

March 1, 2007

Caring

HEADLINES

MGH Heart Center 'Goes Red' for women's health

—submitted by Virginia Walker, RN, and Lin-Ti Chang, RN

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During the month of February, the MGH Heart Center participated in the American Heart Association's 'Go Red' for Women's

Health campaign by hosting a number of educational offerings and activities. On February 7, 2007, they sponsored a free blood-pressure screening booth in the

Warren Lobby, attracting scores of women (patients, staff, and members of the local community).

One woman was especially lucky she decided to stop by for a free

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Karen Zoeller, RN, of the Cardiac Surgical Intensive Care Unit, staffing the MGH Heart Center's 'Go Red' blood-pressure screening booth, checks the blood pressure of MEEI employee, Lynda Ketcham

Staff Perceptions of the Professional Practice Environment Survey

What better way to learn what staff is thinking about their practice environment than to ask them? That's exactly what we've been doing with the Staff Perceptions of the Professional Practice Environment Survey since 1996. And I'm happy to report that every year, more and more of you are taking advantage of the opportunity to tell me what you think. The

survey was sent to all direct-care providers in Patient Care Services, a total of 3,014 clinicians. This year, in our highest response rate ever (61%, up from 46% last year), an overwhelming 92% of respondents reported feeling satisfied or very satisfied with the work environment at MGH. This continues to be a good-news story.

As you know, the survey was created to help me evaluate the

effectiveness of our professional practice model based on the eight organizational characteristics listed below; to identify opportunities for improvement; and to see and respond to changing trends that emerge over time.

In response to staff request, the survey was made available on-line this year, and 42% of those who responded, chose to do so electronically. We'll continue



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

Organizational Characteristics

<i>Autonomy</i>	The quality or state of being self-governing and exercising professional judgment in a timely fashion (Aiken, Sochalski & Lake, 1997)
<i>Clinician-MD relationships</i>	Relationships with physicians that facilitate exchange of important clinical information (Aiken et al., 1997)
<i>Control over practice</i>	Sufficient organizational status to influence others and deploy resources when necessary for good patient care (Aiken, Havens & Sloan, 2000)
<i>Communication</i>	The degree to which patient-care information is related promptly through open channels of communication (Shortell, Rousseau, Gilles, Devers & Simons, 1991)
<i>Teamwork</i>	Unity of effort in the pursuit of shared objectives (Zimmerman, Shortell, Rousseau, Duffy, Gillies, Knaus, Devers, Wagner & Draper, 1993)
<i>Conflict-management</i>	The degree to which managing conflict is addressed using a problem-solving approach (Zimmerman et al., 1993)
<i>Internal work motivation</i>	Self-generated motivation completely independent of external factors such as pay, supervision or co-workers (Hackman, 1989, 1994)
<i>Cultural sensitivity</i>	A set of attitudes, practices, and/or policies that respects and accepts cultural differences (<i>The Cross Cultural Health Care Program</i> , 2000)

to offer this option so staff can respond by whatever means is more convenient for them.

The survey gives us quantitative (numeric) and qualitative (written) data, both of which reveal insight into staff's perceptions of their practice environment, and both of which help identify areas where we need to improve. The good news is that in this complex and demanding hospital setting, most clinicians at MGH are highly satisfied. The other good news is that with the help of this survey, we know where challenges exist, and we're better equipped to intervene to overcome them.

While I love reading comments, such as: "It's an honor to work at MGH with such outstanding staff," and, "I'm very happy with my job; I love my department; I'm learning and growing every day. MGH is a great place to work," I use this survey as a road

map to find those areas where we need to do the most work—that's where I want to commit our time and resources. That's where I want to make a difference.

I'm happy to say the feedback we received was both *constructive* and *instructive*. That tells me that staff appreciate the importance of this survey and are willing to engage in the process of perpetual improvement.

In addition to the many positive comments we received, we heard concern, mostly in the areas of conflict-management and teamwork (though results varied somewhat across disciplines and patient care units). This is valuable feedback. It validates many of the programs and initiatives already up and running, and it underscores the need to redouble our efforts in these key areas.

Currently, conflict-management is embedded
continued on next page

2007 Magnet Re-designation

On October 31, 2007, MGH will submit evidence to the American Nurses Credentialing Center for re-designation as a Magnet hospital. In 2003, MGH was the first hospital in Massachusetts to receive this prestigious distinction. Currently, only 225 healthcare facilities or 4.06% of all healthcare organizations in the United States have achieved Magnet-hospital designation.

Question: How did the Magnet recognition program get started?

