

September 7, 2006

# Caring

## HEADLINES

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# The MGH ProTech Program: opening doors to new opportunities

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

On Wednesday, August 16, 2006, ten bright, talented, and motivated East Boston High School students graduated from the ProTech Program, a structured intern-

ship that combines classroom instruction with work-based learning experiences. The two-year, paid internship introduces students to a variety of professions and opportunities as an educational stepping stone to careers in

health care. MGH has been a leader in the ProTech Program since 1991.

Thier Conference room was abuzz with MGH staff, guests, and family members who had *continued on page 10*



Standing (l-r): ProTech graduates, Jesse Hernandez; Marc Fleury; Mireille Kamanzi; Cherline Gene; Dominica Campbell; Galia Wise, manager of the MGH-East Boston High School Partnership; and Candace Burns, director, MGH-Boston Public Schools Partnerships  
Seated: Graduates, Felicia Sorrentino; Kristen Chianca; John Nichols; and Gina Nardone

(Photo by Abram Bekker)

## Collaborative governance: an essential part of the professional practice model

As with all successful programs, regular monitoring and evaluation are needed to ensure they remain relevant and responsive in a dynamic, perpetually changing, healthcare environment. Toward that end, I asked clinical nurse specialist, Susan Lee, RN, of the Institute for Patient Care, and senior nurse scientist, Dorothy Jones, RN, of the Yvonne Munn Center

for Nursing Research, to conduct an evaluation of collaborative governance as we enter our tenth year in operation.

In April, a survey was sent to all (251) members of collaborative governance committees; to a random sampling of (590) Patient Care Services professional staff; and to (161) members of the PCS leadership team, including associate chief nurses, directors, mana-

gers, and supervisors. The survey was similar to those used in past years, and recipients were asked to return completed surveys by mail within two weeks.

More than 250 surveys were returned: 95 from collaborative-governance participants; 125 from non-collaborative-governance participants; and 36 from PCS leadership, providing meaningful feedback from all sample groups. Respondents represented Nursing, Occupational Therapy, Physical Therapy, Social Services, Speech-Language & Swallowing Disorders, Chaplaincy, and Pharmacy, and ranged in experience from three months to 42 years.

The survey sought to identify trends in empowerment between collaborative-governance and non-collaborative-governance participants. It looked at formal, informal, structural, and psychological empowerment with an underlying assumption that staff who feel empowered are more effective in the workplace. Those who feel empowered report a sense of increased autonomy, higher job satisfaction, greater commitment, and lower stress.

I'm happy to report that 94.6% of those who



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

completed surveys support collaborative governance; and empowerment scores have continued in an upward trend since 2000. Those who serve on collaborative governance committees reported a greater perception of access to opportunity, information, support, and resources than their non-collaborative-governance counterparts.

Some of the comments received in the survey include:

- "Collaborative governance has helped me clarify my position on issues, increased by confidence, and made me less intimidated to offer an opinion."
- "I've learned that issues facing my unit are not necessarily isolated issues."
- "Through collaborative governance, I've established relationships with other members that have evolved into resources."

- "I was able to bring a staff-led initiative from concept to institutional change."
- "Knowing that administration values input from staff to positively change and improve the care of our patients is empowering and gratifying."

It's rewarding to know that staff and leadership alike feel collaborative governance gives clinicians the opportunity to contribute to the professional practice environment, make decisions about their practice, and have an impact on the overall organization.

Based on feedback obtained by the survey, we will be:

- exploring mechanisms to advance inter-disciplinary research and education
  - addressing some operational issues such as: term limits, arranging coverage to allow com-
- continued on next page*

### 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**

## What's the latest on mandatory staffing ratios?

*Question:* The state legislature ended its session in July. What happened with the nurse staffing issue?

*Jeanette:* A final conclusion wasn't reached. Although the House of Representatives adopted a mandatory staffing ratios bill, the Senate did not complete its work before the end of their formal session (July 31st). The legislature may be back in session to address other matters in the coming months, but it's unlikely that staffing ratios will be considered again this year. The entire process may start again next year if proponents of ratios file legislation.

*Question:* Did our letters make a difference?

*Jeanette:* Yes. It's important for legislators to hear directly from the people they represent, and hundreds of MGH nurses took the time to let elected officials know how they felt. I invited a number of legislators to visit MGH to see first-hand how important flexibility in staffing is. When they were unable to come, I went to the State House to make our case. Staff nurses like Meg Soriano, RN, and others spoke on behalf of clinicians at the bedside. And Janet Madigan, RN, represented the Massachusetts Organization of Nurse Executives (MONE).

