

Caring

Headlines

August 16, 2007

MGH vs. BWH blood donor challenge

MGH vs. BWH
Blood Donor
Challenge

August 20–
September 7,
2007

Call 6-8171
to make an
appointment
to give
blood

The annual MGH vs. BWH blood donor challenge will run from August 20–September 7, 2007, in an effort to boost blood donations during these typically low-blood-supply months. Currently, we are experiencing a state-wide shortage of blood, which affects us dramatically as MGH is the largest blood transfuser in the country. The MGH Blood Donor Center, located in the Gray Lobby, will be offering a number of incentives during the challenge, including special foods, gift certificates, raffles, and more. Help MGH maintain its unbroken record. Make a donation. Make a difference.

MGH Blood Donor Center staff nurse, Erica Sanchez, RN, prepares to draw blood from pediatric staff nurse, Karen Kumpavong-Gonsiewski, RN

Retaining Magnet status: the road to re-certification

Thanks to the efforts of the entire organization, from clinicians, support staff, and administrators, to Magnet liaisons, champions, and ambassadors, we are well on the road to Magnet re-certification.

The privilege of being a Magnet hospital requires ongoing vigilance, motivation, and a commitment to provide the highest quality care to our patients and families. Remaining a Magnet hospital requires successful completion of a re-certification process every four years that consists of extensive written evidence-gathering and an on-site visit by Magnet appraisers. Thanks to the efforts of the entire organization, from clinicians, support staff, and administrators, to Magnet liaisons, champions, and ambassadors, we are well on the road to Magnet re-certification.

Under the leadership of Marianne Ditomassi, RN, executive director for Patient Care Services Operations, and Keith Perleberg, RN, nursing director; and with support from Suzanne Cassidy, senior project specialist, and Sheila Golden-Baker, RN, clinical educator, a comprehensive Magnet Re-Certification Committee Structure has been established to ensure all evidence requirements are met.

Four division teams, each linked to the areas of practice led by associate chief nurses: Theresa Gullivan, RN; Jackie Somerville, RN; Dawn Tenney, RN; and Debra Burke, RN, have been working to identify unit-based examples of exceptional nursing care. But evidence is not coming exclusively from patient care units. Magnet liaisons throughout Patient Care Services have brought forth evidence to showcase exem-



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

plary practice. These liaisons include:

- Brian French, RN, Norman Knight Nursing Center for Clinical & Professional Development
- Dottie Jones, RN, Yvonne L. Munn Center for Nursing Research
- Taryn Pittman, RN, The Blum Patient & Family Learning Center
- Barbara Blakeney, RN, The Center for Innovations in Care Delivery
- Susan Lee, RN, collaborative governance
- Carmen Vega-Barachowitz, SLP, the Clinical Recognition Program and Speech, Language & Swallowing Disorders and Reading Disabilities
- Sally Millar, RN, PCS Information Systems and the Office of Patient Advocacy
- Deborah Washington, RN, PCS Diversity
- Steve Taranto, Human Resources
- Georgia Peirce, Communications

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Though Magnet hospital status is an honor bestowed by the American Nurses Credentialing Center, achieving Magnet certification is a testament to the excellent care, services, accomplishments, and contributions of the entire organization, all departments and role groups.

- Robert Kacmarek, RRT, Respiratory Care
- George Reardon, Systems Improvement and liaison to operations coordinators, operations associates, and patient care associates
- Michael Sullivan, PT, Physical and Occupational Therapy
- Ann Daniels, LICSW, Social Services
- Michael McElhinny, MDiv, Chaplaincy
- Carol Camooso Markus, RN, Quality & Safety
- Leila Carbutari, RN, International Patient Center
- Bessie Manley, RN, and Adele Keeley, RN, nursing directors
- Susan Wood, RN, and Marion Phipps, RN, clinical nurse specialists
- Maureen Schnider, RN, clinical supervisors

Magnet champions and ambassadors work together and with division leadership to identify Magnet evidence, support communication, and help maintain momentum and motivation in the re-certification process. Though Magnet hospital status is an honor bestowed by the American Nurses Credentialing Center, achieving Magnet certification is a testament to the excellent care, services, accomplishments, and contributions of the entire organization, all departments and role groups.

The evidence we collect describes the ways we excel within each of the 14 'Forces of Magnetism':

- 1) Quality of nursing leadership
- 2) Organizational structure

- 3) Management style
- 4) Personnel policies and programs
- 5) Professional models of care
- 6) Quality of care
- 7) Quality improvement
- 8) Consultation and Resources
- 9) Autonomy
- 10) Community and the healthcare organization
- 11) Nurses as teachers
- 12) The image of nursing
- 13) Interdisciplinary relationships
- 14) Professional development

You may recall hearing from Jim Barone, RN, a staff nurse in the Main Operating Room in one of our Nurse Week videos earlier this year. Jim said, "As a magnet champion during our initial Magnet journey, I had an opportunity to see the challenges and opportunities we were facing. Now, as an ambassador, staff share their stories with me in support of whatever force of Magnetism we may be working on. That's really rewarding to me."