Jeanette: In 1983, The American Academy of Nursing's Task Force on Nursing Practice in Hospitals conducted a study of 163 hospitals to identify variables that attract and retain qualified nurses. Forty-one of the 163 institutions were considered 'magnet' hospitals because of their ability to attract and retain professional nurses

despite a significant nursing shortage at the time. The characteristics that distinguish Magnet organizations from other organizations became known as the Forces of Magnetism, the conceptual framework for the Magnet recognition program.

Question: Why is Magnet recognition so important? Do people really pay attention to those things?

Jeanette: Recognizing quality patient care, nursing excellence, and innovations in professional nursing practice, provides consumers with a reliable benchmark for assessing the quality of care they can expect to receive. When *U.S. News & World Report* publishes its annual list of America's Best Hospitals, Magnet recognition factors into the score for quality of inpatient care.

Several positive outcomes are associated

tions in Care Delivery. We are deeply invested in creating and maintaining an environment that is safe and conflict-free for our patients and staff.

Your feedback in the Staff Perceptions of the Professional Practice Environment Survey guides our decisions as we tackle these big issues.

Thank-you for taking the time to keep me informed of your thoughts and impressions. You are the voice and conscience of patient care at MGH, and we need to hear from you.

with Magnet hospitals, including, reduced patient mortality and morbidity; improved patient safety and safety in the workplace; higher patient-satisfaction scores; increased nurse retention; and shorter lengths of stay.

Question: What kind of information do we need to submit for Magnet re-designation?

Jeanette: We need to demonstrate that we exemplify nursing excellence in 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) Image of Nursing
- 13) Interdisciplinary Relationships
- 14) Professional Development

Question: How will we gather all that evidence?

Jeanette: That work is already underway. A formal committee has been established to ensure all aspects of the project are addressed. The committee is comprised of individuals throughout the

hospital who represent direct patient-care areas and those who play a critical role in supporting nursing practice. We've established two key staff-nurse roles: unit-based Magnet champions and Magnet ambassadors. These nurses provide valuable support and assistance in identifying best practices, locating and communicating Magnet evidence, and maintaining momentum in the Magnet re-designation process.

Question: When will we be notified if we achieve re-designation?

Jeanette: Evidence will be submitted on or before October 31, 2007. Approximately five months later, Magnet appraisers will conduct a site visit to validate our written evidence. We anticipate hearing about our re-designation status in the spring of 2008. Re-designation is valid for four years.

Question: Have other hospitals in Massachusetts now achieved Magnet recognition?

Jeanette: Yes, four other hospitals in Massachusetts have achieved Magnet recognition: Baystate Medical Center, Dana-Farber Cancer Institute, Jordan Hospital, and Winchester Hospital.

For more information about the Magnet re-designation process, contact Suzanne Cassidy, senior project specialist, at 6-0368.

Jeanette Ives Erickson

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ed in a number of classes offered through The Knight Nursing Center for Clinical & Professional Development, such as, Workforce Dynamics: Skills for Success; our Preceptor Development course; and Conflict-Management for OAs and PCAs. And other classes are being developed.

In a busy, dynamic, teaching hospital like MGH, systems and operational issues can have a profound impact on teamwork and collaborative practice. We are commit-

ted to a culture of ongoing systems-improvement. We've already begun to decrease nurse managers' span of control. We're working with consultants to re-design and automate documentation and communication systems. We're working hard to automate bed management, equipment management, and medication-delivery systems. We're forging relationships with colleges and universities to help ease the workforce shortage. And we've launched our new Center for Innova-

One clinician's path to palliative care

—by Todd Rinehart, LICSW

In July, 2006, I was hired as a clinical social worker on the Palliative Care Service, after serving as a social worker on two inpatient medical units for more than three years. Though it was difficult to leave the units where I felt my skills were appreciated and well utilized, I enthusiastically welcomed the opportunity to be part of the Palliative Care Service. The Palliative Care Service consists of two nurse practitioners, six attending physicians, four fellows, a program manager, a director of Community Relations, an administrative assistant, and one clinical social worker.

Working with chronically ill and dying patients was what led me to return to graduate school in 1996 to earn a master's degree in Social Work; and it's the reason I'm grateful to have the opportunity to do the kind of work I'm passionate about.

In the early 1990s, at the height of the AIDS crisis, I was living in New York City volunteering in the Buddy Program at the Gay Men's Health Crisis Center. It was working as a 'buddy' for people with HIV/AIDS that led to my interest in end-of-life care. At

that time, most people with AIDS only lived a short time after being diagnosed. All the people I cared for, except one, died during the five years I volunteered at the center. Two, in particular, left lasting impressions that will never be erased from my heart. It was my experience with these two gay men that showed me possibilities I never imagined existed.