*Question:* Why would anyone support mandatory staffing ratios?

*Jeanette:* Mandatory staffing ratios offer an easy answer to a complex problem. Proponents of mandatory ratios make it sound as if a 'simple' government mandate will magically produce more nurses and improve patient care. We know it's not that simple.

Mandated, one-size-fits-all staffing ratios would require every medical-surgical unit in the state to set the number of patients a nurse can care for, regardless of the patient's individual needs, the nurse's experience, or the time of day care is being provided. Govern-

ment should not be making those decisions. Nurses should.

Mandated staffing ratios would compromise patient safety and quality of care by taking flexibility, individualized care, and decision-making away from nurses. And the mandatory staffing bill does nothing to address the nursing shortage.

*Question:* Why is the Patient Safety Act better?

*Jeanette:* The Patient Safety Act holds hospitals accountable for

staffing decisions, expands nurse-training programs, and invests in new nursing faculty. It strikes the right balance between public accountability and flexibility and lets caregivers make the decisions about what's best for patients.

*Question:* Is this debate over?

*Jeanette:* Probably not. Mandatory staffing ratios will no doubt be an issue in the upcoming elections, so proponents are likely to re-introduce this legislation again next year.

### Jeanette Ives Erickson

*continued from previous page*

mittee members time away, etc.

- establishing ways for former collaborative governance members to continue to contribute after their terms are up

Collaborative governance is an essential part of our professional practice model, and the collaborative governance survey is an instructive tool as we continually strive to keep our committee structure vital and

responsive. As always, I welcome your comments and feedback. Don't feel you have to wait for the next survey to contact me with your suggestions.

I'd like to leave you with this quote from staff nurse, Ann Eastman, RN, who said, "Collaborative governance means opportunity to me: opportunity to learn about the work of other disciplines; opportunity to understand the perspective of other clinicians; oppor-

tunity to look at systems and see why 'the best laid plans' sometimes fail. But most of all, it's an opportunity for problem-solving with patients at the center and stakeholders having an opportunity to see how our work can help or hinder each other in achieving excellent patient care."

Thank-you, Ann.

#### Update

Paul Arnstein, RN, is the new clinical nurse specialist for Pain Relief. He is located on White 6 and can be reached at 4-8517.

## Clinician Recognition Program

Advanced clinicians and clinical scholars recognized June–August, 2006

#### Advanced Clinicians:

- Maryalyce Romano, RN, Surgery
- Christine Perino, RRT, Respiratory Care
- Eileen Collins, PT, Physical Therapy
- Melanie Struzzi, PT, Physical Therapy
- Jennifer Hovsepian, RN, Cardiac Surgery
- Marissa Legare, RN, Transplant Unit
- Tracey Zachary, RN, Emergency Department
- Noel DuPlessis, RN, Neurology
- Katherine O'Meara, RN, Medicine
- Cheryl Hersh, SLP, Speech, Language & Swallowing Disorders
- Kathleen Mortimer, RN, Surgery

#### Clinical Scholars:

- Robert Larocque, RN, Radiology
- Ann Hession, RN, Obstetrics



## Patient education: current practices and future direction

—by Janet King, RN; Carol Harmon Mahony, OTR/L; and Elizabeth West, RN

New members of the Patient Education Committee have been surprised to learn about the work the committee is doing to support clinical staff in developing patient-education activities. Last fall, the Patient Education Committee set out to assess the current needs, knowledge, and practices of clinical staff in relation to teaching patients. Committee members created a survey to help identify current patient-education practices and identify future goals to improve access, ease of use, and documentation of patient education for healthcare providers.

The Patient Educa-

tion Committee created a 26-question survey, incorporating a patient-education model that includes: education-planning, assessment, evaluation, resources, interventions, teaching, and documentation. The survey was divided into five main areas that addressed the following questions:

- Do clinicians assess patients' learning needs?
- Do clinicians use MGH patient-education resources?
- Do clinicians have adequate skills and confidence to teach patients?
- What documentation do clinicians use for patient-teaching?

- Do clinicians use a 'teach back' method to assess patients' understanding of new materials?

The survey was designed using a four-point Likert scale that rates the responders' level of confidence and frequency of use.

The Patient Education Committee distributed the survey to all members of collaborative governance committees.

