

# Caring

Headlines

April 19, 2007

## The Norman Knight Preceptor of Distinction Award

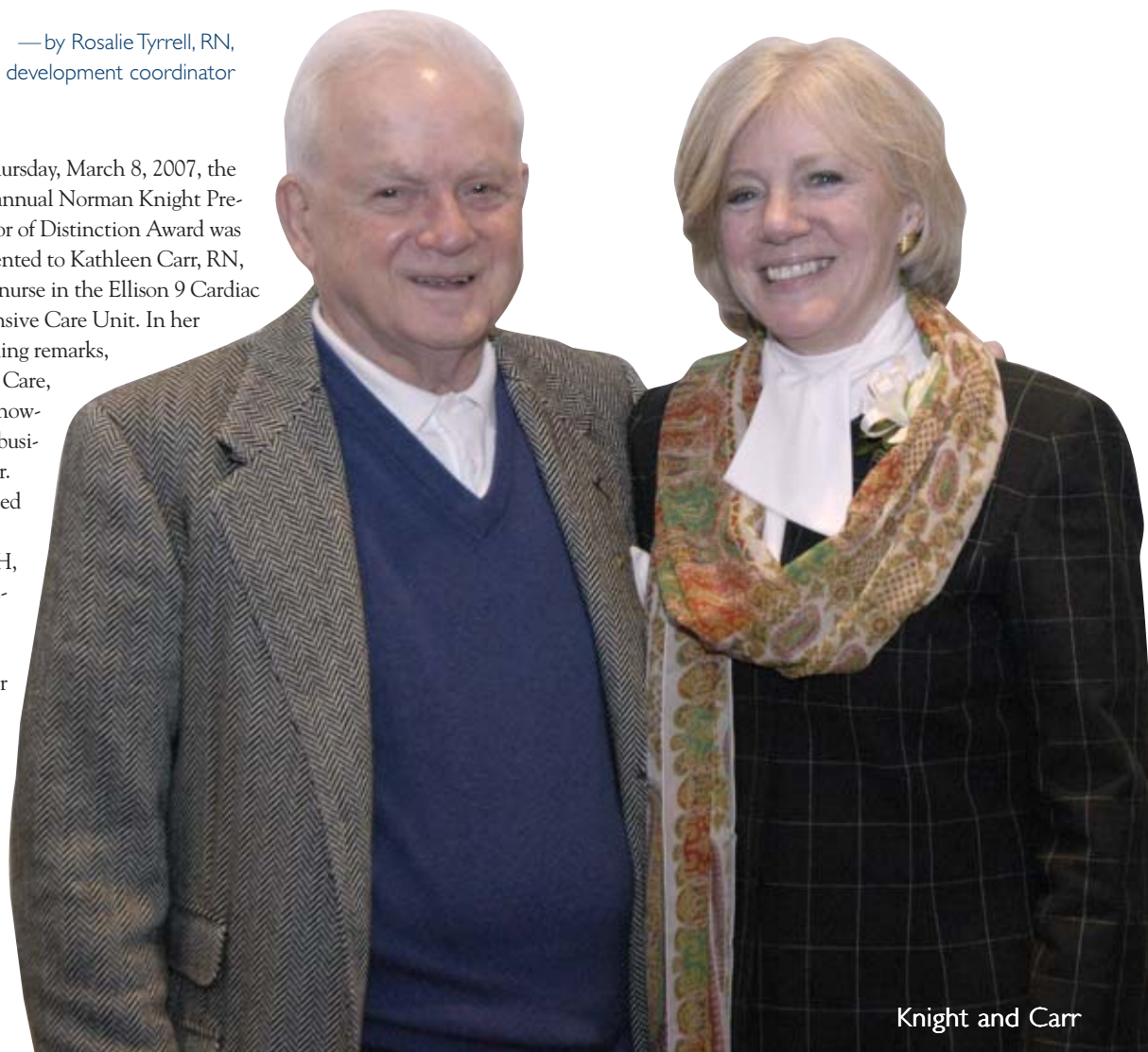
—by Rosalie Tyrrell, RN,  
professional development coordinator

**O**n Thursday, March 8, 2007, the 4th annual Norman Knight Preceptor of Distinction Award was presented to Kathleen Carr, RN, staff nurse in the Ellison 9 Cardiac Intensive Care Unit. In her opening remarks,

senior vice president for Patient Care, Jeanette Ives Erickson, RN, acknowledged award benefactor, noted businessman, and philanthropist, Mr. Norman Knight, for his continued support and generosity.

Said Ives Erickson, “At MGH, we believe a preceptor of distinction creates a safe environment where trust and wisdom can be discovered by both the preceptor and preceptee. Through example, the preceptor encourages a journey of growth and discovery and role-models excellence in patient- and family-centered care. Clinical nurses committed to precepting help create a positive learning environment for new nurses.”

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Knight and Carr

# MGH: a fully licensed and Joint Commission-accredited hospital



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

The Joint Commission conducted its survey of MGH in December, resulting in full re-accreditation with high praise for many, if not most, of our practices.

I want to begin by thanking you all for the excellent work you do, for the unparalleled care you provide, and for the infinite compassion and professionalism you bring to this hospital every day. It's because of you we enjoy a reputation as one of the most accomplished and sought-after academic medical centers in the world.

As a premiere Magnet hospital, the first in Massachusetts, our commitment to provide the highest quality care in a safe, efficient, transparent, practice environment is without question. If you were to log on to the Joint Commission's website right now, you would see that MGH is a fully licensed and accredited hospital in good standing. And with good reason: we hire only the best and brightest to work within these walls.

As you are well aware, the Joint Commission conducted its survey of MGH in December, resulting in full re-accreditation with high praise for many, if not most, of our practices. Like any organization of this size, especially one that is perpetually monitoring, evaluating, and implementing new systems, there were some areas where opportunities for improvement were identified; and in those areas, we received RFIs (requirements for improvement).

Some RFIs we were able to rectify in a matter of hours, others will take longer, but all will be addressed and corrected in a timely manner. I'd like to take this opportunity to share with you the few areas where we need to make changes (ten out of a possible 1,400) and let you know how we plan to address them.

Advance directives is an area where we fell short of the 100% compliance rate set by the Joint Commission. We've already made changes to the Health Care Proxy Questionnaire so that if an advance directive is not on file at the time of initial assessment, one will be filled out on

the spot. We're also working with the primary-care arena to have advance directives obtained *before* patients are admitted to the hospital when it's more appropriate to be making those sensitive healthcare decisions.