'John' was a 39-year-old caucasian man who was, at first, reluctant to accept my services because he felt I was naïve—and he was right. Only when he was taken to the Emergency Department at New York University Medical Center, and I persevered in locating him, did he realize my commitment to him. John was estranged from his family because they couldn't accept his homosexuality. I remember them visiting him in the hospital over the Christmas holidays, two weeks before he died. They couldn't bring themselves to touch or embrace him; they sat across the room away from his bed. The saddest part for me was when John's family left New York and returned home knowing John was near the end of his life. Fortunately, John had an amazing group of friends who were more of a family to him than his bio-

logical family. John had expressed his concern to me that he would die alone. It brought me great joy to be one of the friends who encircled John's bed and held his hand as he took his last breath. We were able to allay his fear of dying alone as he looked at each of us knowing he was loved.

'Scott' was a 37-year-old caucasian man whom I didn't know as well as John, but whose life impacted me all the same. By the time I started caring for Scott, he had already begun to experience AIDS dementia and was quickly declining. I worked closely with his 73-year-old mother during the last two weeks of Scott's life. For seven days Scott was on a morphine drip and no longer alert. His mother came to his hospital room daily but had a difficult time sitting at his bedside. She expressed fear that she'd never seen anyone die before. She was concerned that her son may not have a 'good death' and she wasn't sure she could witness that. During that week, I spoke frequently with Scott's mother to prepare her for what might happen at the end of her son's life. The day Scott died, I was at his bedside and knew he didn't have much time. I asked Scott's mother if she'd like to

come to him as I believed he was actively dying. She came to his bed, brushed his hair from his forehead, told him she loved him, and he died. Afterward, she said she was grateful to have been at her son's side when he died and would remember him leaving this world peacefully.

It was during Scott's hospitalization that I said to a friend, "This may sound odd, but is there a way to get paid for this kind of work?" I began to explore. My search led to the Shirley M. Ehrenkranz School of Social Work at New York University. It took me four years to earn my master's degree because I continued to work full-time while attending classes. When I walked down the aisle to receive my degree, I was proud to be entering a profession that honored intimate relationships, self-reflection, compassion, intelligence, and the ability to provide care when it's most needed.

As a member of the palliative care team, my primary role is to provide supportive services to my patients, their families, and other members of the team. It's my responsibility to systematically assess patients, families, and caregivers' physical, psychological, socioeconomic, and spiritual needs. I explore and assess support systems, family dynamics, roles and relationships, cultural impact, perceptions of illness, cognitive and emotional integration of diagnosis, prognosis, and expressed needs. I have two primary goals:

- provide counseling for individuals and families
- provide education on issues related to life-threatening illness, pain- and symptom-management, death and dying, and adjusting to illness

My objective is to minimize physical, psychological, and spiritual distress, and help people
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Todd Rinehart, LICSW
clinical social worker, Palliative Care Service

Go Red for Women's Health

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screening. 'Mrs. Smith's' blood pressure was 200/93 when initially checked using an automatic testing device. Concerned, nurses staffing the booth checked it again manually only to find it was 198/98.

Mrs. Smith spoke limited English. The nurses called Medical Interpreter Services, who were instrumental in helping obtain some basic information about Mrs. Smith as well as her consent to be taken to the Medical Walk-In Clinic. By telephone, the medical interpreter confirmed that Mrs. Smith was experiencing some dizziness.

Staff nurse, Virginia Walker, RN, escorted Mrs. Smith to the Medical Walk-In Clinic and explained her situation to staff there. It was soon discovered that Mrs. Smith spoke Farsi, and so did a member of the Medical Walk-In staff.

Says Walker, "As I waved good-bye to this woman from Afghanistan, I realized that, even though we weren't able to communicate in the same language, by working together with Interpreter Services and the Medical Walk-In Clinic, we were able to ensure she got the assessment and interventions she needed."



Lisa Porazzo, RN, of the Cardiac Access Unit, provides some educational materials to MGH employee, Susanne Loomis

Path to Palliative Care

continued from previous page

develop coping strategies. I have begun providing limited bereavement services to families and caregivers, and plan to develop a more formal program in the future.

On the Palliative Care Service, once I'm aware that a doctor or nurse practitioner has completed the initial assessment, I follow up with my own biopsychosocial-spiritual assessment. Periodically, an oncology or unit-based social worker has already been involved with the patient and family, in which case my role is to serve as liaison between that social worker and

the Palliative Care Service. This approach ensures the best continuity of care for patients, families and caregivers.

I am an integral member of the Palliative Care Service and have enjoyed working on an interdisciplinary team that respects and honors one another's skills and strengths.