The 105 surveys that were returned represent 52 patient care units and 17 disciplines. Nurses rep-

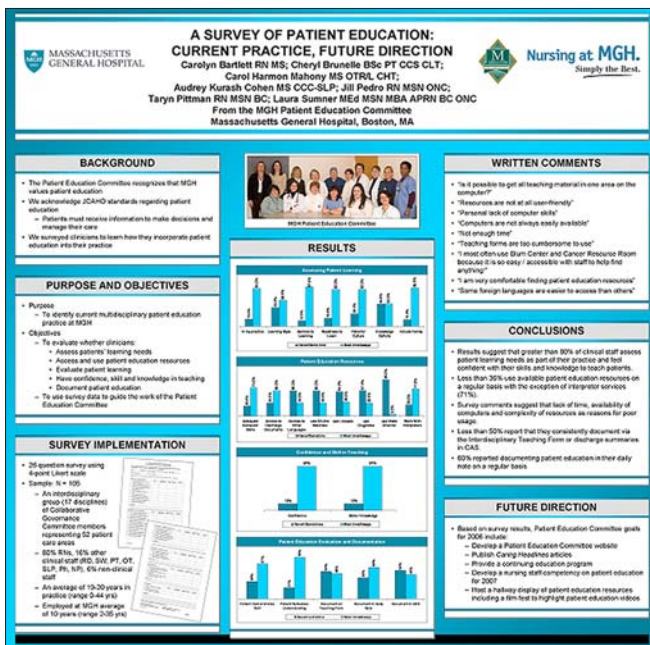
resented 80% of the respondents; 16% were registered dietitians, occupational therapists; nurse practitioners; pharmacists, physical therapists, social workers, and speech-language pathologists; and the remaining 4% were from non-clinical committee members. The average clinical experience for all respondents was 19.5 years, the average work experience at MGH was ten years.

Results of the survey suggest that more than 80% of staff incorporate patient education into their clinical practice. This includes involving family members in the education process, assessing learning barriers,

evaluating patients' readiness to learn, and being sensitive to patients' cultural backgrounds while teaching. Of those surveyed, 80% felt confident with their clinical skill and ability to teach patients.

Interestingly, an average of 66% felt they have adequate computer skills, easy access to discharge documents, and easy access to patient-education resources. However, less than 36% of staff actually use available patient-education resources, such as the Patient & Family Learning Center, the Cancer Resource Room, on-line resources (the MGH In-

*continued on next page*



## Patient Education

*continued from previous page*

tranet or the Internet), the Patient Education On-Demand Video Channel, Lexi-Comp, CareNotes, or DrugNotes. Though staff believe they have adequate access to resources, there is remarkably low utilization of available tools for patient teaching and documentation. Some possible reasons for infrequent use of resources surfaced in the survey's 'Comments' sections. They include lack of time, lack of available computers, and the complex process involved in finding educational resources.

Most clinicians feel that they're providing adequate patient education, but less than 50% are documenting patient

education using the discharge summaries in CAS or in the Interdisciplinary Inpatient Teaching Form. Sixty percent of survey respondents report including patient education in their daily notes.

Upon reviewing the survey results, the committee proposed several 2006-2007 goals to try to address the discrepancy between clinicians' knowledge of patient-education resources and their actual use of those resources. The Patient Education Committee is developing a patient education website, will continue to publish quarterly articles in *Caring Headlines*, and will develop 2007 nursing competen-

cies in the area of patient education. The committee recently hosted a hallway display of on-line, patient-education resources and demonstrations of the on-demand TV channels. In November, the committee will host a patient-education program for clinicians featuring Fran London, entitled, "The Essence of Patient Education."

The Patient Education Committee strives to develop the role that clinical staff play in providing patient education. The patient-education survey generated clear goals for how the committee can help staff expand their familiarity with educational resources and improve their clinical practice. For more information, call Carol Harmon Mahony, OTR/L at 4-8162.

## Blood: there's life-saving power in every drop

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building

The MGH Blood Donor Center is open for whole blood donations:  
Tuesday, Wednesday, Thursday,  
7:30am–5:30pm  
Friday, 8:30am–4:30pm  
(closed Monday)

Platelet donations:  
Monday, Tuesday, Wednesday, Thursday,  
7:30am–5:00pm  
Friday, 8:30am–3:00pm

Appointments are available for blood or platelet donations

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



(Photos by Michelle Rose)

*Far left:* The Patient Education Committee's research poster describing their recent survey of current patient-teaching practices and future goals.

*Center and right:* Members of the Patient Education Committee staff display tables in the Main Lobby disseminating information on patient-education and on-line resources at MGH.