Another finding was in the area of Infection Control, specifically, hand-hygiene compliance rates. This is an initiative we have been championing for years, and we're showing great improvement, but we have a ways to go. The Joint Commission standard calls for 90% compliance. We are striving for 100% compliance. We're currently achieving 70% compliance before patient-contact and 88% after patient-contact. We are redoubling our efforts in this area with enhanced communication, observation, and education to get hand-hygiene compliance up to our own high standards.

Under the heading of Information Management, specifically, documentation, the area for improvement was identified as consistent inclusion of date and time on medical records. We are moving toward electronic documentation where issues of this nature will no longer be applicable, but until then, we need to make sure our documentation is legible, accurate, and complete.

In the area of Patient Safety, specifically, universal protocol (our time-out policy), areas for improvement included verifying patients' identification prior to procedures; and conducting and documenting time-outs. Interviews with staff suggest these important steps are being taken, but there's a gap in our documentation of these measures. We are developing new ways to remind staff to make sure they have 'the right patient for the right procedure on the right site... and to write it down.'

Pain assessment and management have always been a top priority at MGH. We have a number of policies and procedures in place to ensure appropriate pain manage-

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We are looking at ways to improve and streamline all processes to ensure our patients receive the best possible care. We want everyone who comes through our doors to have a safe, positive, professional experience.

ment for all patients. According to Joint Commission findings, we were less than 100% compliant with some standards having to do with assessment and re-assessment after surgical procedures, upon admission and transfer, and following administration of pain medication. We are reinforcing our efforts in this area (see article on page 13 of this issue of *Caring Headlines*). We have a comprehensive program in place to train pain relief champions to work with patients and colleagues to help eliminate barriers to pain-management and promote optimal pain control. To date, 250 pain relief champions have been trained, and we are developing other strategies to ensure patients' pain is properly assessed and treated.

Perhaps the most complex issue identified by the Joint Commission has to do with medication-management. One finding was related to medication reconciliation across the continuum of care. Clinicians (nurses, physicians, and pharmacists) are accountable for demonstrating that medications patients are taking prior to hospitalization are reviewed and incorporated into their plan of care and that discharge instructions cover all self-administered medications including those the patient was taking prior to admission. In truth, we anticipated a Joint Commission finding in this area because we're in the midst of implementing a new medication-reconciliation process, and the Joint Commission's visit occurred mid-way through implementation of this new system. We have added a feature to Provider Order Entry (POE) and the Longitudinal Medical Record (LMR) so when patients are admitted, a Pre-Admission Medication List (PAML) is initiated. As part of the discharge process, nurses review and compare the discharge medication list to the PAML and notify the doc-

tor if any inconsistencies are found. This process is then electronically documented on the computerized nursing discharge form. We're still in the process of communicating this new system to staff and educating them on this new application. I'm confident this initiative will help us achieve the 100% medication-reconciliation compliance rate we strive for.

There were other minor findings, but they were related to one-time occurrences or easily rectified operational issues, which have been or are being addressed (issues such as IV-solution storage; pneumatic tube use; unit service associates having access to medication storage cabinets for cleaning purposes; the physical environment at an off-site location; etc.)

We are looking at ways to improve and streamline all processes to ensure our patients receive the best possible care. We want everyone who comes through our doors to have a safe, positive, professional experience. We're anxious to comply with Joint Commission standards, but more importantly, we strive to satisfy our own desire to be the best we can be by creating a caring, responsible environment for our patients and staff.

#### Updates

I'm happy to announce that Lillian Ananian, RN, has accepted the position of clinical nurse specialist for the Blake 7 Medical Intensive Care Unit, effective immediately.

Cindy LaSala, RN, has accepted the position of clinical nurse specialist for Phillips House 20 and 21; Theresa Cantanno-Evans, RN, will return on a part-time basis, effective April 23, 2007.

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# Patient-education strategies for transplant recipients

—by Mandy Bass, RN; Jane Galley-Reilly, RN; Denise Twiss, RN; and Debra Whitaker, RN; formatted by Emily Curran, RN

**A**s staff nurses on the Transplant Unit, we assume many roles in caring for patients. One of the most significant is patient-educator. All of our patients have either received a solid-organ transplant or participated in some other cutting-edge, experimental surgery. A diverse patient population, each person has his/her own way of adapting to post-surgical life and learning about the adjustments they will need to make for the future. For this reason, transplant nurses create individualized education plans for every patient.

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We have come to realize that patient-education regarding medication and lifestyle changes is just as important as wound-care and pain-assessment in the survival of transplant patients.

At some level, patients understand that transplantation is a life-altering experience. New medications will become part of their routine for the rest of their lives. Other changes, including hygiene practices, preventing infection, monitoring graft function, body-image changes, fluctuations in mood and energy, and general changes in outlook and life-style are part of the package. Each patient responds differently to being hospitalized. The affect an illness has on patients and families, previous experience with the healthcare system, and the responsibility patients take for their own health maintenance all affect their ability to prepare for life after transplant. Educational levels, culture, anxiety, and disability can influence patients' lives and outlook following transplant surgery. Transplant nurses take all these variables into consideration, contributing to the richness of their nursing care.

We have come to realize that patient-education regarding medication and lifestyle changes is just as important as wound-care and pain-assessment in the survival of transplant patients. Following transplantation, patients receive a copy of the *Transplant Unit Teaching Booklet*, which covers medications, diet, infection-prevention, signs of rejection, blood work, post-discharge clinic routines, and many other topics. Patients are encouraged to read and refer to it as needed. The *Teaching Booklet* was written by staff who understand the concerns of patients and know their most frequently asked questions. The booklet is printed in large lettering and has a simple layout for patients with visual impairments.

The second step in patient-teaching is helping the patient become an active participant. This involves hands-on learning and assessing the patient's understanding before he returns home. While in the hospital, each patient receives a medication card listing all his medications organized according to the time they are to be taken. He is given a week's worth of medication with each medication individually wrapped in separate envelopes. The nurse explains the medication plan. The patient then demonstrates that he is capable of taking the medications at their assigned times and has the nurse check for accuracy of time and dose. Patients are quizzed on their knowledge of medication usage and side-effects. During these educational sessions, nurses discuss signs of infection, rejection, stress, and under which circumstances it would be necessary to call the clinic. We explain what to expect when they go home and how clinic appointments are made.