I'm privileged to work alongside social workers, case managers, nurse practitioners, chaplains, nurses, doctors, operations associates, therapists, and patient care associates on various units throughout the hospital. Every encounter I

have with a patient or family member involves support staff and clinicians from all disciplines. No one can do this work alone; it's our collaborative effort and commitment that allows us to provide the best possible care.

I'm often asked why I enjoy this work. It's because it forces me to look within, strengthens my compassion and non-judgmental approach to others, and opens me up to discovering untapped possibilities in my own life. As cliché as it may sound, I receive much more than I give. I'm honored that patients and families let me into their lives at such intimate moments.

To have one's life witnessed and reflected upon can often be of invaluable importance to an individual at the end of his life if he is willing and able to engage in the process. Dying is a stage of life that's often overlooked because of the inevitable feelings that arise related to loss. It can be a difficult time for patients, families, and caregivers, but it can also be an opportunity to redirect focus to the present. It's an opportunity for patients to review their lives, embrace their achievements and disappointments, and acknowledge those who have been close to them in life and death. That's what I strive for when I work

with chronically ill and dying individuals, their families, and caregivers.

I never imagined ten years ago when I began graduate school that I would become the palliative care social worker at one of the most prestigious hospitals in the country. It just goes to show that if you follow your passion and hold onto your focus and your faith, you can realize your dreams beyond your wildest expectations.

For more information about the Palliative Care Service, contact me at trinehart@partners.org, or visit: www.massgeneral.org/palliativecare/.

Domestic-violence case a troubling but ultimately rewarding experience for GCRC nurse

Kathleen Egan is an advanced clinician

My name is Kathleen Egan, and I have been a nurse for 43 years, the last 13 years on the General Clinical Research Unit (GCRC). I'd like to share a story about a patient, 'Mary,' whom I came to know this past summer.

On the GCRC, I'm in charge of the outpatient area, where every day approximately 18–20 volunteers of all ages participate in research studies. Some are healthy individuals who have no known medical problems (we call them 'control subjects'). Others are volunteers who might have a chronic medical problem such as schizophrenia, diabetes, HIV, or osteoporosis; or a terminal condition such as end-stage cardiopulmonary disease, amyotrophic lateral sclerosis (ALS) or Huntington's disease. At any given time, there could be 180 active protocols on our unit.

In the outpatient area, patients come for visits as short as 15 minutes or as long as four hours. Some patients participate in studies for weeks, months, even years, so there's opportunity to get to know patients over time.

Because patients on the GCRC volunteer to be in a study, you get to know them differently

from patients who have no choice but to be hospitalized. Mary was enrolling in a protocol for patients with HIV, and this was her first visit. As I was preparing for Mary to arrive, I did what I often do—I checked the equipment for safety, and I read her medical record to get a sense of how she might present. As long as I've been a nurse, I've always enjoyed this time getting ready so the patient won't feel I'm distracted or rushed.

When Mary arrived, I greeted her and immediately noticed something was wrong. She just looked 'sad.' Her affect was flat; she didn't make eye contact, and she barely spoke.

I introduced myself and accompanied her to the outpatient area. I offered her a seat, pulling the curtain around us to provide some privacy. I explained my role, the protocol, and the procedures. Mary listened and nodded but didn't speak. I checked her identification, vital signs, then sat beside her so I could complete my nursing assessment. She barely acknowledged my questions. Several times, I asked, "Are you okay?" Still nothing. I knew not to push. She seemed emotionally and physically fragile. Call it intuition, or a nurse's sixth sense,

but experience told me to go slowly, just let her know I was there.

I closed the outpatient door to give us more privacy. Her visit wasn't scheduled to be long; I knew I'd need more time with her, so I proceeded watchfully. I asked into which arm she wanted the intravenous line inserted. She held out her right arm. As I leaned down, I again asked, "Is everything all right?"

Very quietly, she began to cry. I pulled my chair closer, leaned in, and she burst into tears. "My husband is beating me," she sobbed. She was so choked up she could barely get the words out.

I'm not sure if I took a deep breath or stopped breathing altogether. No one had ever said that to me before. This was a first for me. Not knowing quite what to do, I got her a glass of water and some tissues and collected my thoughts. As she turned her arm over (her palm now facing down), I saw that the back of her hand was swollen and bruised.

The next words out of my mouth were, "We can help you."

I told her about the HAVEN Program at MGH and assured her we'd support her during this crisis. Written information on the program was



Kathleen Egan, RN
staff nurse, GCRC

right there in the outpatient area. As I handed her the literature, she began to tell me how she was being beaten.

Mary stood up, raised her shirt and lowered her slacks, and showed me the bruises on her back, arms, and legs. She told me she was having difficulty hearing out of her left ear since being hit by her husband on that side of her head. I wondered if she might have some broken ribs, too.

