

Caring

Headlines

November 1, 2007

Diaz, Marquez, receive Ernesto Gonzalez Award

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David Marquez of Police, Security & Outside Services, and Claribell Diaz, RN, staff nurse on the White 6 Orthopaedics Unit, receive this year's Ernesto Gonzalez Award for Outstanding Service to the Latino Community

OA/PCA/USA Connections: the perfect forum for a passionate exchange of ideas

I began by
thanking our
committed
support staff for
their invaluable
assistance in helping
us meet our hand-
hygiene goal.

If you want to be assured of a lively, spirited, passionate discussion, invite this hospital's operations associates, patient care associates, and unit service associates to come together in the same room at the same time. I guarantee — you won't be disappointed. That's exactly what I did on October 11, 2007, for last month's OA/PCA/USA Connections.

I began by thanking our committed support staff for their invaluable assistance in helping us meet our hand-hygiene goal. Their participation in reminding staff and one another to Cal Stat before and after contact with a patient's environment, and their vigilant attention to ensuring that Cal Stat dispensers are re-filled in a timely manner are central factors in our hand-hygiene success story. They assured me they'd keep up the good work, and I asked them to keep me informed of any obstacles that get in the way of our success.

Taking full advantage of this wonderful opportunity, I asked this group to help in another way. Support staff are in a unique position to observe and intervene in many issues related to quality and safety. I asked for their help in preventing clutter on units to ensure the safest possible environment for patients, staff and visi-



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

tors. Patients can be disoriented from medications or certain medical conditions; we all need to be mindful of potential hazards in our midst. They assured me they'd be on the look-out for potentially risky situations and behaviors and take appropriate action to resolve them.

One question that came up during our time together related to family members staying overnight in patients' rooms and the challenges this presents for staff. Everyone understood the importance of providing patient- and family-centered care and the need for families to be involved in their loved ones' healthcare experience. We spoke at length about ways to support family involvement without compromising quality

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of care. We explored a number of options, including converting patient waiting areas for overnight use, purchasing convertible cots and chairs to optimize space, and many other constructive ideas. In the new building, all patient rooms will be private rooms, but until then, we need to address this issue, and we are.

Safety was a frequent topic in our dialogue. One associate brought up the possibility of setting aside space for equipment storage (wheelchairs, monitors, pumps, etc.) to help eliminate clutter. A wonderful suggestion. As we all know, space is at an absolute premium. We need to make a concerted effort to eliminate 'excesses,' make better decisions about what to keep and what to discard. We need to utilize centralized storage and distribution systems. We need to be more efficient in our use of existing systems — returning equipment to Materials Management in a timely fashion. This is important, not just to reduce clutter, but to ensure vital equipment is always available to our patients when it's needed. Equipment storage is something we evaluated very carefully in designing our new building, but again, it will take ongoing vigilance to ensure we use space wisely and economically.

Among the many other topics we discussed was the need for appropriate training for all role groups. We talked about using simulation labs for training and re-training as a way to ensure staff can deliver high-quality

care in the face of competing demands. We talked about changing technology and how we can use computers to enable employees to receive some training off-site, at home, at their convenience. Flexibility is a valuable asset in an environment as busy and space-conscious as ours. We are considering many options.

Recreational activities for long-term patients, the need for more stretchers in the OR, and a myriad of other topics were discussed.

One thing became clear as we shared our thoughts and observations. And that is that these three role groups (operations associates, patient care associates, and unit service associates) are committed to making a difference by holding themselves to the highest standards of patient safety.

I couldn't be more proud of our support staff and the invaluable contributions they make to the smooth operation of this hospital. I'm thankful to have opportunities to hear everyone's perspectives and ideas. It's important for every voice to be heard if we're to continue to deliver the best care possible to our patients and their families.

Update

I'm happy to announce that Teresa MacDonald, RN, has accepted the position of clinical nurse specialist for the Main OR and new Pod Post Anesthesia Care Units, effective immediately.

