I credit my inpatient clinical specialist, who diligently pushed me to be detail-

oriented and allowed me to work on my own. It took caring for a non-routine patient for me to realize I still had a lot to learn as a new therapist. Looking back on my first weeks here, I'm almost certain I would have treated Mr. P differently had I not had the benefit of the expertise of my colleagues. It's easy to gloss over details, but to be an excellent therapist, I've learned to listen to my patients, constantly strive to provide the best possible care, and not be afraid to ask for assistance.

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

It's so important for entry-level clinicians to share their stories. There is much to be learned from reflecting on care at ev-

ery level of competence.

When Sheila first met Mr. P, his posture immediately concerned her as a primary focus of treatment. She recognized the implications for intubation, ambulation, and Mr. P's overall recovery. She recognized the need to consult with an experienced colleague. Sheila sought out theoretical knowledge on cervical spinal exams and worked with a clinical specialist to gain hands-on experience. This is a wonderful example of clinical inquiry, hands-on learning, and the important role experienced clinicians play in developing new clinicians.

Sheila is an entry-level clinician; she did what every novice should do in the face of a clinically challenging situation—she sought the guidance and consultation of an expert colleague and based her interventions on evidence-based practice.

Improving the Health of Women

Perspective on women's health in the 21st century

presented by Vivian Pinn, MD
director, Office of Research on Women's Health, National Institutes of Health

**Wednesday, October 4, 2006
12:00–1:00pm
O'Keeffe Auditorium**

A light lunch will be provided

For more information, call staff specialist, Mel Heike, RN, at 4-8044

Domestic Violence Education and Support Group

The Employee Assistance Program is offering a confidential, ten-week education and support group for women employees who have been affected by domestic violence, in past or current relationships.

Weekly discussions will help members understand the impact of domestic violence on their lives and the lives of their children while promoting strength and healing.

The group is free, confidential, and open to all women employees of the Partners HealthCare System

**First meeting:
Thursday, October 5, 2006
4:30–6:00pm**

For more information and location, contact Donna at 617-726-6976 or 866-724-4EAP

Collaborative governance membership drive

**Open enrollment
September 1–October 15, 2006**

Collaborative governance is the formal, multi-disciplinary, decision-making structure of Patient Care Services. Its mission is to stimulate, facilitate, and generate knowledge to improve patient care and enhance the environment in which clinicians practice

Open House

Attend a committee meeting any time during the month of September to see collaborative governance in action (please notify a co-chair beforehand)

Ice Cream Social

Come get the 'scoop' on collaborative governance!

**Tuesday, September 26, 2006
11:00am–3:00pm
Under the Bulfinch Tent**

CNS role allows OB nurse to contribute on many levels

—by Lynda Tyer-Viola, RN, clinical nurse specialist

My name is Lynda Tyer-Viola, and I am one of the perinatal clinical nurse specialists for the Vincent Obstetrical Service. I have been a member of the OB team at MGH for the past seven years. My career in nursing has taken me all over the world, and it brought me back to my home, Boston, and the practice I love, Obstetrics.

As a clinical specialist, my focus is on the care of patients and the knowledge of nurses. Knowing how pregnancy affects the body is very important for obstetrical care, because you're caring for more than one patient—the mother and the unborn child. The Vincent Obstetrical Service was re-opened in 1996 with a mission to provide comprehensive perinatal care. Although pregnancy is a normal occurrence, it affects both the physical and emotional state of the mother and family. Often our patient population includes women who have complex medical problems in addition to being pregnant: cancer, cardiac disease, transplants, cystic fibrosis, HIV, and a host of other chronic or terminal conditions.

Creating a birth experience for women with complex medical needs can be challenging; this is where the multi-faceted expertise of MGH clinical nurse specialists shines. My role is to use my knowledge, my communication and research skills, and my bedside expertise to assist nurses throughout the MGH community to create a safe and healthy birth experience. Let me tell you about two of our families.

Ms. R was a computer specialist living in a Boston suburb. Ms. G was a wife and mother from Nigeria. Both women believed they were healthy and were excited to be pregnant. Yet, both found they weren't as healthy as they believed. One knew she would one day be a mother; the other knew she should never give birth again. Both wanted a birth experience they would remember for the rest of their lives.

Ms. R and her husband had a life plan. It included education, great careers, new home, and then a family. Ms. R felt well most days yet knew that something was odd. Her elbow and shoulder were sore especially after a long day of computer work. She didn't think it had anything to do with

her pregnancy. She had been evaluated for a strain and was using acetaminophen and heat to ease the pain. One day, she went to pick up a box and her humerus (upper arm bone) snapped. In the Emergency Room she was told she had multiple fractures of her arm. She was devastated. Her job depended on her being able to type, and with the baby coming, she wanted to use her time off after the baby was born.