The sight of her bruises startled me. This was the first abused woman I'd ever cared for. I'm sure, over the years, I've cared for victims of domestic violence. But I hadn't been aware of it at the time. (literature indicates abuse is often hidden because of feelings of guilt or shame).

I was struck by how desperate Mary seemed to be and by how willing she was to expose herself to me physically and emotionally. It horrified me to think of what it must be like to be with someone who could brutalize her like that. When

she told me she had a 14-year-old son, I immediately asked if he was also being abused. Mary assured me he wasn't. I wondered how much of this abuse her son had witnessed and what effect it might be having on him.

Mary continued to tell me how controlling her husband was; she had no money because he took the small amount she received from disability. I was scared for her. I asked if her husband had any weapons in the house. She said there were no guns in the house.

As I went to the computer to print out more information about the HAVEN Program, I realized I needed to let my colleagues know what was going on so they could help with my next patient who would be arriving soon. While at the computer, I text-paged the nurse practitioner for Mary's protocol. She came immediately to the unit and into the room.

I asked Mary for permission to tell the nurse
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Clinical Narrative

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practitioner what she had told me. Mary not only gave permission, she began to undress to show her bruises. She shared with the nurse practitioner the difficulty she was having hearing. When the nurse practitioner looked in her ear with an otoscope, she saw that Mary's eardrum had been ruptured.

As the nurse practitioner finished her exam, she suggested that Mary consider withdrawing from the protocol. Mary did not want to with-

draw. Concerned for her well-being, I told her, "Your safety is more important than anything else. We can take you to see the HAVEN social worker; she'll help you get the assistance you need and make sure you and your son are safe."

Mary insisted on staying in the protocol, but agreed to let us escort her to the HAVEN office.

Before leaving the unit, I obtained a urine sample for a pregnancy test, which is part of the protocol. Initially, I as-

sumed it would be negative; then I thought, if he raped her, it could very well be positive. The pregnancy test was negative. I also tested her urine for blood (this was not part of the protocol). Her urine tested negative for blood.

I wondered if Mary would leave her husband, and if she didn't, what would happen to her. Typically at this point in the visit, Mary would have gone to see a bionutritionist. But because we were concerned about the seriousness of her injuries, the nurse practitioner and I discussed modifying the visit. (This

is considered a protocol deviation and requires reporting to the hospital IRB). We asked the bionutritionist to come to the outpatient area to do a visual evaluation so Mary wouldn't have to walk down the hallway and undress again. She was still very upset. The bionutritionist agreed to come to the outpatient area.

After the visit, the nurse practitioner and I walked Mary to the HAVEN Office. We offered her a wheelchair, but she declined.

A few days later, I saw the nurse practitioner and asked if she'd heard anything about Mary. I knew I might never find out because her safety was at risk, and confidentiality was of utmost importance. Mary had called the nurse practitioner and thanked her for the help we had given her. She had been taken to a 'safe house' where she and her son stayed until it was safe for them to go home.

Several weeks later Mary came to the GCRC for a scheduled visit. She looked wonderful. She was smiling, her head was held high. When she saw me, she came over and gave me a big hug. She thanked me for caring about her and helping her and her son. Her husband had left the house and not returned. She was looking for a job and felt good about herself.

When I saw her on her next visit about a month later, she had a part-time job and was

working hard to make a life for herself. The nurse practitioner keeps me updated on Mary's progress. She now has a full-time job and has signed a lease on a new apartment.

As a nurse, I'm so happy to have had a small part in helping Mary. I went into nursing to help people. I had no idea how much the people I would meet would impact me. I can honestly say the experiences I've had as a nurse have impacted me in ways that are hard to describe. It may sound trite, but I would not be the person I am today if it weren't for all the patients I've known and cared for over the last 43 years.

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

This narrative underscores the need for clinicians to be fully present to their patients. Kathleen recognized a subtle irregularity in Mary's countenance. Because of her presence, her concern, and her willingness to get involved, Mary was able to get the help she needed to make a major life change.

No matter how experienced we are, we can still be shocked by disturbing patient situations. It's our ability to suspend judgment, suspend our own fear, and act in the best interest of the patient that makes our care exceptional. And Kathleen's care was exceptional. Mary's life and future are very different because of Kathleen's interventions.

Thank-you, Kathleen.

MGH is committed to improving hand hygiene

What is the correct procedure for hand-washing?