Our patient-education program is based on adult-learning principles, developed through experience and tailored to fit the needs of each individual patient and family. Over the years, we've developed creative ways of approaching educational challenges. The goal of our teaching is to provide concrete, objective information to help patients during their hospitalization, and give them to tools they need to sustain life-long, positive behaviors after transplantation.

For more information on patient-education strategies for transplant recipients, call 4-8610.

A preceptor of distinction consistently demonstrates excellence in educating, precepting, mentoring, and coaching. Said Ives Erickson, “By these or any other standards, Kathy Carr is most certainly a preceptor of distinction.”

A preceptor of distinction:

- is caring and non-judgmental
- possesses a spirit of inquiry
- is guided by knowledge
- is a leader
- values teamwork

A preceptor of distinction consistently demonstrates excellence in educating, precepting, mentoring, and coaching. Said Ives Erickson, “By these or any other standards, Kathy Carr is most certainly a preceptor of distinction.”

Reading from a nomination letter submitted by Colleen Snyderman, RN, Ives Erickson said, “Kathy’s strength comes from her own clinical confidence and her ability to assess the knowledge of her preceptees so she can allow them space to begin to make decisions and clinical judgments independently.”

Katie Swigar, RN, wrote, “Kathy embraces a holistic view of the orientation process; she supports new nurses in their clinical practice while helping them become integrated into the culture of the unit as they transition into a professional role. Kathy promotes critical thinking in her preceptees, knowing when the time is right to step back and allow them to safely soar.”

Keith Perleberg, RN, nursing director for Phillips House 20 and 21, shared his thoughts on the power of clinical narratives. “Stories put a human face on statistics,” said Perleberg. “They have depth and dimension, drama and emotion, making them more memorable than data. Stories give us instructions for living, instructions for practice, and a sense that we’re not alone. Stories reveal fundamental truths about human experience and point us toward the importance of meaning.”

Carr read her narrative, entitled: “Being There,” in which she described the teaching strategies she uses in precepting new nurses: role-modeling, prepping, reflection, and presence. Said Carr, “We consciously and continuously support the growth and blossoming independence of our new graduate nurses. We’re

always there for them (sometimes without their awareness). We teach them. We support them. We assess their readiness. We step in when necessary and, when appropriate, we let them fly. Then, we step back and marvel at how sensitive, competent, and professional our new graduates have become; at how they have grown.”

Perleberg engaged Carr in a dialogue to ‘unbundle’ and reveal the lessons contained her narrative.

Recognizing the other nurses nominated for the award, Ives Erickson observed, “Just as Florence Nightingale charted the course for other nurses to follow, today’s nominees are charting the course for tomorrow’s nurse preceptors.” She thanked the Review Board for their hard work in reviewing the portfolios of the seven distinguished nominees.

Ives Erickson once again thanked Mr. Knight for his generosity in funding the following important initiatives:

- The Norman Knight Preceptor of Distinction Award
- The Knight Visiting Professor Program
- The Norman Knight Nursing Center for Clinical & Professional Development
- And most recently, a nursing scholarship fund, the details of which are still being developed

For more information about the Norman Knight Preceptor of Distinction Award, contact Rosalie Tyrrell, RN, at 4-3019.



(L-r): Rosalie Tyrrell, RN, award coordinator; Kathy Carr; Keith Perleberg; a friend of Mr. Knight's; and Mr. Knight

# Bo, the Beatles, and end-of-life care for an organ-donation patient

—by Susan Sargent, RN; Cara Taylor, RN; and Mary McKenna Guanci, RN

April is  
National  
Organ and  
Tissue Donor  
Awareness  
Month

**M**y name is Susan Sargent, and I am a staff nurse in the Main Operating Room. On this particular morning in November, I had been assigned to Operating Room 36. Upon arrival, I was asked by the clinical service coordinator if I'd be willing to

care for a patient who would be donating organs following cardiac death. In the past, I had expressed an interest in caring for patients who had consented to donate organs. Two nurses and a scrub person are usually assigned to care for donor patients. After collaborating with my colleagues, I assumed the role of supporting the family.

It was evident that collaboration between all members of the healthcare team and representatives of the New England Organ Bank (NEOB) would be crucial to providing a caring environment for family members and caregivers. My first concern was to learn as much as I could about the patient. I reviewed his record and learned our patient was a 25-year-old man named, Bo, who had suffered a subarachnoid hemorrhage. I could only imagine how devastating this must have been for his family. I shared this information with the operating room team. Together we reviewed the procedure, the procedure card provided by the NEOB, and the procedure card that had been written up for the OR. The nurse assigned to work with me gave me some helpful hints from her past experience supporting families of organ donors. And I sought out another colleague who'd cared for the family of an organ donor for any other suggestions. I prepared the induction room for the arrival of Bo and his family. Privacy and comfort, as well as consideration for other patients being transported to the OR, were taken into consideration in selecting the operating room for this procedure.

Good communication between units and caregivers was going to be key. I proceeded to the Neuro Intensive Care Unit where I reviewed Bo's chart and met with the family counselor, representatives from NEOB, Bo's nurse, clinical nurse specialist, and the nursing director. A nota-

tion in the progress notes written by the neurosurgeon described the catastrophic subarachnoid hemorrhage Bo had suffered and the meeting he'd had with the family to explain the seriousness of the event. It was evident that the family counselor had established a good rapport with the family. I asked to meet them and introduced myself. I explained what my role would be supporting them in the Operating Room. The family included Bo's mother, father, and two older sisters. After meeting the family, I asked to meet Bo.

I entered the room and saw a young man surrounded by loving family members and friends. I walked to the side of the bed, put my hand on his, and leaned closer to speak to him. I introduced myself and explained I would be helping to care for him and his family when he came to the OR. Bo's mother was grateful I had an opportunity to meet and speak to Bo before going to the OR.

Once I knew how many family members and friends would be accompanying Bo, I returned to the OR to get the proper attire for the family, for the Neuro ICU staff accompanying Bo, and for the NEOB staff members. I kept the OR staff informed of our estimated time of arrival.

A prayer service was held in Bo's room for family and friends. Afterward, I waited outside with the family while the Neuro ICU staff prepared Bo to go to the OR. This gave me an opportunity to better assess the individual needs of each family member. Bo's mother was chatty; his father quiet; one sister appeared to be in control, the other was quiet and not sure she'd be able to accompany us to the OR. When the time came to transport Bo, the Neuro ICU staff escorted him, while I accompanied the family and the family counselor on a separate elevator.