Currently, all evidence is in the hands of the Magnet Writers Group: Marianne Ditomassi, RN; Chris Graf, RN; Nancy McCarthy, RN; Mel Heike, RN; Donna Jenkins, RN; and Lori Carson, RN, who are synthesizing and re-organizing information into a finished document that can be presented to the American Nurses Credentialing Center by October 31, 2007.

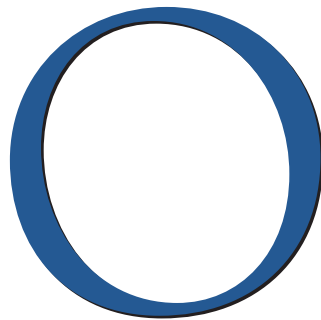
Watch future issues of *Caring Headlines* for updates on our journey to Magnet re-certification.

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Banister named first executive director, Institute for Patient Care

In her new role, Banister will be responsible for advancing the Institute's vision around interdisciplinary education and research, supporting our commitment to meet patients' needs, and fostering the professional growth and development of clinicians within Patient Care Services.



On August 13, 2007, Patient Care Services welcomed Guardia E. Banister, RN, to MGH as the first executive director for The Institute for Patient Care. In her new role, Banister will be responsible

for advancing the Institute's vision around interdisciplinary education and research, supporting our commitment to meet patients' needs, and fostering the professional growth and development of clinicians within Patient Care Services.

The Institute for Patient Care is comprised of The Norman Knight Nursing Center for Clinical & Professional Development; The Yvonne L. Munn Center for Nursing Research; The Maxwell & Eleanor Blum Patient and Family Learning Center; The Center for Innovations in Care Delivery; and a number of other programs including: collaborative governance, the Clinical Recognition Program, our Culturally Competent Care curriculum, and the International Visitors Program, to name a few.

Banister comes to MGH from Providence Hospital in Washington, DC, part of the Ascension Health System, where she served as senior vice president for Patient Care Services, overseeing Nursing, Pharmacy, Respiratory Care, Diagnostic Cardiology, and the Sleep Lab. She has completed fellowships in the Robert



Guardia Banister, RN
executive director, Institute for Patient Care

Wood Johnson Nurse Executive Program and the Johnson & Johnson Wharton Program in Management for Nurse Executives; and she has received numerous grants from a variety of funding sources, including Health Resources and Services Administration.

Banister is a member of the African Scientific Institute, the National Black Nurses Association, the American Organization of Nurse Executives, and the American Nurses Association.

Please welcome Dr. Banister to MGH and Patient Care Services. She can be reached at 6-3111; her office is located on Founders 3.

Team 'USA' scores gold

— by Stephanie Cooper, training and development specialist

The Norman Knight Nursing Center for Clinical & Professional Development and Environmental Services welcomed more than 75 unit service associates (USAs) and their managers to Ruth Sleeper Hall for the inaugural session of Team USA, a new series to update and review environmental cleaning procedures and other skills with USAs throughout Patient Care Services.

The open-house style program consisted of several stations in an open classroom, allowing employees time to observe demonstrations, ask questions, and get hands-on practice with various cleaning products,

tools, and procedures. Employees learned about new flat mops, the suction canister liner system, safe bodily fluid clean up, hazardous waste disposal, proper use of cleaning chemicals, and the array of towel dispensers used throughout the hospital.

Tom Drake, training specialist, showed how using certain products on blood spills keeps employees from being exposed to bodily fluids and enables spills to be cleaned up quickly, easily, and in compliance with prescribed infection-control measures. Unit service associate, Juan Carlos Henriquez, volunteered to demonstrate the procedure for new-comers. Said Henriquez, "This is much safer and cleaner for patients and workers."

Environmental Services manager, Allan Dollinski, demonstrated the proper way to replace paper towels in automated towel dispensers. The touchless dispensers are being installed throughout the hospital, and employees welcomed the opportunity to practice.

Unit service associate, Pearline Morrison, gave Team USA high praise. "It was very, very good. It gave us experience with things we need to know." After visiting the suction canister liner station, Morrison shared, "I was worried about being exposed to bodily fluids, but I feel much better about it now."

Team USA was an opportunity for trainers to get important feedback from employees who use these products every day. The two-way flow of information contributed to an atmosphere of fun and teamwork throughout the two-hour program.

The Team USA program was a great success. Plans are already in the works for future sessions touching on other important service initiatives, some scheduled to accommodate night and weekend employees.

In September, Team USA will focus on, "Myth-Busters: clarifying best practices around everyday tasks."