- 1) Have a clean paper towel ready before you begin. (Don't touch the paper-towel dispenser after you wash, or you may re-contaminate your hands)
- 2) Turn on the water and adjust temperature. It should be warm, not hot (Hot water can contribute to excessive dry skin)
- 3) Moisten hands, keeping hands lower than your elbows so soil and germs go down the drain, not onto your sleeves, wristwatch, and forearms
- 4) Dispense soap into one palm, then spread it onto both hands. Rub all surfaces of hands and fingers vigorously for at least 15 seconds, approximately the time it takes to sing "Yankee Doodle"
- 5) Clean underneath fingernails. Moist debris under nails can provide a place for bacteria to grow
- 6) Rinse hands well to remove all soap residue, keeping them lower than wrists and elbows
- 7) Pat hands dry with the paper towel. Avoid rubbing, as dry friction can abrade your skin
- 8) Use the paper towel to turn off the water. This prevents re-contamination of your hands by contact with the faucet
- 9) Discard used paper towel in proper waste receptacle
- 10) Apply Cal Stat to destroy remaining germs (except before eating)



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The road to re-designation is paved with Magnet moments

—by Sheila Golden-Baker, RN, and Keith Perleberg, RN

At the January 18, 2007, Nursing Grand Rounds, five Magnet ambassadors presented the plan for MGH Magnet re-designation to their nursing colleagues in a packed O’Keeffe Auditorium. Magnet ambassadors are nurses who serve as a communication link between nursing administration and unit-based

Magnet champions as we prepare for Magnet re-designation. Magnet ambassadors support the work of Magnet champions in providing timely communication, coaching, unit-based evidence-collection, and forward momentum before, during, and after the Magnet site visit.

Suzanne Algeri, RN; Heather Parker Fealtman,

RN; Joanne Parhiala, RN; and Diane Lyon, RN, presented a history of the Magnet Recognition Program, outcomes demonstrated through research at Magnet Hospitals, success factors contributing to Magnet recognition, and examples of written evidence. Presenters urged attendees to get involved in the journey to Magnet re-designation by

getting to know the 14 Forces of Magnetism and

helping their colleagues from Nursing and other disciplines identify “Magnet moments,” situations from their daily practice that demonstrate why we are a Magnet hospital.

Gayle Peterson, RN, Phillips House 21, joined the group for a question-and-answer session, where questions ranged from how to get involved in the Magnet re-designation process to the differences between qualitative and quantitative data. The five ambassadors conveyed their excitement about Magnet re-designation and gave a number of examples of how the Forces of Magnetism live in every nurse-patient and nurse-colleague encounter at MGH.

Look for Magnet re-designation updates in future issues of *Caring Headlines*.

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) Image of Nursing
- 13) Interdisciplinary Relationships
- 14) Professional Development



Magnet ambassadors present at special Nursing Grand Rounds. Left to right, they are: Joanne Parhiala, RN; Heather Parker Fealtman, RN; Suzanne Algeri, RN; Diane Lyon, RN; and Gayle Peterson, RN

The Documentation and Communication initiative: an update

—by Mandi Coakley, RN, staff specialist

The Documentation and Communication initiative began last year when MGH invited a team of consultants to examine how patient information is documented and communicated on and between units as we prepare to automate our medical records. A team of MGH employees worked closely with consultants as they analyzed current practice on White 8 and Bigelow 14. Staff nurses, clinical nurse specialists, nurse managers, project managers, associate chief nurses, and representatives from many other role groups participated in the review.

Teams were developed and have been meeting weekly to help the hospital prepare for an automated documentation system to be implemented in the near future. Part of the work focuses on ensuring that important patient information is captured in the medical record where it's available to all caregivers. In the past, some information has been communicated informally during change-of-shift report; the goal of this initiative is to ensure that *all* information is documented in the patient's medical record.

The Documentation and Communication team is comprised of three subgroups: the Plan of Care Group, the Communication Group, and the Accountability and Continuity Group. Each group meets weekly. The Plan of Care Group has revised forms such as the new Nursing Dataset form that replaced the Nursing Assessment

form. The Communication Group recommended a change in how shift report is conducted to improve communication and ensure all relevant information is transferred. The Accountability and Continuity Group established guidelines to be used when determining nurse-patient assignments to ensure the best-possible pairing of patients and caregivers.

Some of these changes began to be implemented in September, 2006, on White 8 and Bigelow 14. A research study was conducted to look at how nurses on these two units communicated patient information before and after the changes were implemented; how nurses and patients perceived information was being communicated; and how patients were assigned. In focus groups, staff overwhelmingly reported liking the new system. Some of

their comments were: "It's nice to write things once," and "I feel like I really know what's going on with my patients."