Bo was taken into the OR to be prepped and draped while the family waited in the induction room with the family counselor and me. Bo's family used this time to reflect. Many happy memories were shared of a vibrant, fun-loving son and brother. They had brought a CD-player to play some of Bo's favorite songs. While his mother spoke

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(L-r): Cara Taylor, RN; Mary McKenna Guanci, RN; and Susan Sargent, RN

with the family counselor, his sisters recalled recent events with their brother. Bo's father kept to himself.

Once Bo was brought into the induction room, his family gathered around and spoke to him. They had been prepared by the Neuro ICU staff of what to expect. In a few minutes, the monitor indicated that Bo's heart had stopped, and the emotions of the family poured out. But suddenly, unexpectedly, his heart started again, causing his family a painful moment of confusion and false hope. Due to Bo's age and otherwise good health this kind of heart activity is not unusual. Coincidentally, at that moment, Bo's favorite song began to play. A noticeable change took place in the family as they took advantage of a few more precious moments with Bo. Within the next 20 minutes, all cardiac activity had ceased and the family said their final good-byes. The family counselor hugged Bo's mother, his sisters hugged each other. Bo's father was standing alone; I gave him a hug. He held on to me for dear life. I expressed my condolences and told him I was concerned that he was standing alone. He told me he'd be okay.

I escorted the family back to the Neuro ICU where other family and friends were waiting. I returned to the OR knowing I had provided essential support during a devastating event in the lives of this family.

Knowing that Bo's organs would help other patients was comforting to the family. In their grief, they saw hope for others and expressed gratitude that Bo's death would have a positive impact on someone else. They knew they had done the right thing, remembering a conversation Bo had had with his sister only three months earlier on his birthday.

He had said, "If I should die..."



Paul McCartney was singing and Bo was dying. Sometimes it's in these, the strangest of moments, that I find myself reflecting on my practice. My name is Mary McKenna Guanci, I'm the clinical nurse specialist in the Neuroscience ICU, and I had begun this day the same as any other. I was greeted by staff telling me of a patient who was a candidate for Donation after Cardiac Death (DCD). Bo was a young man who had suffered a massive stroke and cardiac arrest. I had worked with the team the previous day to minimize the damage caused by these two events. His nurse, an experienced ICU nurse, and the team had provided excellent care to Bo and his family. But despite our best efforts, Bo continued to deteriorate. I left that day never having had the opportunity to meet Bo's family. That evening his family agreed that, given the grim prognosis, Bo would not want to be kept alive by artificial means. His mother made arrangements with the New England Organ Bank, and Bo was now ready to go to the OR to have his organs removed for possible donation.

In order for organ donation after cardiac death to be successful, patients must be brought to the OR for withdrawal of medical support. I helped develop the DCD guidelines in my role as clinical nurse specialist and because of this, I feel a responsibility to continually look for opportunities to evaluate the process. We are asking families to spend their most intimate moments in an unfamiliar environment, and we're asking nurses to administer end-of-life care with the same compassion and competency they would in the ICU. Bo's nurse had been involved in many end-of-life scenarios, but I sensed she was uncomfortable with this unfamiliar and highly emotional process. I made the decision to accompany her for support and to evaluate the process once more.

As nurses in a critical-care setting, we often enter situations at emotionally charged times. I feel like this is an expectation of the role, and I think many families welcome the addition of anyone who is in a position to help. Somehow, arriving in the midst of a death-and-donation scenario seems different, and interjecting myself into this moment was challenging. I was another stranger in what should have been a very private time.

Bo's nurse advised me of the family dynamics as I prepared to in-

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By donating his organs, Bo was able to save lives, and his family was grateful for the opportunity to do so... I think of the honor I had to be present with Bo at the end of his life whenever I hear the song, *I Will*.


introduce myself. We often ask families about end-of-life customs or rituals. The nurse told me Bo's mother had requested that Beatles music be played in the OR. A life-long Beatles fan myself, I knew I had my connection in the form of John, Paul, George, and Ringo. I introduced myself, talked with Bo's mom about Bo and the Beatles. She introduced me to the family and I explained that I would be helping Bo's nurse when she transported him to the OR. I reviewed the procedures and care Bo would need with the nurse and fellow.

In the OR, Beatles music played. Bo's nurse assessed him for pain. In an anteroom outside the OR, we removed his medical support. Bo's family gathered as Beatles songs serenaded us. The family was quiet, overwhelmed by the moment. But with each new song came another story of Bo's life. The music seemed to spark their memories, marking different eras in his life. Staff, who are sometimes at a loss when witnessing a person's death, shared their own memories of familiar songs. The music became an integral part of the setting as we grieved and waited.

Bo's heart slowed, and we informed the family that things were starting to change. They became quiet. Then, almost like a last message to his family, the song, *I Will* filled the room. With his family at his side, Bo's heart stopped for the last time. Everyone present felt the power of the music at that moment. After a final good-bye, Bo was taken into the OR. The nurse and I returned

to the ICU to say good-bye to Bo's family.

By donating his organs, Bo was able to save lives, and his family was grateful for the opportunity to do so. I saw that the DCD process provided comfort for this family. The nurse shared her positive feelings about organ-donation after witnessing such a peaceful end. Bo and his family provided me with insight about the power of music in the stark surroundings of the OR. I think of the honor I had to be present with Bo at the end of his life whenever I hear the song, *I Will*.

 My name is Cara Taylor, and I am a nurse in the Neuroscience Intensive Care Unit. I have become an organ-donation champion as a result of my experience caring for Bo.

Bo was a 25-year-old young man, who had suffered a cardiac arrest while at a friend's house-warming party. He was transferred to our unit after successful resuscitation at a community hospital. Bo had also suffered a stroke as a result of a dissection of his carotid artery. An MRI showed devastating anoxic injury to his brain.

As I entered the room, I knew Bo was in danger of suffering further neurological damage as the brain tissue

began to swell. I immediately began to treat his worsening symptoms and shortly thereafter met his mother. At a family meeting, we informed the family of the seriousness of Bo's condition. After the meeting, something unexpected happened. Bo's mother requested information about organ donation. It's unusual for families to request such information so soon in the course of care. His mother explained that Bo had spoken to the family about his desire to be an organ donor. I called the New England Organ Bank (NEOB) and arranged a meeting.