For more information about Team USA or to suggest topics for future sessions, contact Stephanie Cooper at 4-7841, Tom Drake at 6-9148, or Mark Barish or Allan Dolinski at 6-2445.

Unit service associate, Juan Carlos Henriquez (center) of the Ellison 12 Neuroscience Unit, practices replacing suction canister liner system.



(Photo by Stephanie Cooper)

An advance directive in every patient's record

At MGH, we respect the right of every patient to have a voice in his or her healthcare decisions, and we're committed to informing patients of their right to execute an advance directive.

Question: What is a healthcare proxy form?

Jeanette: A healthcare proxy form is a type of advance directive that is completed by patients to identify their designated healthcare agent, or proxy. A healthcare agent is authorized to make healthcare decisions in the event a patient becomes unable to make decisions on his or her own.

Question: Why is it important to have an advance directive?

Jeanette: Most of the time, patients are able to tell members of the clinical team their preferences regarding their care. However, when patients temporarily or permanently lose their capacity to make decisions due to illness or injury, an advance directive can help clinicians know the patient's wishes. That's why it's so important to have an up-to-date advance directive in every patient's record.

Question: As an MGH clinician, what is my responsibility regarding advance directives?

Jeanette: At MGH, we respect the right of every patient to have a voice in his or her healthcare decisions, and we're committed to informing patients of their right to execute an advance directive. The MGH Advance Directives Policy requires that, upon admission, patients are informed of this right and given an opportunity to provide an advance directive to us or be offered assistance in completing one if they wish to do so.

We support the collaborative work of physicians, nurses, social workers, chaplains and other health professionals in ensuring all patients (18 and older) have an advance directive.

Question: Where do I find a healthcare proxy form?

Jeanette: The Massachusetts healthcare proxy form can be ordered in English or Spanish from Standard Register. It can be found on the Patient Care Services website in English, Spanish, large-print English, and 11 other languages, including: Portuguese, Arabic, traditional Chinese, French, Greek, Haitian, Creole, Italian, Khmer, Russian and Vietnamese. The PCS website offers guidance for communicating with patients who don't speak English, and a medical interpreter can be reached by calling 6-6966 (or 4-5700 during off hours and holidays).

Question: Does an attorney have to be present when signing an advance directive?

Jeanette: Patients do not need a lawyer to complete an advance directive; it is a simple document with clear instructions. It is important, however, for patients to understand the process for identifying the person who will act as their healthcare agent. The MGH Advance Care Planning Task Force has developed two excellent brochures: "Preparing to be a Healthcare Agent" and "Planning in Advance for Your Health Care." Both are available through Standard Register.

Question: Has the advance directive process changed recently?

Jeanette: A new advance directive questionnaire has been designed. The form is simple and encourages patients who don't have an advance directive at the time of admission to be given an opportunity to fill one out if they so desire.

The journey from job to career

— by Stephanie Cooper, training and development specialist

On Wednesday, July 11, 2007, the Norman Knight Nursing Center for Clinical & Professional Development and the Central Resource Team presented the OA/USA/PCA Connections Program, “Journey from Job to Career,”

hosted by director of PCS Diversity, Deborah Washington, RN, and featuring a panel of MGH employees who ‘worked their way up the ranks’ at MGH.

Human Resources program manager, Helen Witherspoon, provided an overview of the Support Service Grant, tuition reimbursement, and AMMP Scholarship programs.

Julie Goldman, RN, professional development coordinator, reviewed the resources available on the Patient Care Services website under, “Choosing a Nursing Career.” Employees can find links to BSN and

MSN programs, financial resources, professional nursing organizations, and more.

Panelists included, Ingrid Beckles, operations coordinator; Maryanne Spicer, director of Corporate Compliance; Michael Gillespe, executive administrative director for Medicine; Donna Lawton, senior program manager in the Center for Faculty Development; and Dawn Tenney, RN, associate chief nurse. Panelists shared aspects of their professional journey from entry-level positions to where they are today. Each offered advice, experiences, and inspiration, urging attendees to take advantage of the many resources available through hospital programs and departments.

Beckles, who started at MGH as a unit assistant (a role that no longer exists), shared that the support of her family, friends, and manager enabled her to earn her bachelor’s degree. She took advantage of financial assistance through the MGH tuition-reimbursement program and encouraged attendees to do the same.

Said Beckles, “If you want it, you can do it. Ask for help and you will get it.”

Lawton stressed, “Every job provides invaluable experience for the future. I gained an understanding of the hospital’s operations I never would have had if I hadn’t worked on an inpatient unit.”

Spicer encouraged attendees to, “Get out of line. Put up your hand. Get involved. Committee participation is a great way to learn and gain exposure.”

For information about opportunities in the MGH community, visit http://is.partners.org/hr/new_web/mgh/mgh_training.htm, the Patient Care Services website for career and employment opportunities within PCS, or call the Knight Nursing Center at 6-3111.