As it turned out, the break was the least of her worries. She learned she had an invasive tumor and was referred to MGH for evaluation. I was asked by a nurse on the Oncology Service to see her regarding pain management. She had been told that morning she had multiple myeloma.

Ms. R. was sitting up in bed. One arm was in a sling; the other was draped across her pregnant abdomen. There were greeting cards, stuffed animals, and a book about pregnancy on her bedside table. This was not a woman suffering; this was a woman with hope. I introduced myself, and we talked about her experience and present condition. I asked her to tell me her plans. She told me about her arm, the tests, and the need for radiation.



Lynda Tyer-Viola, RN
clinical nurse specialist

I interrupted. "I'm sorry," I said. "I meant plans for your baby."

Her eyes lit up. She patted her stomach and said, "No one asks me about the baby."

We talked about her stay at MGH, her pain medication, and her plans for delivery. Having gathered what was important to Ms. R and her perceptions about her care, the nurses and I discussed how we could meet her medical and pregnancy needs. The oncology team feared that medicating her over a long period of time could hurt the baby. We discussed physiological changes during pregnancy and fetal circulation. It was important for Ms. R to be comfortable and mobile to increase perfusion (transfer of fluids) to the baby and prevent hemostasis. We planned to have the OB nursing team evaluate the fetal heart status daily, do prenatal teaching, and be available as a resource.

We also discussed the need to acknowledge the

pregnancy. Ms. R felt no one asked about the baby because of the cancer, and this was making her anxious. Acknowledging a mother's perception is very important during pregnancy. Knowing the patient, seeing her world, allows the nurse to provide care that is unique and meaningful. Ms. R needed to be comfortable in order to heal and for her pregnancy to continue to develop. Nurses needed to know that Ms. R's care was being tailored to the unique needs of her situation. I connected our OB resource nurses with Ms. R's care team. Together, OB and oncology nurses developed a care plan for a safe and comfortable delivery. My role as perinatal specialist was to help blend those two worlds so the nurses would be knowledgeable and confident in their care.

Mr. and Mrs. G were an animated couple from Nigeria. During her first pregnancy, Mrs. G had been short of breath and

continued on next page

Clinical Nurse Specialist

continued from previous page

debilitated for many months. She had been diagnosed with postpartum cardiomyopathy. Since coming to the United States, she'd been treated by a team of cardiologists and had been advised against becoming pregnant again due to the risk of cardiac problems and potentially, death.

But Ms. G wanted more children and had become pregnant two years after the birth of her twins. She would need invasive cardiac monitoring and the care of an ICU team. Our goal was to enable her family to experience the birth with her while ensuring her intensive care needs were met. My role was to develop a plan that could be activated whenever she went into labor. This required educating and coordinating a multi-disciplinary team that could be activated any time of the day or night. In collaboration with the Surgical Intensive Care Unit (SICU) team, we created a plan for Ms. G to be induced in the SICU. The family was given a tour of the unit before her scheduled visit. Ms. G and her husband were very anxious and felt that all the 'fuss' wasn't necessary. Ms. G met some of the nurses and on the day of her delivery, the OB and SICU teams were well prepared. The set-up of the room was amazing; on one side there was

invasive monitoring of the mother's heart, on the other, the sound of a fast-beating fetal heart. The room was abuzz. Staff were enjoying the camaraderie and sense of common purpose. I prepared the OB staff for the changes that would occur in Ms. G's hemodynamic status during labor and potential deviations and effects on the fetus. The nurses enjoyed caring for Ms. G as a joint specialized team and were impressed with the expertise each had in their respective specialties. Despite being one of the most high-risk patients at MGH, Ms. G had a pro-

blem-free birth with her husband at her side.

The multi-faceted role of clinical specialist allows me to influence care from the perspective of clinical expert, educator, and researcher. Nurses who don't practice in Obstetrics fear they may harm the baby if they give the mother treatments such as chemotherapy or pain medication. Integrating the ethic that 'caring for the mother is caring for the baby' can be distressing. Often, there's no way to know the best practice. Evidence-based practice in Obstetrics requires integrating existing knowledge within the clinical context and state of pregnancy. Applying relevant knowledge and evaluat-

ing outcomes informs our care for the next patient. Involving staff in the plan of care allows us all to share experiential knowledge in a way that continuously informs practice. As a CNS, I cultivate these discussions and use best practices to improve systems and design care. Our hospital-wide and ICU collaborations are becoming more frequent, and they always present extraordinary learning opportunities.