MGH and NEOB staff met, as we do before meeting with the family of any potential donor. The purpose

of the meeting was to allow the multi-disciplinary team to share their insights with members of the organ-procurement team. The meeting was instrumental in answering Bo's mother's questions, and hearing about the process seemed to give her some comfort. The meeting reinforced to many of us, myself included, the importance of individualized family-education.

Over the next 24 hours, Bo's condition worsened. All medical treatments were quickly exhausted. Despite our

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*I Will*  
—by Paul McCartney  
Who knows how long I've loved you  
You know I love you still  
Will I wait a lonely lifetime?  
If you want me to I will  
And if I ever saw you  
I didn't catch your name  
But it never really mattered  
I will always feel the same  
Love you forever, and forever  
Love you with all my heart  
Love you whenever we're together  
Love you when we're apart  
And when at last I find you  
Your song will fill the air  
Sing it loud so I can hear you  
Make it easy to be near you  
And the things you do endear you to me  
Oh, you know I will...  
I will...



Unfortunately, those awaiting life-saving organs far outnumber the pool of viable organ donors. As healthcare professionals we need to let patients and families know that this selfless, comforting, life-saving option exists.

best efforts, there was nothing else we could do. The family was told there was no hope of a meaningful recovery. Bo's family made the difficult decision to stop his medical treatment and do everything possible to 'make him comfortable.' The New England Organ Bank was once again contacted, and the family decided that Bo would want to take advantage of this opportunity to help others.

After the meeting, the focus of my nursing care changed. I have learned to accept when it's time to transition my nursing skills from aggressive, intensive care to end-of-life care. The needs of Bo's family and friends were equally important now.

Bo's mom had requested time for Bo's family and friends to visit and say good-bye. Within an hour after the meeting, Bo's friends began to arrive, sharing hugs and stories at his bedside. I knew it was my role to listen, aid in the healing process, and answer their questions and allay their fears about this experience.

I felt privileged to learn about Bo from his family and friends. His mother told me about his childhood in vivid detail. He had the ability to make you laugh and always kept his friends smiling. His mother's face lit up as she spoke. His friends added their own recollections of times spent with Bo. They took turns in silence, surrounding the bed with tears in their eyes.

Each of Bo's loved ones had a different way of coping with the impending loss. His mother seemed to gain strength in supporting his sisters and friends in their grief. Seeing this, I let her answer their questions to the best of her ability. She wasn't shy about asking me for information when she needed to.

Bo's two sisters were visibly upset. They weren't eating or sleeping and were showing signs of physical exhaustion. One sister actually collapsed before entering his room. I brought her some juice and crackers, and with much coaxing, finally got her to eat. We talked about how upset her brother would be if he knew she wasn't taking care of herself. She finished her crackers and headed to the family waiting area to have a sandwich.

Bo's father gained support from prayer. I allowed him as much time alone with his son as I could.

I gave each loved one what he/she needed, hoping to ease some of the pain of the situation.

The morning Bo was to be taken to the OR, his family held a prayer service in his room. His friends gathered to say their final farewells. As the time approached to bring Bo to the operating room, his mother came into the hallway and hugged me. She thanked me for the care I had given her son and her family. We shared a hug and parted as I prepared myself and her son for the OR.

I had some trepidation about the Donation after Cardiac Death process. This type of donation requires the

withdrawal of medical support to take place in the OR setting to minimize the time between cardiac death and donation. The family can be present during withdrawal of support in the OR, just as they can in the ICU.

The OR is an unfamiliar environment for me. I was leaving my 'comfort zone' to withdraw medical support in a place I have rarely visited. I discussed our plan of care with my clinical nurse specialist and the OR nurse. They reassured me they'd be there to help me in this unfamiliar setting. Providing comfort care was my focus as we entered the OR. I turned my attention to Bo and soon the unfamiliar surroundings became less of a source of anxiety for me.

In a private anteroom, Bo's breathing tube was removed as his family sat with him as his favorite Beatles songs played. Tears welled in my eyes. It doesn't seem fair that life has to be so painful sometimes. As much as we know death is a part of life, it's difficult to watch others experience it. Bo's family stayed with him until he took his last breath and his heart slowed to a stop. Then they were escorted back upstairs to our family waiting area as Bo was brought in to the OR.

I was invited to stay and observe the surgery, one I've never seen, but I felt an overwhelming need to stay with Bo's family. They had all become my patients over the past few days. I felt we all needed some closure. I needed to let them know how sorry I was for their loss and how much I admired them for being able to act for the betterment of others despite their own personal tragedy. With those thoughts, I headed back to the family waiting area, wiped the tears from my own eyes, and entered with tissues, juice, and water. As Bo's family and friends were preparing to leave, one of his sisters approached me in the hall. She told me that as she was leaving the operating room, she was overcome with a sense of peace for the first time since her brother had been rushed to the hospital.

Being part of such a life-giving experience was very rewarding for me. It made me feel more comfortable with the death of such a young person, knowing that some good came from his untimely passing. As a result of the generosity of Bo's family and the collaborative efforts of MGH and NEOB staff, the tragic loss of this young life resulted in life-saving surgery for some fortunate transplant recipients.

Unfortunately, those awaiting life-saving organs far outnumber the pool of viable organ donors. Caring for Bo and his family throughout this emotionally trying time showed me there's no greater gift than donating an organ. As healthcare professionals we need to let patients and families know that this selfless, comforting, life-saving option exists.

# Orren Carrere Fox Award for family-centered care

—by Mary Ellin Smith, RN, professional development coordinator

Henry and Elizabeth Fox created the Orren Carrere Fox Award as a way to acknowledge the commitment to family-centered care they experienced when Orren was a patient ten years ago.

**O**n Thursday March 15, 2007, Orren Fox, accompanied by his brother, parents, Elizabeth DeLana and Henry Fox, along with other friends and family members returned to the Neonatal Intensive Care Unit (NICU) to congratulate staff nurse, Staci Quinlan, RN, the 2007 recipient of the award that bears his name. DeLana and Fox created the Orren Carrere Fox Award for NICU caregivers as a way to acknowledge the commitment to family-centered care they experienced when Orren was a patient in the NICU ten years ago.

In her introductory remarks, Peggy Settle, RN, nursing director, observed that 18 staff from a number of roles and disciplines were nominated. “The incredible number of

caregivers nominated this year is a testament to the importance we place on family-centered care and the pride we take in receiving this award.”

Said Settle, “Staci epitomizes our commitment to family-centered care. She creates and updates educational materials for families and goes out of her way to address individual family needs and concerns. She is always there for her patients and families.”