Below: panelists (back row, l-r): Helen Witherspoon, Dawn Tenney, RN; Deborah Washington, RN; (and seated): Donna Lawton; Michael Gillespe, and Maryanne Spicer; talk about career opportunities at MGH.



(Photo provided by staff)

Continuity of care a treasured part of practice for oncology case manager

Working as a case manager provides a wide range of opportunities and responsibilities, including the most treasured part of my practice, the ability to follow patients through the continuum of care.

My name is Rosanne Karp, and I am a case manager on the Bigelow 7 Gynecology-Oncology Unit. Working as a case manager provides a wide range of opportunities and responsibilities, including the most treasured part of my practice, the ability to follow patients through the continuum of care. I meet incredibly strong, wonderful women and their families and follow them from initial diagnosis, through treatment, and for many, through their final days. It is an incredibly rewarding experience.

I first met Mrs. P in September, 2001. She was referred to MGH with new findings of stage III ovarian cancer. She had had surgery for tumor staging and experienced a complicated post-operative course that included a pulmonary embolus and wound-care issues. When Mrs. P was admitted, I introduced myself and encouraged her and her husband to use me as a resource, especially for questions about discharge planning and anything she needed once she started treatment. Mrs. P was referred to her local VNA for wound care and anticoagulation management, which included a transition from Fragmin injections to Coumadin, and on-going monitoring of her blood tests. She wanted her primary care physician to manage her anticoagulation care, so I coordinated contact between our team and her PCP.



Rosanne Karp, RN, case manager,
Bigelow 7 Gynecology-Oncology Unit

Within a month, Mrs. P's course became more complicated. She required TPN (total parenteral nutrition), intravenous antibiotics, and drain care. They hired a home infusion service to provide these specialty therapies, and her care was coordinated with the VNA. Both Mrs. P and her husband took this in stride, willing to do whatever was necessary to be able to return home. This was the hallmark of their attitude throughout her increasingly complex care.

For the next few months, Mrs. P underwent chemotherapy. During her treatment, she required the support of specialty drugs to maintain her blood counts so she could continue treatment. Again, she accepted these challenges without question. I explained the approval process and prerequisites necessary for her to obtain these medications.

Mrs. P returned to MGH in March of 2003 with recurrent disease after several months of relatively good
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Whenever one of my patients transfers to hospice care, I stress that this is not the end of care, rather, a change in the focus and goals of care to meet their changing needs... One of the most common fears I hear is that patients feel they'll no longer have access to the team that has cared for them for so long.

health. She underwent another surgery that resulted in a colostomy, and she was started on a new line of chemotherapy. When I went to see her for discharge planning, we picked up where we had left off. We had the same easy rapport we had enjoyed from the beginning.

In time, I would see Mrs. P periodically as she came in for treatments. Though she had no complex needs, we spent time talking about how she felt and her concerns for herself and her husband. I saw her intermittently, but kept abreast of her progress as she went through four more courses of chemotherapy.

In October of 2004, Mrs. P presented for placement of a gastrostomy tube as she was developing recurrent small bowel obstructions. After several months, the tube was removed, and she continued with chemotherapy.

I saw Mrs. P again at the beginning of 2007. By this time, she had undergone many lines of chemotherapy. She had no G-tube, no active services, and was managing her home activities. Mrs. P was admitted with a new bowel obstruction. Her goal was to get home as soon as possible, and indeed, she decided to leave for home late one evening before her obstruction had resolved. I discussed the situation with her attending physician, and we agreed it was more important for her to be at home in light of the likelihood of her disease progressing. I worked with the office staff to arrange for her to have home intravenous fluids and services and follow-up to monitor her condition.

Unfortunately, Mrs. P was re-admitted three weeks later with the same issues. I could see she was becoming progressively distraught as her situation worsened. I alerted Social Services that she would need supportive counseling. Mrs. P told me she wanted to try again to manage oral fluids on her own and keep her life as normal as possible. She declined support services, but I assured her that supports would be in place when she felt ready. We all recognized the need for her to have some control over her situation.

In February, 2007, another G-tube was placed to manage the progression of her disease and its symptoms. She declined home nursing care, but knowing Mrs. P had experience managing a G-tube, I wasn't concerned. I was concerned, however, that her situation was becoming more complex. Again, I discussed her case with the team, and we decided to let her indicate to the us when she felt ready to accept support.

Over the next month, the team started to discuss palliative care with Mrs. P, but she wasn't emotionally ready. She requested one more course of chemotherapy. At this time, she agreed to VNA support, especially to

help with pain-management and intravenous hydration. She was starting to lose weight and had a rapidly increasing pain-medication regimen. Throughout this difficult time, the lines of communication stayed open between Mrs. P, her physician's office, home-care providers, and our team on the inpatient unit. This thread of continuity and constant communication proved invaluable.