I recently earned a doctorate degree in Nursing Research. My program of study focuses on the care of HIV-positive, pregnant women and perinatal depression. Though this is a discrete population, women with

chronic diseases who give birth represent a broad spectrum of the obstetrical population.

Current research tells us HIV-positive, pregnant women suffer emotional distress, fatigue, and the stigma of giving birth when there's a chance they could transmit HIV to their babies. Nurses play a vital role in the care of people with chronic disease. Conducting research from the perspective of a clinical care provider allows me to translate literature into practice and continuously mine for meaningful research questions at the bedside. The CNS role allows me to make a difference in the lives of pregnant women and those who care for them.

MGH recognized by AARP as one of best employers for workers over 50

The American Association of Retired Persons (AARP), the leading non-profit organization for people over the age of 50 in the United States, has named MGH one of the best employers in the country for workers over 50. Only two organizations in Massachusetts were included on the list; the Massachusetts Institute of Technology (MIT) was the other.

AARP started this program six years ago to acknowledge companies and organizations that provide programs and policies that address issues affecting older employees. With an aging workforce, programs for older employees have increasing value in today's marketplace.

MGH was selected because of the programs and services we offer that serve mature workers as well as younger employees. Training and career-development pro-

grams, health benefits for current employees and retirees, a wide range of options for retirement plans, financial-planning services, flexible work hours, and special accommodations to the work environment to meet the needs of all employees are just some of the reasons MGH was selected by the AARP.

Says Jeff Davis, senior vice president for Human Resources, "The MGH workforce over the age of fifty has grown through retention of

current employees and hiring of new employees over the age of 50. We value our mature staff for their broad range of life experiences, knowledge, expertise, and the value they bring to the MGH community. Receiving this honor from the AARP demonstrates our commitment to being an employer that meets the work-life needs of all employees."

Ensuring safe 'hand-offs' at every juncture

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

In an effort to improve the effectiveness of communication among caregivers, one of the 2006 National Patient Safety Goals instructs hospitals to, "Implement a standardized approach to hand-off communications."

There are many types of hand-offs in a hospital setting, including: change of shifts, coverage for breaks, patient transfers to other areas such as the Post Anesthesia Care Unit, Radiology, the ICU, among others.

Hand-offs can occur at any time during the

course of care; they can be temporary or permanent; they can be of varying durations. Implementing a standardized approach to hand-offs means establishing a consistent process for giving and receiving information that limits interruptions and provides an opportunity for discussion between the clinicians involved. The intention of this Patient Safety Goal is to ensure accurate information is exchanged about a patient's care, treatment, condition, recent or anticipated changes, and other relevant information.

MGH has developed a policy called, "Transferring Responsibility of Care." Every hand-off should follow a specific format called SEAM.

- **S:** Summary of the patient's status, including identification, responsible physician, diagnosis, and status of life-sustaining orders
 - **EA:** Every Active clinical issue, including recent changes and anticipated events
 - **M:** Management of active clinical issues and planned next steps
- Hand-off communications should be verbal (preferably face to face) and direct whenever possible. At the time of hand-off, clinicians should

describe how to access the written information available to all providers. Hand-off communications should be interactive, uninterrupted, confidential, and allow for verification and questions.

Our "Safe Transport Policy," says that, "All patients transferred from a care unit will be assessed to determine their status related to transfer. All pertinent clinical information will be documented by the clinician providing care to the next clinician responsible for their care."

Nurse manager, Kathleen Myers, RN, and Andrew Karson, MD, represent Nursing and Medicine on an interdisciplinary group working to ensure compliance with the new hand-off policy. A script has been

developed to help clinicians adhere to the information they need to exchange when transferring responsibility for a patient's care.

Patient hand-offs represent one of the most prevalent opportunities for break-downs in communication among caregivers. And communication break-downs can lead to an interruption in the continuity of care. All caregivers are responsible for providing accurate, thorough information about their patients' care.

Use the SEAM approach to ensure your patients' safety when transferring responsibility of care.

For more information about SEAM or policies regarding transfer of care, call Katie Farraher at 6-4709.