Accepting the award, Quinlan thanked the Fox family for their generosity in funding the award and her colleagues for their support and commitment to family-centered care.

Speaking on behalf of the family, Henry Fox said, “I know I speak for all the families of the patients you’ve cared for over the years when I say, ‘Thank-you for the exceptional care you provide.’”

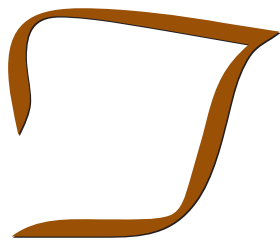


Award recipient, Staci Quinlan, RN (center), Peggy Settle, RN (right), and members of the DeLana-Fox family

(Photo by Paul Batista)

# Patient-education resources in one central, on-line location

— by Kristen Samatis, CHES; Sarah Ballard Molway, RN; and Angela Sorge-McColgan, RN, of the Patient Education Committee



The Patient Education Committee recently developed a website that pulls all patient-education resources together into one central location (<http://www.mghpted.org>). Take a look at the following case study

to see how this website makes finding patient-education resources simple and convenient.

Mr. D is a 65-year-old male newly diagnosed with type II diabetes. Upon hearing his diagnosis, Mr. D confided in his nurse that he really didn't know what having diabetes meant. A great place to start when establishing a teaching plan is the *Clinical Policy and Procedure Manual*: "Patient and Family Education" section. This link contains tips for assessing Mr. D's readiness to learn and his learning style. By using this tool Mr. D's nurse was able to determine his preferred learning style. After talking with Mr. D, it was

clear he was a visual learner and would most likely benefit from a variety of teaching media, such as handouts, demonstrations, and videos.

To find general information about diabetes and self-administering insulin injections, the nurse accessed CareNotes in the Patient Education section of the website to see what was available. She was able to find some great teaching materials that she gave to Mr. D so he could refer to them at home. This reinforced the hands-on teaching she had already conducted at the bedside.

Mr. D's nurse wanted him to have information about managing his diabetes with diet and nutrition. In addition to referring him to a dietician, she thought it would be beneficial for him to see a video. From the Patient Education website, she clicked on the MGH Patient Education Television Channel link and scrolled down to the Diabetes and Nutrition video (#107, also available in Spanish). She dialed 4-5212 on Mr. D's bedside phone and in less

than 30 seconds, Mr. D and his daughter were learning about healthy food choices and portion sizes. After the video, Mr. D and his nurse were able to have a meaningful conversation about diabetes and the importance of maintaining a good diet.

Mr. D's nurse documented her teaching in the progress note and other appropriate locations.

Mr. D's daughter was impressed with all the information her father had received. She expressed an interest in learning more about the disease herself. Mr. D's nurse informed her that she could go to the Patient & Family Learning Center (PFLC) off the Main Corridor and PFLC staff would help her find more information about diabetes.

The Patient Education Committee encourages all clinicians to visit the Patient Education website at <http://www.mghpted.org> to make finding your patient-education resources easier. For more information, call Kristen Samatis at 4-7352.

For all your patient-education needs, go to: [www.mghpted.org](http://www.mghpted.org)

Visit the Patient Education Committee Website

[www.mghpted.org](http://www.mghpted.org)

Great resource for MGH clinicians!

Need discharge documents? Drug information? Patient-Education videos? Log on to our website for all your patient-education needs!

# Students and mentors celebrate achievement

—by Susan Berglund, manager, MGH-Timilty Partnership



MGH scientists often assemble in the Simches Conference Room to discuss the latest achievements in scientific research. On March 15, 2007, the room was filled with a different kind of scientist. These scientists were seventh and eighth grad-

ers participating in the MGH-Timilty Partnership's Science Connection Program. The students gathered with their MGH mentors to share their science fair projects and celebrate the completion of the Science Fair Mentoring Program.

Britain Nicholson, MD, senior vice president and chief medical officer, congratulated students and mentors saying, "Today we have seen the efforts of a select group of Timilty students. Of the thirty students here, eight presented their projects at the annual SAC Poster Session. Eleven were school science fair finalists, and eight competed at the regional fair where two students took first place awards, one student took third place, and one received honorable mention."

Two veteran mentors, biomedical engineering technician, Vincent Riggi, RRT, and nursing director, Peggy Settle, RN, of the Neonatal Intensive Care Unit, were recognized for their years of service to the MGH-Timilty Partnership. Riggi was honored for his ten years of participation. Riggi thanked his supervisor, Joe Kratochvil, and co-workers, Roe and Yurithe, for their support. Said Riggi, "They have to work a little harder so I can spend time mentoring, but they never complain. In fact, they look forward to the time I spend with the students. It's that kind of support that makes mentoring at MGH such a great experience."

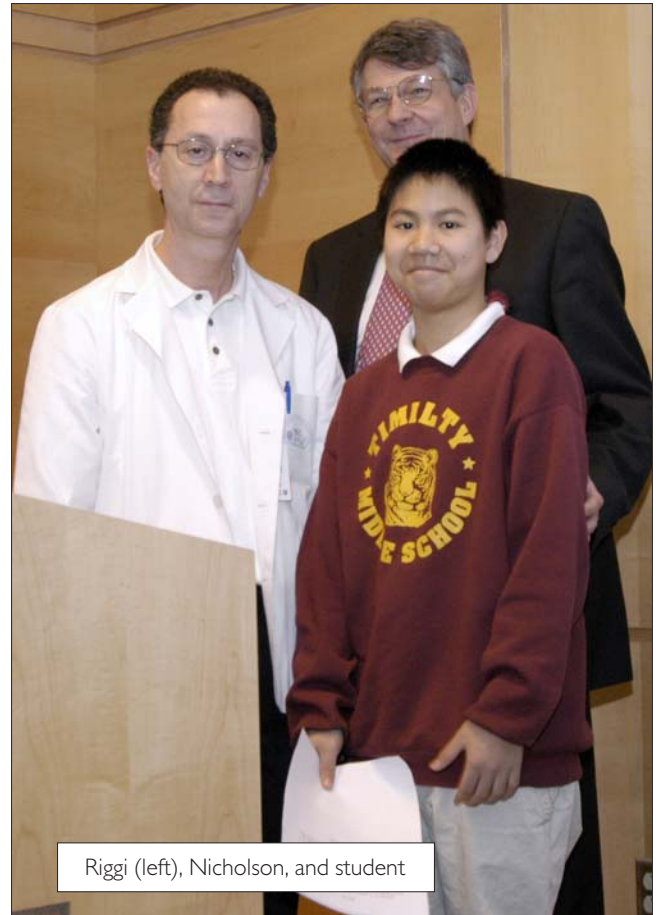
Graduating eighth grader, Steven, spoke of the relationship he and Riggi formed over the past two years. "I've learned how to work with a partner. You have to put in equal effort; you can't just have one person doing all the work. I wish I could

stay for another year, but I can't."