In April, Mrs. P returned with worsening symptoms of bowel obstruction. She felt she was ready to prepare for and accept hospice care. I met with her and her husband to discuss what this transition would mean. I always clarify with patients and families before initiating a conversation about hospice care. What is their understanding of what this means. Whenever one of my patients transfers to hospice care, I stress that this is not the end of care, rather, a change in the focus and goals of care to meet their changing needs. Most patients appreciate this information. One of the most common fears I hear is that patients feel they'll no longer have access to the team that has cared for them for so long.

Mr. and Mrs. P clearly verbalized their accurate understanding of hospice care and let us know they wished to proceed. I reviewed the options with Mr. and Mrs. P, and they chose an agency. As soon as the referral was completed, Mrs. P was discharged home with a plan for the hospice nurse to meet her the next morning.

A round of teary good-byes was shared with staff, as Mrs. P said, "I don't expect I'll be back to see you again. I just want to thank you for all your help." We knew she was right, we likely would not have an opportunity to see her again. Before she left, her husband, who had always been a quiet, gentle man, came over to me and said, "Thank you for always being there for us." It was all I needed to hear.

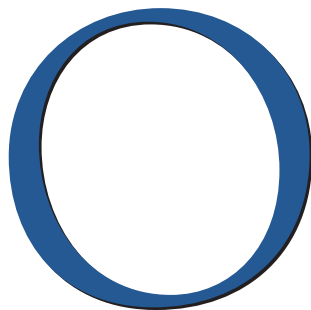
**Comments by Jeanette Ives Erickson, RN,
senior vice president for Patient Care and chief nurse**

Rosanne's narrative describes the importance of allowing the patient to lead the way. She understands the need for Mrs. P to maintain control for as long as possible and tailors her interactions to meet that need. Their long-standing relationship informed Rosanne's actions in arranging care and services and in maintaining a presence as a concerned and compassionate caregiver. So many patients require extended services after they leave the safety and security of MGH. Rosanne ensured that Mrs. P received high-quality, patient-centered care throughout her long illness.

Thank-you, Rosanne.

Magnet re-designation: the forces of magnetism

— by Suzanne Cassidy, senior project specialist



On October 31, 2007, MGH will submit evidence to the American Nurses Credentialing Center (ANCC) to become re-designated as a Magnet hospital. The ANCC

has established 14 'Forces of Magnetism,' or characteristics of exemplary nursing practice that define what it means to be a Magnet hospital. In a series of articles that began in June, *Caring Headlines* is highlighting each of the forces of magnetism.

Force 5: Professional models of care

Models of care are used that give nurses the responsibility and authority for the provision of patient care. Nurses are accountable for their own practice and are the coordinators of care.

MGH is dedicated to a model of care that focuses on the patient and family. Patient-centeredness is at the core of our professional practice model helping us to:

- articulate the work of clinicians across settings and disciplines
- provide a framework to guide clinical practice, education and research
- promote communication among and between disciplines
- guide the allocation of resources

- provide a framework for charting the strategic direction
- establish a framework in which to evaluate practice

The ability to efficiently and effectively care for patients and families requires the support of a vast array of resources, programs, and processes. One example is The Norman Knight Nursing Center for Clinical & Professional Development. Its mission is to create a professional practice environment that supports nurses and other members of the healthcare team in providing safe, high-quality, cost-effective care. Through continuing-education programs, relationships with academic institutions, and simulated learning programs, nurses are able to continuously enhance skills needed to maintain accountability for coordinating patient care.

Force 6: Quality of care

Nurses perceive that they're providing high-quality care to their patients. Providing quality care is seen as an organizational priority, and nurses serving in leadership positions are viewed as responsible for developing the environment in which high-quality care can be provided.

At MGH, nurses confirm they're providing high-quality care through their responses to the Staff Perception of the Professional Practice Environment Survey. Responses provide clear evidence that nurses feel:

The 14 Forces of Magnetism

- 1) Quality of nursing leadership
- 2) Organizational structure
- 3) Management style
- 4) Personnel policies and programs

5) Professional models of care

6) Quality of care

- 7) Quality improvement
- 8) Consultation and Resources
- 9) Autonomy
- 10) Community and the healthcare organization
- 11) Nurses as teachers
- 12) The image of nursing
- 13) Interdisciplinary relationships
- 14) Professional development

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- they have the freedom to make important patient care and work decisions (87% agree or strongly agree)
- their patient care assignments foster continuity of care (81% agree or strongly agree)
- they have enough time and opportunity to discuss patient care problems with other nurses (80% agree or strongly agree)
- they have access to the necessary resources to provide culturally competent care (90% agree or strongly agree)

Nurses and other members of the healthcare team use the Six Aims for Performance Improvement put forth in the Institute of Medicine Report, *Crossing the Quality Chasm*, to guide their practice. These include:

Safety — no needless death, injury, pain, or suffering for patients or staff

- For patients: harm no patient in our care
- For staff: ensure the safest possible work environment
- For the hospital: seek out and maximize opportunities to learn and improve; support and encourage every effort aimed at ensuring safety

Nurses and other members of the healthcare team use the Six Aims for Performance Improvement to guide their practice... A strong professional practice model coupled with an environment that supports high-quality care are among the many characteristics that make MGH a Magnet hospital.