The Documentation and Communication team's recommendations have been implemented on ten units, to date. As we move forward, the recommendations will be rolled out on two more units every other week. To prepare for these changes, a number of retreats and educational sessions will be offered. So far, sessions have been very well attended, contributing to a successful implementation process. For those interested in attending, four-hour retreats will be held on: March 12th, April 9th, May 7th, and June 4th. For more information, contact Rosemary O'Malley, RN (6-9663); Mary Ellin Smith, RN (4-5801); or Mandi Coakley, RN (6-5334).

National Patient Safety Awareness Week

March 5–9, 2007, is National Patient Safety Awareness Week

In celebration of National Patient Safety Awareness Week, MGH will be distributing bookmarks containing *Five Steps to Safer Health Care*. Bookmarks will be distributed to staff, patients, and visitors throughout the hospital and will be available in several different languages

For more information, contact Katie Farraher, senior project specialist, at 6-4709

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Submission of Articles

Written contributions should be submitted directly to Susan Sabia **as far in advance as possible**. *Caring Headlines* cannot guarantee the inclusion of any article.

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

Next Publication Date:

March 15, 2007



Curley presents

Suzanne Curley, OTR/L, occupational therapist, presented, "Extensor Tendon Anatomy: Maintaining a Balance," at Tufts University, January 22, 2007.

Neurology nurses certified

Carol Corcoran, RN, Annette Kavanagh, RN, Sue Kuncis, RN, and Jill Papandrea, RN, were certified by the American Association of Neuroscience Nurses in January, 2007.

Burchill and Curley present

Occupational therapists, Gae Burchill, OTR/L, and Suzanne Curley, OTR/L, presented, "Anatomy of Flexor and Extensor Tendons," at Tufts University, January 22, 2007.

They also presented, "Management of Flexor Tendon Injuries," at Tufts, January 30, 2007.

Mulgrew and Squadrito present

Physical therapists, Jacqueline Mulgrew, PT, and Alison Squadrito, PT, presented, "Management of the Acute Care Patient," at the Good Samaritan Wellness Center in Downers Grove, Illinois, December 8-9, 2006, and at South Shore Hospital in Weymouth, January 6-7, 2007.

Brier spotlighted

Marilyn Brier, LICSW, oncology social worker, was profiled in Hope Lodge's bi-annual newsletter in January, 2007. Hope Lodge is a temporary lodging facility run by the American Cancer Society for cancer patients receiving treatment.

Dorman and Mulgrew publish

Physical therapists, Robert Dorman, PT, and Jacqueline Mulgrew, PT, authored the article, "Minimally Invasive Hip Arthroplasty versus Traditional Hip Arthroplasty Surgery: Early Functional Outcomes and the Impact on the Frequency and Duration of Acute Care Physical Therapy," in the fall, 2006, issue of *Acute Care Perspectives*.

Hackel and Radwin publish

Mary Hackel, RN, Ellison 11, and Laurel Radwin, RN, Yvonne L. Munn nurse researcher, in collaboration with nurses from another hospital, authored the abstract, "Cancer Patients' Trust in Oncology Nursing Care," in the January-February, 2007, *Oncology Nursing Forum*.

Oncology team presents

Katie Binda, LICSW; Barbara Cashavelly, RN; Kathy Clair-Hayes, LICSW; Karen Donelan, ScD; Elizabeth Alterman; and Peter Maramaldi, LICSW, presented, "Preventing Burnout Among Staff Supporting Interdisciplinary Teams in an Oncology Center," at the Society for Social Work Research, Bridging Disciplinary Boundaries Conference, in San Francisco, January 12, 2007.

Simulation team presents

Jeanne McHale, RN; Beth Nagle, RN; Monique Mitchell, RN; Gail Alexander, RN; of The Knight Simulation Center, and Theodore Stern, MD, Psychiatry, presented their poster, "Using Interdisciplinary Simulation to Promote the Assessment and Management of a Patient with a Change in Mental Status," at the Society for Simulation in Healthcare's International Meeting in Orlando, Florida, January 15, 2007.

Brush appointed

Kathryn Brush, RN, clinical nurse specialist, Surgical Intensive Care Unit, was appointed a member of the Board of Directors of the National Association of Clinical Nurse Specialists in January, 2007.

Mian publishes

Patricia Mian, RN, clinical nurse specialist in the Emergency Department, authored the chapter, "Crisis Intervention in Trauma," in the *Handbook of Clinical Trauma, The First Hour*, which is compiled by Alice Gervasini, RN, nurse manager, Trauma and Emergency Surgery Program, and others.

Gonzalez spotlighted

Genevieve Gonzalez, LICSW, obstetrical social worker, was the featured 'Special Latino Professional' in the December 14-20, 2006, issue of *El Mundo*. The article was part of a series, the result of a collaboration between the Latino Professional Network, MGH, and *El Mundo* to promote and profile Latino professionals.