Settle was honored for her five years of service as a mentor. Settle thinks of mentoring as, "an opportunity to meet people from other departments. It allows us to foster meaningful connections that continue long after the science fair is over. Like being an astronaut, being a mentor is like touching the future. And when all is said and done, I've definitely received more than I given."

For more information about the MGH-Timilty Partnership Science Connection Program, contact Susan Berglund at: [sberglund@partners.org](mailto:sberglund@partners.org), or visit the Community Benefit website at: [www.massgeneral.org/cb/](http://www.massgeneral.org/cb/).

Two mentors, biomedical engineering technician, Vincent Riggi, RRT, and nursing director, Peggy Settle, RN, were recognized for their years of service to the MGH-Timilty Partnership.



Riggi (left), Nicholson, and student

## Pain relief champions: a valuable resource

—by Paul Arnstein, RN, clinical nurse specialist for Pain Relief



Paul Arnstein, RN  
clinical nurse specialist for Pain Relief

Despite attempts to identify patients at high risk for pain, researchers have determined that all patients are at risk, therefore attention must be paid to this clinical issue in all areas.

**P**ain is a pervasive and common problem that affects all people. You or a loved one may not be experiencing pain right now, but according to the Centers for Disease Control, 40% of Americans are experiencing pain that has persisted for more than a day. They estimate that nearly 60% of people over age 65 have had continuous pain for at least one year. Pain was recognized as a major health concern for the first time this year in the Centers for Disease Control's annual report, *Health Trends in America*. Pain is a leading reason why people seek health care in both the inpatient and outpatient settings. Despite attempts to identify patients at high risk for pain, researchers have determined that all patients are at risk, therefore attention must be paid to this clinical issue in all areas.

Pain Pulse surveys conducted at MGH between 1999 and 2006 indicate that the majority of patients we serve experience pain. Nearly half of patients who report pain describe it as moderate to severe in intensity and say it interferes with their enjoyment of life. Failure to treat pain is associated with poor clinical and financial outcomes for both patients and healthcare organizations. Since 1999, MGH has addressed this important clinical need by training pain relief champions as part of the MGH Cares about Pain Relief Program.

After two full days of training, pain relief champions return to their units and work with patients and colleagues to eliminate barriers to pain-management while promoting optimal pain control. To date, 250 pain relief champions have been trained since the inception of the program. All pain relief champions pledge to:

- listen to their patients' reports of pain and take them seriously
- carefully assess their patients' pain
- provide patients with information about the best way to manage their pain
- prevent pain when possible and treat it promptly

Some of the outcomes of pain relief champions' activities include:

- improvement in pain-control following heart surgery
- better ways of assessing and treating pain in children and older adults
- better pre-admission evaluation and post-operative treatment of pain
- Pamphlets that help patients and families understand the technology used to control pain (such as patient-controlled and epidural analgesia)

In an effort to improve the way pain is assessed and documented, pain relief champions are sharing their insight and enthusiasm by randomly asking staff:

- When should pain be assessed and documented? (Upon admission, transfer, and following invasive procedures)
- For patients receiving pain medication, how often should pain be re-assessed and documented? (About an hour after most analgesics; every two hours for epidural patients, and every four hours for patients receiving PCA or continuous opioid infusions)

As technology and systems change, the demand for new skills and accurate documentation of patients' needs and responses to treatment is key. As rapidly changing science reveals new approaches to pain-control or identifies hidden dangers of current therapies, pain relief champions must continually update their knowledge. The monthly publication, *Pain Relief Connection*, is one way to help stay current. Members of the Pain Service (6-8810) and Palliative Care Service (4-9197) are available for expert consultations in this area of clinical practice. The feasibility of offering periodic review or booster courses to pain relief champions is currently under consideration.

Demand for pain-relief training remains high. This year's course was fully enrolled within the first 24 hours of being announced. We would consider offering the course twice a year to accommodate the demand if necessary. If you're thinking of enrolling in the Pain Relief Champion class, please contact The Norman Knight Center for Clinical & Professional Development at 6-3111.

For more information about pain relief champions or the MGH Cares about Pain Relief Program, contact Paul Arnstein, RN, clinical nurse specialist for Pain Relief at 724-8517.

# Announcements

## Nursing Research Fair

### Interactive Poster Session

Meet and talk with the investigators and authors of many of the posters on display throughout Nurse Week

### Nursing Research Consultation

Do you have a clinical question you would like to study? Would you like to do a research study but need help?

Make an appointment to meet with a research expert  
Call 6-3111 to schedule a 30-minute consultation

Exhibitors will include:

- Nursing Research Committee
- Munn Center for Nursing Research
- Clinical Research Program
- Treadwell Library
- Eastern Nursing Research Society
- Sigma Theta Tau International
- Research Book Vendor

Wednesday, May 9, 2007  
12:00–4:00pm  
under the Bulfinch Tent

## Coaching Boys to Men

Partners Employee Assistance Program brings this seminar to you in collaboration with MGH Men Against Abuse/Domestic Violence Working Group

As fathers, brothers, coaches, teachers, uncles and mentors, men are in a unique position to promote positive attitudes to the next generation to prevent violence before it begins.

The Family Violence Prevention Fund has started a global campaign called, "Coaching Boys to Men" to engage men in the prevention of violence against women and children.

This seminar is designed to motivate us to prevent violence and give us the tools and information to guide our young men.

Thursday, May 17, 2007  
12:30–1:30pm  
Thier Conference Room

## Eating Right and Staying Healthy with Today's Busy Lifestyles

The Be Fit program has helped employees maintain a healthy lifestyle through a program of fitness and nutrition. Be Fit nutritionist, Suzanne Landry, will help employees decide which foods are nutritious. Topics will include food labeling, choosing healthy snacks, and planning healthy meals when time is limited.