Effectiveness — care and services are based on best evidence and informed by patients' values and preferences

- For patients: care and services at MGH always reflect the best evidence and are always informed by patient values and preferences
- For staff: staff are equipped with the education and resources needed to perform at their best and to learn continuously
- For the hospital: we develop systems and a culture that make it easy to do the right thing.

Patient-Centeredness — all care and services honor individual patients, their values, choices, culture, social context and specific needs

- For patients: partner with patients to incorporate and respect their needs and preferences in all we do
- For staff: create an environment that fully supports staff working in patients' best interests
- For the hospital: actively seek patient- and staff-participation in the design and implementation of programs that affect them

Timeliness — waste no one's time; no unnecessary waiting

- For patients: provide care without delay
- For staff: treat staff time as one of our most valuable assets
- For the hospital: develop systems to facilitate and enhance timely interactions between patients and staff

Efficiency — remove all unnecessary processes or steps in a process; streamline all activities

- For patients: focus on getting it right the first time, valuing patients' time, money, and other resources
- For staff: support our staff with systems that maximize their ability to do their best work
- For the hospital: remain open to ideas that decrease waste and improve efficiency while ensuring the quality of patient care and staff life are not compromised

Equity — all care and services are fair and equitable — the system treats all patients equally

- For patients: provide every patient with the same high-quality care and safety
- For staff: ensure an environment in which all staff are treated with dignity and respect and provided opportunities to realize their goals
- For the hospital: develop programs, policies, and practices that do not discriminate against patients, employees or clinicians

A strong professional practice model coupled with an environment that supports high-quality care are among the many characteristics that make MGH a Magnet hospital.

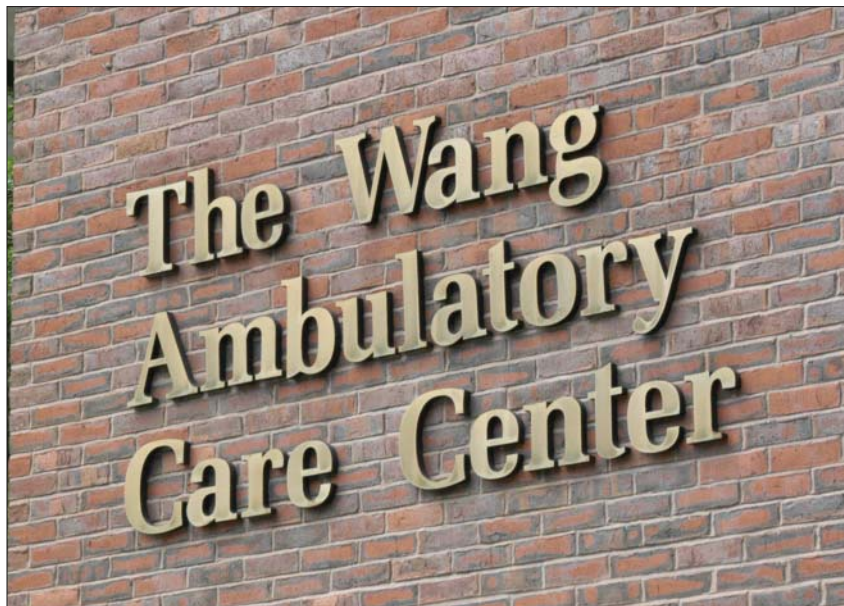
For more information, contact Suzanne Cassidy, senior project specialist, at 6-0368.

WACC: new discharge and drop-off site

To better and more safely accommodate patients during construction of the Building for the Third Century, patients leaving and entering the hospital between 6:00am and 8:00pm Monday through Friday will be asked to do so through the Wang

Ambulatory Care Center (WACC). Effective August 20, 2007, patients awaiting pick-up from family, friends or chair-car services, patients being discharged from inpatient units, and patients leaving treatment or procedure areas (Electrophysiology, Catheterization Lab, Radiation Oncology, Dialysis, Interventional Radiology, or Endoscopy) will use the Wang Lobby. Patients

For more information about changes to the patient discharge and drop-off sites, contact Angela Marquez at pager #1-5167 or by e-mail.



visiting the Yawkey Center for Outpatient Care will not be affected by this change.

If patients require wheelchair assistance, MGH volunteers will continue to be available to help. The recommended wheelchair route to the Wang Lobby is via the Main Corridor on the first floor to the service elevators located behind the information desk in the Main Lobby. Patients leaving the hospital at all other times (8:00pm–6:00am Monday through Friday, Saturdays, Sundays, and holidays) will be able to exit through the Main Lobby.