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(Cover photo by Abram Bekker)

Ernesto Gonzalez Award for Outstanding Service to the Latino Community

— by Carmen Vega-Barachowitz, SLP, director,
Speech, Language & Swallowing Disorders and Reading Disabilities

Award namesake,
Dr. Ernesto Gonzalez,
with award recipient,
Claribell Diaz, RN.

Since 1988, the country has observed the month of September 15th – October 15th as National Hispanic Heritage Month. MGH marks Latino Heritage Month with various events, including the presentation of the Ernesto Gonzalez Award for Outstanding Service to the Latino Community. The award is given annually to honor MGH employees who have made significant contributions to the experi-

ence of Latino patients, families, and the MGH community at large.

This year, the Ernesto Gonzalez Award for Outstanding Service to the Latino Community was presented to Claribell Diaz, RN, staff nurse on the White 6 Orthopaedics Unit, and David Marquez of Police, Security & Outside Services.

Accepting the award before a standing-room only crowd in the Thier Conference Room, Diaz told of her journey to become a nurse and her desire to answer the need for more Latino nurses in the Boston area. She thanked Gonzalez, nursing director, Kathie Myers, RN, her White 6 colleagues, and the PCS Diversity Committee for their commitment and support over the years. Said Diaz, “We have only scratched the surface in revealing what the Latino people can do and the value we bring to the healthcare community. It is a privilege to receive the Ernesto Gonzalez Award for Outstanding Service to the Latino Community. Thank-you for inspiring me. I am proud to be a Latino nurse at MGH.”

Marquez, a nine-year veteran of Police, Security & Outside Services, thanked Gonzalez, his family, friends, and fellow officers. He quoted British author and orator, Edmund Burke, saying, “All that is necessary for the triumph of evil, is for good men to do nothing.” He added, “Though I don’t feel worthy of such a prestigious award, I am honored to receive it both as a person and as an MGH police officer.”

For more information about the Ernesto Gonzalez Award for Outstanding Service to the Latino Community, call 6-2230.



(Photo by Abram Bekker)

Nurses nurturing their young: reflections of a new graduate nurse

— by Jane Perkins, new graduate nurse,
Burns/Plastic Surgery Unit

At MGH, I haven't experienced the phenomenon of nurses eating their young. As a new graduate nurse on the Burns/Plastic Surgery Unit, I have been nurtured and respected as someone who is learning new things and needs time, patience, and guidance.

In the last semester of nursing school, we hear a lot about nurses, 'eating their young.' One lecturer calls it, 'collateral violence,' describing it as nurses with high levels of responsibility but low levels of power, tearing each other down in a subconscious effort to rise to the top and ally with those in power. Others say the phenomenon is something many nurses experience but try to avoid.

At MGH, I haven't experienced the phenomenon of nurses eating their young. As a new graduate nurse on the Burns/Plastic Surgery Unit, I have been nurtured and respected as someone who is learning new things and needs time, patience, and guidance. This support has been shown not only by my preceptor, but by all the nurses on the unit.

One day recently, I was feeling overwhelmed by all the information, and I just sat in front of a computer and cried. My preceptor handed me a box of tissues and assured me I wouldn't always feel this way. At least three other nurses shared their 'new nurse' stories with me and admitted they had cried, too. They'd all been there. Their sympathetic understanding gave me the freedom to feel what I needed to feel and keep moving forward, as they had done.

I asked a lot of questions that showed my inexperience despite having a BSN. It was obvious I knew very little about nursing in the real world. Early on, I asked if there was a room where nurses could take a 15-minute nap during a break. A more experienced nurse replied with a look of puzzlement and a little cough (I

think he was trying to suppress a laugh). He thought about it and gave me an answer designed to validate my inquiry without making me feel bad. "No," he said, "but maybe there should be."

I was concerned about being the new kid on the block, even though I'm probably older than many of my colleagues. I was nervous about fitting in and being liked. When I expressed my fears to my preceptor, he told me the most important thing about the job is to provide good, safe, patient care. Everything else will follow.