Third Annual Kidney Care Day

Thursday, October 5, 2006
8:00am

O'Keefe Auditorium

Medical Grand Rounds
"Epithelial Sodium Channel Function and Dysfunction: Revisiting Diuretic Therapy"
presented by Bernard Rossier, MD
University of Lausanne, Switzerland

9:00am–2:00pm
Main Corridor

Information tables with representatives from the Center for Renal Education, Renal Associates, Hemodialysis, Peritoneal Dialysis, Social Services, Food & Nutrition Services, and the Transplant Service

Come learn about the resources available for patients with kidney disease and meet some of the professionals in those specialty areas

For more information, contact Laurie Biel, RN, at 617-720-1317

Hand Hygiene

Gloves do not provide a perfect barrier

- Gloves can have microscopic holes or tears that are invisible to the naked eye
- Germs can pass through those holes

How well do gloves prevent hand contamination?

- The good news is, gloves are 70–80% effective
- The bad news is, gloves are only 70–80% effective

Gloves do not protect you from germs already present on your skin

- Gloves provide a protective covering for your skin, but they also create a warm, moist environment where bacteria on your skin can multiply, especially when gloves are worn for extended periods of time

Use Cal Stat *before* and *after* glove use



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

A cup of this... a tablespoon of that...

—by Susan Doyle, senior manager, Patient Food Services

When cooking, most of us have followed a recipe at one time or another. I find the most tedious and time-consuming part of cooking is measuring all the ingredients. A cup of this... a tablespoon of that... a handful of something else.

I'll bet you'd be surprised to see 462 pounds of flaked tuna on your list of ingredients for tuna salad. Well, at MGH, that's an everyday occurrence for Food & Nutrition employees who work in the Ingredients Room.

The Ingredients Room is a critical part of food production in the department of Food & Nutrition Services. Employees

in the Ingredients Room are responsible for slicing, dicing, weighing, and measuring all the ingredients for all 150 recipes prepared there daily. They portion out ingredients and distribute them so that each cook has exactly what he/she needs to complete a given recipe.

Each year, almost 94,000 pounds of flaked tuna are prepared; 30,000 pounds of hamburger; and 53,000 pounds of turkey. Up to 40 fruit-and-cheese platters are prepared daily, which accounts, in part, for the 20,500 cantaloupes sliced annually and the 7,800 honeydew melons. Some *countries* don't consume that much!

How many employees does it take to manage the volume of food prepared in the Ingredients Room at MGH each day? Forty people? Fifty? Typically, eight employees staff the Ingredients Room every day (nine on a good day) and two on weekends. This is a skilled and talented group of employees that functions at a high level of order and efficiency.

So, the next time you go to the fish counter at your local grocery store, imagine asking for 14,000 pounds of scrod, 12,000 pounds of salmon, or 15,000 pounds of tuna. (That's a lot of omega-3 fatty acids.)

For more information about the Ingredients Room, or any of the other services provided by the department of Food & Nutrition Services, contact Susan Doyle at 6-2579.



In the Ingredients Room are (l-r): Judith Higginbotham, Gary Montout, Sing Tosi, Ellie Flore, Jamie Valentin, and Neslie Exilus. Not pictured: Kenrick Harvey, Stephen Russell, Jean Gelin, Mike St. Jusin, David Hall

Published by:

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

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

Next Publication Date:

October 5, 2006



New Graduate Nurse in Critical Care Program graduation

—by Laura Mylott, RN, New Graduate Nurse in Critical Care Program

On Wednesday, August 23, 2006, eight registered nurses were recognized for completing the intensive MGH-IHP New Graduate Nurse in Critical Care Program. The integration of these new professionals into practice brings the total number of graduates from this program to 99. Certificates of completion were presented to: Kristen Bradley RN; Lindsay Waller, RN; Meaghan Kanser RN; Aileen Schiller, RN; Halary Patch, RN; Jessica Fellman, RN; Kathryn Lizotte, RN; and Bioja Pires, RN.

Speaking at the ceremony, nurse manager of the Coronary Care Unit, Colleen Snyder, RN, congratulated participants on meeting the rigorous and demanding challenges of the program. After thanking preceptors and unit-based nursing leaders for their expertise and support, Snyder acknowledged senior vice president for Patient Care, Jeanette Ives Erickson, RN, medical directors of the ICUs, and clinicians who taught in the program for their generous support.

Speaking on behalf of her fellow graduates, Halary Patch, RN, read her narrative describing the nursing care she provided to a woman who

had suffered cerebral anoxia and eventually became an organ donor while a patient in the Ellison 9 Cardiac Care Unit. Patch described how she came to 'know' her comatose patient through a developing relationship with her husband. This knowledge enabled her to effectively advocate for, coach, and develop an individualized plan of care for both the patient and her husband.

Patch's dedication to the comfort and well-being of the family was exemplary. She thrived under the expert guidance of preceptors, Katie Swigar, RN; Lisa Davies, RN; and Kathy Carr, RN.