## From discharge planning to end-of-life care: a challenging and rewarding experience

*Marissa Legare is an advanced clinician*

**M**y name is Marissa Legare, and I have been a staff nurse on the Transplant Unit for four years. I began working on the Transplant Unit right out of nursing school because I was drawn to the many opportunities it offered for growth and learning. In my time on Blake 6, I've grown from a novice to an experienced ICU nurse. I've cared for the simplest of patients and the most complex. Coming to work every day presents a new challenge, which I love.

One of the greatest and most rewarding challenges occurred this past January. Mr. G was a man in his 50s who'd recently undergone a liver transplant for hepatocellular cancer and Hepatitis C. He did well after surgery. He 'flew' through the recovery phase, and soon his discharge planning was in full swing. During this initial phase I was not one of Mr. G's nurses. I'd say "Hi" in passing. I knew he and his wife had been married for 25 years and had no children. They were inseparable and so in love. It was nice to see.

The fifth night after Mr. G's transplant, he spiked a temperature of 103°. Things spiraled downward after that. The following morning his

liver-function readings tripled and his kidney began to shut down. He went for an immediate CT scan and returned to the unit in respiratory distress. He was intubated and placed on continuous veno-venous hemofiltration (CVVH), a mechanical blood-filtering system that runs 24 hours a day to filter out toxins when a patient is in kidney failure. Within a matter of 20 hours Mr. G had gone from being a soon-to-be-discharged patient to an ICU patient.

Mrs. G, who'd been by her husband's side during his entire hospitalization, went home that morning before he was intubated because she couldn't handle it. She didn't want her husband to see her upset, but she was terrified, so she thought it would be best for her to go home and let the transplant team do his job.

My shift had started at 3:00pm that day. The evening was busy because Mr. G's condition had become so complicated. His biggest issues were that he was severely fluid-overloaded and had low blood pressure. I worked closely with the nephrology team and our transplant team. Our goals were to relieve Mr. G of some fluid through CVVH and get his blood pressure up to a safer

level. Initially, the nephrology team wanted to take out 100cc of fluid an hour, but Mr. G could not tolerate that dramatic a fluid shift. When I tried, his blood pressure would drop to an unsafe level. So I began by taking off 50cc of fluid an hour, and Mr. G's blood pressure tolerated this well. I went back to the nephrologists and let them know I was taking fluid out at a rate of 50cc an hour. They were comfortable with this and let me run the machine as needed to get as much fluid off Mr. G as was safely possible. It felt like a balancing act. By the end of my shift, he had stabilized slightly, but still had a ways to go.

About four days after Mr. G had decompensated, I was again his nurse. He was still critically ill, on a ventilator, and receiving CVVH. Mrs. G decided she was ready to come in and see him for the first time that afternoon. I talked with her on the phone that morning, and she let me know what time she'd be in. I planned my day around this, because I knew she'd need a lot of time and support when she arrived. When she came in, we sat together in the visitor's lounge. I tried to mentally prepare her for what she would see. I explained what each of the tubes, lines, and ma-



Marissa Legare, RN  
staff nurse, Blake 6 Transplant Unit

chines did; I tried to give her a good mental picture before she went into her husband's room. I knew she didn't want to get upset in front of him, so the less shock she felt, the better the visit would be for both of them. After explaining things, I walked Mrs. G to her husband's room. She went over to the bed and started talking to him. She asked me if he could hear her. I told her I wasn't sure, but I talked to him all the time, and he'd probably rather hear her voice than mine. For the rest of the evening, she sat by his side, held his hand, and spoke to him. From that day on, she came in every day, and we developed a trusting relationship.

Over the next three weeks, I cared for Mr. G almost every shift I worked. He remained very ill, and in fact, his condition got worse instead of better. Mr. G's liver was dying, his kidneys had failed, and he had contracted an infection that didn't respond to any of

the antibiotics. Each day our team would round, and there would seem to be fewer and fewer treatment options.

One Wednesday afternoon, after another CT scan, it was decided that the source of the infection could be the spleen, so it was decided that it should be removed. The team was hesitant to put Mr. G through the ordeal of moving him to the operating room (OR) but they felt it was his last hope. The following day, Mrs. G gave her consent, and Mr. G was taken to the OR for a splenectomy.