Speaker: Suzanne Landry, RD  
clinical nutrition specialist

Sponsored by the Employee Assistance Program  
617-726-6976

[www.eap.partners.org](http://www.eap.partners.org)  
feel free to bring a lunch

Thursday, April 19, 2007  
12:00–1:00pm  
Thier Conference Room

## Blum Center goes wireless

The Maxwell & Eleanor Blum Patient and Family Learning Center now has a wireless signal available for MGH patients and visitors. The joint project between the Blum Center, Patient Care Services Information Systems, and Partners Information Systems gives patients and families direct Internet access separate from the Partners network. The service comes in response to numerous requests from families and visitors who need to be in contact with work and others while visiting loved ones in the hospital.

The signal can be accessed from the Blum Center, on the first floor of the White Building. Patients and families will be given instructions on how to access the Internet from their laptops. We are pleased to be able to provide this service to MGH patients and families.

The Blum Center is open Monday–Friday, 9:30am–6:30pm; Saturday, 11:00am–3:00pm. The center is closed on Sundays and all major holidays.

## Nurse Recognition Week 2007

"Celebrating a Legacy of Leadership"

Sunday, May 6–Friday, May 11, 2007

See complete schedule of events in the May 3rd issue of *Caring Headlines*

## April is Occupational Therapy Month

The theme of this year's American Occupational Therapy Association celebration is: "Serving Our Military"

Many events and activities are planned at MGH

See the May 3, 2007 issue of *Caring Headlines* for coverage of Occupational Therapy Month at MGH

For more information, call 4-0147

## The MGH Blood Donor Center

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

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

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### Submission

All stories should be submitted to: [ssabia@partners.org](mailto:ssabia@partners.org)  
For more information, call: 617-724-1746

### Next Publication

May 3, 2007

# Educational Offerings - 2007

April

26

Nursing Grand Rounds  
O'Keefe Auditorium  
1:30–2:30pm  
Contact hours: 1

April

27

End-of-Life Nursing Education  
Curriculum  
O'Keefe Auditorium  
8:00am–4:30pm  
Contact hours: 7

May

1

CPR Re-Certification  
Founders 325  
7:30–10:30am and 12:00–3:00pm  
No contact hours

May

2

OA/PCA/USA Connections  
"Be Fit Program"  
Bigelow 4 Amphitheater  
1:30–2:30pm  
No contact hours

May

2

On-Line Electronic Resources for  
Patient Education  
Founders 334  
9:00am–12:00pm  
Contact hours: 2.5

May 7

7, 8, 14, 15,  
21 & 22

Greater Boston ICU Consortium  
Core Program  
BMC  
7:30am–4:30pm  
Contact hours: TBA

May

9

New Graduate RN  
Development Seminar I  
Training Department  
Charles River Plaza  
8:00am–2:00pm  
Contact hours: TBA  
(for mentors only)

May

10

CVWH Core Program  
Yawkey 2210  
8:00am–12:00pm  
No contact hours

May

11

PALS Re-Certification  
Burr 6 Conference Room  
8:00am–4:00pm  
No contact hours

May

11

ACLS Instructor Course  
O'Keefe Auditorium  
8:00am–3:00pm  
No contact hours

May

14

The Surgical Patient: the  
Challenge of the first 24 Hours  
O'Keefe Auditorium  
8:00am–4:30pm  
Contact hours: TBA

May

14

Building Relationships in the  
Diverse Hospital Community:  
Understanding our Patients,  
Ourselves, and Each Other  
Founders 325  
8:00am–4:30pm  
Contact hours: 6.8

May

16

Nursing Research Committee's  
Journal Club  
Yawkey 2210  
4:00–5:00pm  
Contact hours: 1

May

18

BLS Certification for Healthcare  
Providers  
Founders 325  
8:00am–12:30pm  
No contact hours

May

21

CPR Re-Certification  
Founders 325  
7:30–10:30am and 12:00–3:00pm  
No contact hours

May

21

Diabetic Odyssey  
O'Keefe Auditorium  
8:00am–4:30pm  
Contact hours: TBA

May

23

New Graduate RN  
Development Seminar II  
Training Department  
Charles River Plaza  
8:00am–12:00pm  
Contact hours: TBA  
(for mentors only)

May

23

Congenital Heart Disease  
Haber Conference Room  
7:30am–12:00pm  
Contact hours: TBA

May

24

Nursing Grand Rounds  
O'Keefe Auditorium  
1:30–2:30pm  
Contact hours: 1

May

24

Workforce Dynamics:  
Skills for Success  
Yawkey 10-640  
8:00am–4:30pm  
Contact hours: 6.5

# The Center for Innovations in Care Delivery: an update

Patient Care Services was awarded an opportunity grant by CIMIT. The grant will be used to support a summit to explore technology and the aging nursing workforce.

**Question:** In November, we heard about the new Center for Innovations in Care Delivery. What's been happening since we first heard about it?

**Jeanette:** There has been tremendous activity in The Center for Innovations in Care Delivery. On January 22, 2007, the center held its first retreat where more than 130 members of Patient Care Services gathered to help set a strategic direction. National and local speakers provided valuable insight into the opportunities available in our hospital environment.

We were fortunate to hear Pat Rutherford, vice president for the Institute for Healthcare Improvement, speak about Transforming Care at the Bedside. Richard Bohmer, of the Harvard Business School, spoke about Capturing Insights at the Bedside; and Jeff Cooper, corporate director for Partners Biomedical Engineering, spoke about the importance of using simulation as a tool in innovation.

We heard Gregg Meyer, MD, senior vice president for Quality & Safety, speak about quality and the lessons learned by NASA. He stressed how we can think innovatively and still maintain safety.

Break-out sessions gave us an opportunity to reflect on our organizational culture and brainstorm ideas for innovations in care-delivery. Ideas generated in break-out sessions are being analyzed and will be used in developing the action plan for the coming year.

**Question:** Has an initial area of focus been identified for the center?

**Jeanette:** Yes. Patient Care Services was awarded an opportunity grant by the Center for Integration of Medicine and Innovative Technology (CIMIT). The grant will be used to support a summit in September to explore technology and the aging nursing workforce. Our hope is that the outcomes of this summit will have applicability to our current nursing workforce, promoting safety for nurses and patients alike.

**Question:** How can we reach the center?

**Jeanette:** We are in the process of creating an interactive website to provide up-to-date information on the center's activities and events. Such a website would be able to present grand rounds and other presentations via pod-casts, have opportunities for vertical discussions, and provide a forum for staff and others to ask, "What if" questions.

Until the center's website is up and running, for information about the center call innovation specialist, Barbara Blakeney, RN, at 4-7468.

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