Swigar spoke about her five years of experience coaching new nurses and shared some pearls of wisdom, like the importance of collaborating with senior staff to facilitate meaningful patient assignments during ori-

entation. Carr, who has mentored new nurses since the program began in 2001, described the importance of balancing guidance with enough space to allow the new nurse to develop an independent clinical practice, experience success, and develop confidence. Carr emphasized that a preceptor's knowledge of the new nurse's strengths and her own comfort with relinquishing control are key for optimal balance.

Coordinators of the New Graduate Nurse in Critical Care Program, Miriam Greenspan, RN,

and Laura Mylott, RN, spoke about the unique partnership that preceptors and new graduates form during the six-month program, and how critical that relationship is to the successful transition of the new nurse into practice.

For more information about the New Graduate Nurse in Critical Care Program, contact the nurse manager or clinical nurse specialist in any of the ICUs, or call Laura Mylott at 4-7468. For application information, call Sarah Welch or David Pattison in Human Resources at 6-5593.



New graduates (l-r; back row): Bioja Pires, Jessica Fellman, Meaghan Kanser, Aileen Schiller, and Lindsay Waller (front row): Kathryn Lizotte, Halary Patch, and Kristen Bradley

Educational Offerings

September 21, 2006

<i>When</i>	<i>Description</i>	<i>Contact Hours</i>
September 29 8:00am–4:30pm	MGH School of Nursing Alumni Homecoming Program O'Keefe Auditorium	TBA
October 3 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
October 4 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
October 6 8:00am–4:00pm	Special Procedures and Diagnostic Tests: What you Need to Know O'Keefe Auditorium	TBA
October 10 and 13 8:00–4:30pm	End-of-Life Nursing Education Program Burr 6 Conference Room	TBA
October 10 7:30am–2:00pm	Congenital Heart Disease Yawkey 2220	4.5
October 11 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
October 11 8:00–11:30am	Intermediate Arrhythmias Haber Conference Room	3.9
October 11 12:15–4:30pm	Pacing Concepts Haber Conference Room	4.5
October 11 1:30–2:30pm	OA/PCA/USA Connections Bigelow 4 Amphitheater	---
October 12 and 19 8:00am–4:00pm	Oncology Nursing Society Chemotherapy-Biotherapy Course Yawkey 2220	16.8 for completing both days
October 12 and 13 Day 1: 7:30am–4:00pm Day 2: 8:00am–1:00pm	Pediatric Advanced Life Support (PALS) Certification Program Training Department, Charles River Plaza	---
October 12 1:30–2:30pm	Nursing Grand Rounds O'Keefe Auditorium	1.2
October 13 and 30 8:00am–5:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O'Keefe Auditorium. Day 2: Thier Conference Room	---
October 17 11:00am–12:30pm	Chaplaincy Grand Rounds "Guided Imagery." Sweet Conference Room	---
October 18 11:00am–12:00pm	Nursing Grand Rounds "Zambia Nursing Project." Haber Conference Room	1.2
October 23 and 24 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: SRC-3110; Day 2: VBK607	14.4 for completing both days
October 25 8:00am–2:00pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
October 26 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK401	---
October 26 8:00am–4:30pm	Psychological Type & Personal Style: Maximizing Your Effectiveness Training Department, Charles River Plaza	8.1
October 26 1:30–2:30pm	Nursing Grand Rounds "Pulmonary Hypertension." O'Keefe Auditorium	1.2
October 31 8:00am–12:00pm	BLS Certification—Heartsaver VBK601	---

Neuroscience units investing in the future

—by Ann Kennedy, RN, nurse manager

Recently, the White 12 and Ellison 12 Neuroscience units welcomed students from a number of nursing programs in the region to learn more about the specialty of neuroscience nursing. The students functioned as patient care associates, supporting the care of acute and complex neuroscience patients. The experience was a positive and rewarding one for patients, staff, and students. In a note to nurse manager, Ann Kennedy, RN, student, Karoline Grogan from St. Anselm's College wrote, "Thank-you for the incredible opportunity you gave me this summer. I learned so much every minute I was there. The nurses and patient care associates were so helpful and valuable in my learning experience. I already miss everyone I met."

To thank the students for their interest and contributions, they were invited to participate in a day-long conference on neuroscience diagnoses and professional practice. Ann Kennedy, RN; Marion Phipps, RN; Jean

Fahey, RN; Patricia Galvin; and Jackie Somerville, RN, provided students with an array of perspectives on caring for patients in the neuroscience setting.



Jean Fahey, RN, clinical nurse specialist (center), gives students an up-close look at the care of neuroscience patients. Above, students review information in a classroom setting

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