Friday afternoon, I came in and took care of Mr. G again. When I got report, I knew he was dying. He was on maximum support, 100% oxygen on the ventilator, an extremely high rate on the CVVH machine, and he was getting a lot of phenylephrine to keep his blood pressure at a low but safe level. Within the first hour of my shift, I had to increase his phenylephrine because his

*continued on next page*

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

## Clinical Narrative

*continued from previous page*

blood pressure had dropped again. It occurred to me that this shift was going to be just as challenging as my first shift caring Mr. G, but in a very different way. Now, instead of trying to save Mr. G, we were going to have to let him die the best way we knew how. I began to think about how I could make this as peaceful as possible for both Mr. and Mrs. G. During evening rounds, the teams concluded that nothing more could be done. They were going to talk to Mrs. G. There had been other meetings with Mrs. G in the past few weeks, but those had involved exploring options to save Mr. G's life. This meeting was going to be hard for everyone. As a team, we brought Mrs. G and her family into the visitors' lounge for this end-of-life discussion.

The doctors explained that nothing more could be done and broached the subject of a DNR (a do-not-resuscitate order). Until this point Mr. G had been a 'full code.' Mrs. G listened, then asked about the possibility of withdrawing care if there was no hope. She didn't want her husband to suffer a second longer than he had to. She expressed concern about turning off his sedation medications.

I explained exactly what would happen if she decided to withdraw

care. I explained that we would take Mr. G off the CVVH machine, turn down the ventilator, and then turn off the blood-pressure medications. I stressed the fact that we wouldn't turn off, or even decrease, his sedation medications.

After the meeting, team members offered their condolences and left. I was the last staff member in the room. I went up to Mrs. G and told her she should be proud of herself and her husband. We both started to cry, then I left to let the family make a decision about how they'd like to proceed.

Twenty minutes later, Mrs. G came to me in her husband's room and asked to speak to me in the hall. They had decided to withdraw care and let Mr. G go. I asked her to give me five minutes to prepare the room for her and her family. The transplant fellow, another nurse, and I went into the room. I took Mr. G off the CVVH machine and moved it out of the room while my co-workers removed the IV medications and placed chairs around the bed so everyone could be close. We combed Mr. G's hair (he was very particular about his hair) and told the family they could come in. When everyone was settled, I left the room so the family could have some time alone with him.

Mr. G died about 30 minutes later. I let the family know they could stay as long as they needed, but they were ready to go. I helped Mrs. G pack up her husband's belongings and she said one final good-bye to Mr. G. Out in the hall, Mr. G's family thanked staff for all they had done.

Mrs. G thanked us all and hugged us. She came to me last and thanked me for taking such good care of her husband. I told her I wished we could have done more.

I left that night feeling I had helped Mr. G die peacefully and helped Mrs. G feel at peace with his death. This was re-

warding, but left me feeling helpless. Getting a transplant is supposed to be the start of a new life not the end of one. Although this is something I don't want to go through again any time soon, I was glad I was there and able to help Mr. and Mrs. G through this trying time in their lives.

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

This is a wonderful, instructive narrative. In a matter of days, Mr. G's condition went from stable to gravely ill. At each juncture, Marissa was present to Mr. G and

sensitive to his wife's needs as she came to grips with her husband's changing prognosis. Led by compassion and empathy, Marissa ushered Mr. and Mrs. G through frightening, unfamiliar times with strength and focus. She collaborated with other team members, made herself available to Mr. G's family, and tended to the smallest details to ensure Mr. G had a peaceful death. Explaining how care would be withdrawn, stressing that Mr. G's sedation medications would not be changed, gave Mrs. G peace of mind.

Thank-you, Marissa.

## MGH: improving hand hygiene

### Glove Safety:

*When should gloves be worn?*

Gloves are used to protect healthcare workers and patients, and reduce the cross-contamination between patients, workers, and the environment.

*Standard precautions: used for all patients*

Glove use is recommended when contact is anticipated with non-intact skin, mucous membranes, bodily fluids, or items contaminated with bodily fluids or excretions.

*Is there a correct way to put gloves on and take them off?*

Yes. If you're unsure of the proper technique, contact your nurse manager or the Infection Control Unit for a demonstration.

*Special precautions: for patients on airborne, contact, droplet, neutropenic, or other precautions*

Gloves may be required for *all* contact with patients on the above-mentioned precautions (including intact skin) and/or contact with items in the patients' environment.

See posted signs or the Infection Control Manual for further information on the specific precaution requirements for your patient.