Starting August 20th, staff and employees should remind patients that, unless they're being transported by ambulance, they should exit the hospital through the Wang Lobby. And family members should park in the Fruit Street or Parkman Garages on weekdays.

Keep in mind:

- Patients with appointments in the WACC or those having surgery in the Same Day Surgery Unit will continue to enter and exit through the Wang Lobby
- Cancer patients with appointments in the Cox Cancer Center will continue to enter and exit through the Cox Building
- Patients with appointments in the Yawkey Center for Outpatient Care will continue to enter and exit as they currently do (including patients requiring chair-car transportation)
- All other patients requiring chair-car transportation will continue to use the Wang location for pick-ups and drop-offs

To help reduce congestion at the main entrance, MGH staff and employees being picked up or dropped off between 6:00am and 6:00pm, Monday through Friday, should use the Warren, Gray, or Jackson entrances.

For more information about changes to the patient discharge and drop-off sites, contact Angela Marquez at pager #1-5167 or by e-mail.

PAML and the Medication Reconciliation Project

— by Liz Johnson, RN, clinical nurse specialist

The Medication Reconciliation Project reduces the potential for adverse drug events by reconciling pre-admission and post-hospital medication instructions and making sure patients have a clear understanding of both.

In an effort to enhance medication safety and ensure all patients understand their prescription medications at the time of discharge, MGH has embarked on the Medication Reconciliation Project. Under the new system, clinicians (nurses, physicians, and pharmacists) are accountable for demonstrating that medications patients were taking prior to hospitalization are reviewed and incorporated into the discharge plan, and that discharge instructions include directions for self-administered medications including those patients were taking prior to admission.

It's important to look at 'the whole picture' ensuring that patients' pre-admission, hospital, and post-hospital medications are compatible and understood by patients and family members. The Medication Reconciliation Project reduces the potential for adverse drug events by reconciling pre-admission and post-hospital medication instructions and making sure patients have a clear understanding of both.

MGH has added a feature to CAS (the Clinical Application Suite) and the LMR (Longitudinal Medical Record) to help promote medication reconciliation. When patients are admitted, a prescribing clinician (attending physician, nurse practitioner, resident, or physician's assistant) initiates a Pre-Admission Medication List (PAML) in the LMR or CAS. Nurses review the list and revise it based on information gained from patients and family members during the nursing assessment, and a pharmacist reviews the list for accuracy and to identify any potential drug interactions. As part of the discharge



Liz Johnson, RN, clinical nurse specialist
Bigelow 7 Gynecology-Oncology Unit

process, nurses should compare the discharge medication list with the PAML, notify the physician of any inconsistencies, then electronically check off the medication reconciliation button on the computerized nursing discharge form. Nurses should use the, "Taking Medications at Home" booklet to provide written instructions to patients about their discharge medications. Medication profiles in patient-friendly language are available on-line from the MGH Formulary or Micromedex websites. Tutorials are available to help nurses access and use these programs, and staff in the Knight Nursing Center and the Blum Patient & Family Learning Center are available to help.

Coaching is available to help staff familiarize themselves with the computerized PAML application. Nurses can complete a self-learning module on PAML by clicking the Options button on the CAS screen and following prompts to get to the PAML learning module.

For more information on PAML or the Medication Reconciliation Project, call 4-4118.

Announcements

Clinical Pastoral Education fellowships for healthcare providers

The Kenneth B. Schwartz Center and the Nursing Service are offering fellowships for the 2008 MGH Clinical Pastoral Education Program for Healthcare Providers.

Fellowship is open to clinicians who work directly with patients and families and who wish to integrate spiritual caregiving into their professional practice.

Deadline for application is September 1, 2007.

For more information, call the Chaplaincy at 726-4774.

HAZMAT Team looking for a few good volunteers

The HAZMAT Response Team was established to protect MGH employees and the hospital from contamination during large-scale disasters. The HAZMAT Team is trained to decontaminate a large influx of victims during a mass-casualty or industrial-accident situation. Clinical and non-clinical team members ensure patients arriving on campus are decontaminated before receiving treatment.

HAZMAT volunteers comprise three teams that rotate on-call every three months. Team members are trained to respond to hazardous-materials incidents in healthcare settings. Preparation involves 24 hours of training with a private institute and eight hours of specialized MGH training.

To learn more about the HAZMAT Response Team, contact Jacky Nally at 617-726-5353.

RN Residency Program at MGH

MGH has been awarded a grant from the US Department of Health and Human Services, Health Resources and Services Administration Division of Nursing to conduct an innovative RN Residency Program, which will provide nurses with an opportunity to improve their care to older patients.