Albert, French, and Greenspan publish

Brian French, RN, and Miriam Greenspan, RN, of The Knight Nursing Center for Clinical & Professional Development, co-authored the chapter, "The Preceptored Clinical Experience," in *Innovative Teaching Strategies in Nursing and Related Health Professions*, 4th edition. Staff nurse, Jennifer Albert, RN, wrote a narrative for the same publication.

Nagle presents for team

Beth Nagle, RN, on behalf of Jeanne McHale, RN; Gail Alexander, RN; and Ellen Mahoney, RN, of The Knight Nursing Center for Clinical & Professional Development, presented the poster, "Enhancing the Confidence of New Graduate Nurses Using High-Fidelity Simulation, Didactic Lecture, and Hands-On Practice," at the Society for Simulation in Healthcare's International Meeting in Orlando, Florida, January 16, 2007.

CORRECTION

In the February 15, 2007, issue of *Caring Headlines*, the article, "IV Team hosts New England Infusion Nurses Society," was written by Mary McCormick-Gendzel, RN, not Deb Guthrie, RN, as identified. For more information about the IV Nursing Team, contact, nurse manager, Janet Mulligan, RN

Educational Offerings

March 1, 2007

<i>When</i>	<i>Description</i>	<i>Contact Hours</i>
March 9 and 26 8:00am–3:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Thier Conference Room	TBA
March 12 7:30–10:30am/12:00–3:00pm	CPR—American Heart Association BLS Re-Certification FND 325	---
March 13 8:00am–12:30pm	BLS Certification for Healthcare Providers FND 325	---
March 14 8:00am–4:30pm	Phase I Wound-Care Education Program Training Department, Charles River Plaza	TBA
March 14 8:00am–2:00pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	TBA
March 14 11:00am–12:00pm	Nursing Grand Rounds O’Keeffe Auditorium	1
March 14 1:30–2:30pm	OA/PCA/USA Connections “Understanding Diabetes.” Bigelow 4 Amphitheater	---
March 14 4:00–5:00pm	Nursing Research Committee Journal Club Yawkey 2210	1
March 15 and 16 8:00am–4:30pm	Pain Relief Champion Day Day 1: Yawkey 2210; Day 2: Yawkey 10-660	TBA
March 20 11:00am–12:00pm	Ovid/Medline: Searching for Journal Articles FND 334	---
March 20 and 27 8:00am–4:00pm	Medical-Surgical Nursing Certification Prep Course Yawkey 10-660	TBA
March 21 8:00am–4:30pm	Oncology Nursing Concepts: Advancing Clinical Practice Yawkey 2220	6.2
March 22 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1
March 22 8:00am–4:30pm	Preceptor Development Program Training Department, Charles River Plaza	6.5
March 26 8:00am–4:30pm	Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other FND 325	6.8
March 27 8:00am–4:00pm	Medical-Surgical Nursing Certification Prep Course (Day 2) Yawkey 10-660	TBA
March 28 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	TBA
March 28 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification FND325	---
March 29 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills FND325 (No BLS card given)	---
March 30 8:00am–12:00pm	BLS Certification—Heartsaver FND325	---
March 30 8:00am–4:30pm	Coronary Syndrome O’Keeffe Auditorium	TBA

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

Burn Awareness Week

According to the Massachusetts Burn Injury Reporting System, scalding is the leading cause of burn injuries in the United States. In observance of National Burn Awareness Week, February 4–10, 2007, the MGH Burn Unit sponsored an educational booth in the Main Corridor to help inform patients, staff, and visitors about some of the burn hazards lurking in our homes. With the help of a mock (toy) kitchen, passers-by had an opportunity to identify some common risks and learn ways to help prevent fires and burns in the home. Among some of the recommendations:

- Put a lid on grease fires to smother, then turn off the heat. Baking soda will also work
- Wear tight-fitting sleeves when cooking; loose-fitting sleeves can catch fire



Above right: Mary Hardiman, RN, and below left: Nancy Giese, RN, share burn-safety information with visitors in the Main Corridor



- Never throw water on a grease fire; water only helps spread the fire
 - Never move a burning pan. You can easily ignite your clothes or 'spill' the fire onto someone or something else
 - Stay by your pans; never leave pots and pans unattended
 - Keep hot liquids out of reach of children
 - Turn pot handles away from the front of the stove
 - Don't let appliance cords dangle where children can reach
 - Always turn off irons when not in use
 - Set water heaters at 125° or lower
 - Always check bath water before putting a child in the tub
- If a burn occurs, remember these important steps:
- Call 911 immediately
 - Cool a burn with cold water until help arrives
 - Never use grease, butter, or ointments on a burn
 - Don't try to remove clothing from a burn

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