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

## PCS executive team welcomes Flaherty

In February, 2006, Christina M. Graf, RN, announced her intention to retire as director of Patient Care Services Financial Management Systems and assume a part-time position focusing on health services administrative research and other projects. As anyone in Patient Care Services will tell you, Graf's departure left some very big shoes to fill. After an extensive national search, it was announced on August 29,

2006, that Eileen Flaherty, RN, nurse manager of the Bigelow 11 Medical Unit, would become the new director of PCS Financial Management Systems.

Responsible for coordinating, analyzing, and implementing key financial systems and ensuring optimal utilization of human, fiscal, and material resources, the role calls for a highly specialized blend of strategic-planning, operational, and financial expertise. Flaherty, who has

been at MGH since 1997 serving as assistant project manager, staff specialist, and most recently, nurse manager, brings a wealth of essential knowledge and experience to the role.

Says senior vice president for Patient Care Services, Jeanette Ives Erickson, RN, "I'm thrilled that Eileen chose to pursue this opportunity to expand her influence in the MGH community. Her accomplishments as a nurse manager, her success in ensuring high-

quality care, exploring flexible staffing options, and promoting operational efficiency made her the perfect choice, distinguishing her from a field of many other highly qualified candidates."

As a nurse manager, Flaherty has worked closely with many of the systems and programs designed by her predecessor. In January, 2005, a project team under the leadership of Graf, implemented the Unit-Based Dashboard, a quality-assurance tool developed to provide unit leadership with relevant information about their operations, clinical outcomes, staffing, and financial prac-

tices. The dashboard combines information from workload productivity reports, quality outcome reports, fiscal reports, and many other sources to help nurse managers, associate chief nurses, and operations coordinators make informed decisions about issues that impact their units.

As an end-user of the Unit-Based Dashboard, Flaherty has had firsthand experience using the tool to monitor, evaluate, and implement improvements on Bigelow 11. She's in a unique position to be able to build on the success of this and other initiatives, using her skill and experience to help others use the data in a meaningful way.

Teamwork and collaboration have always been hallmarks of Flaherty's leadership style, fueling her efforts to develop strong communication skills in herself and others.

Says Flaherty, "I'm thrilled to be joining such a dynamic leadership team during such an exciting time in health care. While my heart will always be with the staff of Bigelow 11, I'm proud to be able to build on the skills and experiences we shared to influence patient care in new ways. I'm grateful for my years as a nurse manager and look forward to this wonderful opportunity to broaden my commitment to Patient Care Services."



Eileen Flaherty, RN, new director, PCS Financial Management Systems



## Emergency discharge prescriptions when Outpatient Pharmacy is closed

**Question:** I understand there's a new policy around the dispensing of emergency discharge medications for free-care patients. What is the new policy?

**Answer:** The new policy applies to medications prescribed after the MGH Outpatient Pharmacy is closed. In those instances, the MGH Inpatient Pharmacy will dispense an emergency supply of medication(s) to patients who have been pre-approved for free care. The Inpatient Pharmacy will provide an emergency supply of medication(s) that will last the patient until the remainder of the prescription can be obtained from the Outpatient Pharmacy. Patients will be given up to a two-day supply. The policy may also be used when patients need medication(s) not available at outside pharmacies due to extenuating circumstances.

**Question:** What are the hours of the Outpatient Pharmacy?

**Answer:** The Outpatient Pharmacy, located on the first floor of the Wang Building, is open Monday–Friday: 9:00am–5:30pm; Saturdays, Sundays, and Holidays: 9:00am–12:30pm.

**Question:** How does the policy work?

**Answer:** When a patient is identified as someone who is receiving free care and needs to be discharged with medications when the Outpatient Pharmacy is closed, the nurse will page the case manager on call to obtain approval. The case manager will contact the Pharmacy for authorization.

The nurse or case manager will fax the prescription(s) to the Inpatient Pharmacy. It should be noted on the cover sheet that the prescription(s) are for an emer-

gency discharge patient. (Prescriptions must be faxed; the Pharmacy will not accept verbal orders.)

The Inpatient Pharmacy will hand deliver an emergency supply of the medication(s) to the unit and give them to the nurse caring for the patient.

Prescription(s) will be sent to the Outpatient Pharmacy the following day for the remainder of the prescription to be filled.

**Question:** Why was this policy enacted?

**Answer:** The policy was developed to improve the care, safety, and overall hospital experience of patients pre-approved for free care. By establishing a means for free-care patients to obtain discharge medications any time of the day or night, we can discharge patients in a more timely manner and improve their hospital experience.