The RN Residency Program, a nine-month, mentored residency, will help nurses gain competence in geriatric and palliative care. The three-year grant provides a unique opportunity for nurse preceptors and nurse residents.

Nurse preceptors will be registered nurses:

- age 45 or older
- currently employed at MGH working 24 or more hours per week
- working in an acute care unit
- identified by nursing director as proficient or expert
- possessing emerging qualities of mentors:
 - effective communication skills
 - respect, patience, good listening skills
 - trustworthiness in working relationships
 - positive attitude, enthusiasm, optimism
 - belief in the value and potential of others

Nurse residents will be registered nurses:

- currently employed at MGH working 32 or more hours per week
- interested in geriatrics and palliative-care specialties
- who have a two-year commitment to employment at MGH,
- recommended by nursing director

Information sessions are scheduled

For more information about the RN Residency Program, contact Ed Coakley, RN, project director and coordinator, at 6-6152.

Conversations with Caregivers: an Eldercare Series

Sponsored by the MGH Geriatric Medicine Unit for staff, patients, families, and friends of the MGH Community

Tuesday, August 28
Caring for Yourself while Caring for Another

Tuesday, September 11
Juggling Caregiving and Work

All sessions held in the Blum Patient & Family Learning Center (attendance is free)
5:15–6:30pm

Refreshments will be served
For more information, call:
617-726-4612

Submit a clinical narrative

Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The 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 at 6-8177 to schedule an appointment.

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Submissions

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

Next Publication

September 6, 2007

Educational Offerings – 2007

August

29

Intermediate Arrhythmia

Yawkey 10-660
8:00 – 11:45am
Contact hours: 3.5

August

29

Pacing Concepts

Yawkey 10-660
12:15 – 4:30pm
Contact hours: 3.75

August

29

BLS Instructor Program

Founders 325
8:00am – 4:30pm
No contact hours

September

5

CPR Re-Certification

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

September

6

BLS Certification
for Healthcare
Providers

Founders 325
8:00am – 12:30pm
No contact hours

September

7 & 17

Neuroscience Nursing
Certification Course

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

September

10

Building Relationships in the
Diverse Hospital Community:
Understanding our Patients,
Ourselves, and Each Other

Founders 325
8:00am – 4:30pm
Contact hours: 6.8

September

10

BLS Heartsaver Certification

Founders 325
8:00am – 12:30pm
No contact hours

September

11

CPR Re-Certification

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

September

12

Phase I Wound-Care Education
Program

Training Department
Charles River Plaza
8:00am – 4:30pm
Contact hours: 6.6

September

12

New Graduate RN
Development Seminar I

Charles River Plaza
8:00am – 12:00pm
Contact hours: 3.7
(for mentors only)

September

12

Nursing Grand Rounds
"Caring for Patients with a Trach"

Haber Conference Room
11:00 – 12:00pm
Contact hours: 1

September

12

OAVPCA/USA Connections
"Assisting in Emergency
Situations"

Bigelow 4 Amphitheater
1:30 – 2:30pm
No contact hours

September

12

Nursing Research Committee's
Journal Club

Yawkey 10-660
4:00 – 5:00pm
Contact hours: 1

September

13

Nursing Grand Rounds
"The Visiting Professor Program"

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

September

14 & 24

ACLS Provider Course

Day 1: 8:00am – 4:30pm
O'Keefe Auditorium
Day 2: 8:00am – 3:00pm
Thier Conference Room
No contact hours

September

17

CPR Mannequin Demonstration

Founders 325
Adults: 8:00am and 12:00pm
Pediatrics: 10:00am and 2:00pm
No BLS card given
No contact hours

September

19

Oncology Nursing Concepts:
Advancing Clinical Practice

Yawkey 2220
8:00am – 4:00pm
Contact hours: TBA

September

19

Phase I Wound-Care Education
Program

Charles River Plaza
8:00am – 4:00pm
Contact hours: 6.6

September

20

Psychological Type & Personal
Style: Maximizing your
Effectiveness

Charles River Plaza
8:00am – 4:30pm
Contact hours: TBA

For more information about educational offerings, go to: <http://mghnursing.org>, or call 6-3111

PT/OT: 100% compliance before and after contact with patients' environment

Bob Dorman wants you to know...

As the hand hygiene champion for Physical and Occupational Therapy, I have had the distinct pleasure of being involved with this important initiative for the last three years. During that time, PT and OT have steadily improved their hand-hygiene performance all the way to 100% compliance before and after patient contact. How did we do it? That's simple. We made it about the patient. Our patients rely on every healthcare worker to use good hand hygiene; they're the ones who benefit the most. Incorporating good hand-hygiene habits into your practice is easy when you understand the impact this small task has on patients' health and outcomes. Good hand hygiene is all about protecting our patients and creating a safer working environment for everyone!

Robert Dorman, PT,
physical therapist, hand hygiene
champion for Physical and
Occupational Therapy



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