**Question:** When did this policy go into effect?

**Answer:** The policy was developed by the Pharmacy in March, approved by the Clinical Policy and Record Committee in April, and approved by the Medical Policy Committee in August.

**Question:** Whom can I call if I have questions about the policy?

**Answer:** You can call the Inpatient Pharmacy at 6-2503, or page the pharmacist for your patient care unit. Alternatively, you can look up 'Pharmacy' in the Partners Directory and select the pager for the appropriate unit.

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For more information, call: 617-724-1746.

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## Improve your English!

### Enroll in an English for speakers of other languages class

- Ten classes range from Beginner to High Intermediate
- Classes meet from 2:00–3:30pm or 3:30–5:00pm Mondays and Wednesdays, or Tuesdays and Thursdays
- Fall classes begin September 11, 2006
- Classes are geared for support staff

Améliorer votre Anglais!  
Melhore o seu Inglês!  
¡Mejore su Inglés!

For more information, or to enroll, contact Beth Butterfoss at 6-2388 or by e-mail



## ProTech Graduation

*continued from front cover*



Photos clockwise from top left: Galia Wise, manager, MGH-East Boston High School Partnership; 2004 ProTech graduate, Melissa Diaz; 2006 ProTech graduate, Dominica Campbell; and Candace Burns, director, MGH-Boston Public Schools Partnerships



(Photo by Abram Bekker)

come together to honor the ProTech graduates. Galia Wise, manager, MGH-East Boston High School Partnership; Candace Burns, director, MGH-Boston Public Schools Partnerships; and MGH president, Peter Slavin, MD, addressed the gathering with words of wisdom and hopes for a bright future as students embark on their new journey. All ten graduates will attend college in the fall.

Guest speaker, Melis-

sa Diaz, a 2004 ProTech graduate, gave a heartfelt speech about how ProTech continued to provided her with opportunities even after she graduated.

Said Diaz, "Being in the ProTech Program and working at MGH helped me be more focused on my academics and got me really thinking about my future. MGH staff and ProTech staff took the time to talk with me when I had doubts about my thoughts and deci-

sions... I came to the United States from the Dominican Republic at age 14 without knowing anyone or speaking a word of English. I just had the American dream in my head. I wanted to accomplish everything my family had not been able to. I wanted to finish high school and go to college, something my mother had not been able to do because she needed to work to support her family. When my mother came to this country she

worked two jobs to provide for four children. I remember as a teenager seeing my mom wake up at 4:00 every morning and not return home until midnight. It made me sad, but at the same time, it started a fire inside of me. That fire gave me the determination to achieve and succeed."

Diaz is currently working as a medical assistant at the MGH Cancer Center and will be starting her junior year of nursing school at the University

of Massachusetts in the fall.

Speaker, Dominica Campbell, a 2006 ProTech graduate, spoke about the lessons she learned during her ProTech experience. Originally from Nigeria, Campbell spoke passionately about her past, present, and future.

Said Campbell, "The ProTech program has definitely made a difference in my life. It has helped me grow in many ways. I understand the meaning of responsibility and compassion more than I ever did before. I now firmly believe that people can make a difference in other people's lives, and that is what I want to spend my life doing. I have always wanted to work in the medical field because I want to belong to that special group of people who have compassion for others and do everything they can to help those in need."

Campbell is one of three recipients of this year's MGH Edward M. Kennedy Health Career Scholarship and will be attending the University of Massachusetts, Amherst, in the fall where she plans to enroll in the Pre-Med program.

The ProTech Program is a School Partnership initiative of the MGH Community Benefit Program funded by Partners Human Resources. For more information about the ProTech Program, call Galia Wise at 4-8326.

# Educational Offerings

September 7, 2006

When/Where	Description	Contact Hours
September 15 and 18 8:00am–4:15pm	<b>Neuroscience Nursing Review Course</b> Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room	TBA
September 20 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
September 20 8:00am–4:30pm	<b>Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other</b> Training Department, Charles River Plaza	7.2
September 20 8:00am–4:30pm	<b>Medical-Surgical Nursing Certification Prep Course</b> Yawkey 10-660	TBA
September 21 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	<b>CPR—Age-Specific Mannequin Demonstration of BLS Skills</b> VBK401 (No BLS card given)	---
September 21 8:00am–4:30pm	<b>Preceptor Development Program</b> Training Department, Charles River Plaza	7
September 21 11:00am–12:30pm	<b>Chaplaincy Grand Rounds</b> “An Introduction to Hinduism.” Yawkey 2-220	---
September 26 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK401	---
September 27 8:00am–2:00pm	<b>New Graduate Nurse Development Seminar II</b> Training Department, Charles River Plaza	5.4 (for mentors only)
September 28 12:00–4:00pm	<b>Basic Respiratory Nursing Care</b> Sweet Conference Room	---
September 28 1:30–2:30pm	<b>Nursing Grand Rounds</b> “Anticoagulation.” O’Keeffe Auditorium	1.2
September 29 8:00am–4:30pm	<b>MGH School of Nursing Alumni Homecoming Program</b> O’Keeffe Auditorium	TBA
October 3 8:00am–2:00pm	<b>BLS Certification for Healthcare Providers</b> VBK601	---
October 4 7:30–11:00am/12:00–3:30pm	<b>CPR—American Heart Association BLS Re-Certification</b> VBK401	---
October 6 8:00am–4:00pm	<b>Special Procedures and Diagnostic Tests: What You Need to Know</b> O’Keeffe Auditorium	TBA
October 10 and 13 8:00am–4:30pm	<b>End-of-Life Nursing Education Program</b> Burr 6 Conference Room	TBA
October 10 7:30am–2:00pm	<b>Congenital Heart Disease</b> Yawkey 2220	4.5
October 11 8:00am–2:00pm	<b>New Graduate Nurse Development Seminar I</b> Training Department, Charles River Plaza	6.0 (for mentors only)
October 11 8:00–11:30am	<b>Intermediate Arrhythmias</b> Haber Conference Room	3.9
October 11 12:15–4:30pm	<b>Pacing Concepts</b> Haber Conference Room	4.5
October 11 1:30–2:30pm	<b>OA/PCA/USA Connections</b> Bigelow 4 Amphitheater	---
October 12 and 19 8:00am–4:00pm	<b>Oncology Nursing Society Chemotherapy-Biotherapy Course</b> Yawkey 2220	16.8 for completing both days

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



## The MGH Fall Reduction Program

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

Every patient is at risk for falling. Some patients, because of medical or cognitive issues, are at greater risk than others. Falling presents such a safety risk that in 2005, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) introduced a new National Patient Safety Goal related to falls and patient harm. The goal says: “Reduce the risk of patient harm resulting from falls; implement a fall-reduction program including an evaluation of the effectiveness of the program.”

Our existing Fall Prevention Program includes

an evaluation of current standards, practice, related policies, and guidelines. The Patient Care Services (PCS) Patients At Risk for Injury Committee continuously monitors and analyzes fall data gathered through the MGH Safety Reporting System. The committee reviews all fall data quarterly and reports their analysis to Patient Care Services leadership.

The Patients at Risk for Injury Committee collaborates with other groups and committees to introduce improvements such as a review of current standards or the introduction of safety equipment. The recent revision of the Nursing

Assessment Form to include the use of the Morse Fall Scale is one example. Nurses assess patients upon admission, every 24 hours thereafter, or whenever the patient’s condition changes. The scale quantifies the patient’s risk for falling by evaluating his/her history of falls, secondary diagnoses, mobility aids, reliance on equipment, gait, and mental status. The assessment is documented on the Patient Care Flow Sheet. Nurses match interventions to patients’ specific risks and document them on the Intervention Sheet. The policy, “Risk for Injury: Falls,” in the *Nursing Practice Manual*

provides guidelines for the assessment/intervention process.

Another example is the introduction of new hospital beds. One feature of the bed is a tri-level alarm system that can be set based on each patient’s individual risk factors. Strategies are in place to prevent falls and identify opportunities for improvement. Guidelines have been established that target the safety issues of specific patient populations (such as the on-line Problem/Outcome/Intervention Sheet and clinical pathways for Managing Patients with Delirium, Dementia and Alcohol Withdrawal). Guidelines have also been established for patients who require restraints for medical-surgical or behavioral reasons. The Patients at Risk for Injury Survey

was developed for use in clinical areas and implemented to help identify opportunities for improvement.

Hospital administrators and clinical leadership ensure that MGH policies are consistent with JCAHO standards, but every clinician is responsible for assessing and re-assessing patients’ risk for falling and adhering to MGH policies and procedures.

For more information on the MGH Fall Reduction Program or related policies and procedures, go to the on-line *Clinical Policy and Procedure Manual*, the *Nursing Policy Manual*, the *Nursing Clinical Practice Manual* or Clinical Pathways: Problem/Outcome/Intervention Sheets. Or contact Katie Farraher at 6-4709.



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