My preceptor taught me to think about what the experience of being in a hospital is like for patients. He showed me through his practice what I can do to help patients feel more comfortable — things like offering them mouthwash when they come out of anesthesia; placing a cool towel on their foreheads after they vomit; showing them they're cared for, making them feel as if they're the most important person in the room.

I guess you could say my preceptor treated me the same way he treats his patients. One time when a woman came up from surgery in tears, my preceptor asked if her family was here, and she said, No. He promptly told her, "Then we'll be your family."

He has offered me the same acceptance. My 'family' isn't here, but I feel cared for, I feel my experience as a new nurse is valued, and my questions are encouraged. This 'young' nurse is being nurtured. And when it's my turn to welcome a nurse into the family, I'll do the same thing. I'll pay it forward.

There's no good time to get the flu; there's an excellent time to get a flu shot

Most people are aware that the flu (influenza) is a contagious disease that can lead to other serious conditions if not contained. The flu can lead to pneumonia, high fever, and/or seizures, and more than 225,000 people are hospitalized every year for flu-related symptoms.

The flu can lead to pneumonia, high fever, and/or seizures, and more than 225,000 people are hospitalized every year for flu-related symptoms.

Current research suggests that anyone at risk for contracting the flu should receive flu vaccine, and some people are at higher risk than others. Flu vaccine is recommended for:

- all healthcare providers
- children between the ages of 6 months and 5 years old
- anyone 50 years old or older
- women who will be pregnant during flu season (October–December)
- anyone with long-term health problems
- residents of nursing homes and other long-term-care facilities

Occupational Health Services kicked off its annual flu-awareness campaign, Monday, October 22, 2007, with week-long flu clinics. All employees, staff, and volunteers are encouraged to be vaccinated. Clinics will be held:

November 1, and November 8, 2007

MGH East/Charlestown Navy Yard (CNY)
CNY Building 149, first floor lobby
8:30am–3:00pm, November 1
8:30am–1:00pm, November 8

November 5, 2007

MGH West, PARC Conference Room
2:00–5:00pm

November 6, 2007

MGH Somerville, Training/Conference Room,
second floor
9:00–11:30am

To be vaccinated at an Occupational Health clinic, you must bring your MGH ID badge. It's a good idea to wear sleeves that roll up easily to expose the top of your arm.

For those unable to attend flu clinics, Occupational Health Services is available by appointment. Walk-in service is available every Thursday, starting November 1, 2007, from 10:30am–5:00pm at 165 Charles River Plaza (165 Cambridge Street), Suite 404.

The Medical Walk-In Center is holding flu-shot clinics in the WACC Lobby throughout the month of November for adult patients, 18 years old, or older. Patients must possess an MGH blue card (though they need not have it with them at the time of the shot). High-risk patients are encouraged to attend. Flu shots are available at the Medical Walk-In Center seven days a week (9:00am–7:00pm, Monday through Friday; 9:30am–4:00pm, weekends).

For more information about flu shot clinics, call 866-504-1026.

USAs recognized with Excellence in Action Award

— by Stephanie Cooper, training development specialist

On Thursday, September 27, 2007, unit service associates in the Surgical Intensive Care Unit (SICU) were presented with an Excellence in Action Award by MGH president, Peter Slavin, MD. Aziza

Alleyne, Yvonne Daniel, Teodora DaSilva, Mark Hector, Barnave Jourdain, Alix Manigat, Tibe Nemariam, Frisneur Racine and Saida Zrigui shared the honor which recognizes outstanding commitment and contributions to patient care.

In November, 2006, staff of the SICU entered into a joint project with Infection Control, Environmental Services, and The Norman Knight Nursing Center for Clinical & Professional Development to replicate interventions employed at Rush Medical Center to reduce VRE transmission in the ICU. USAs were observed and monitored by staff of the participating departments. Observations occurred twice a day with an evaluation at the end of the period.

Unit service associates received in-service reviews of correct cleaning procedures and education on the importance of regular cleaning and disinfection to pre-

vent the spread of infection. USAs showed tremendous commitment to the project and to impacting patient care. After the first three months it was decided that the project should continue through the end of the year. By June, some USAs had been observed 25 times.

The dedication of the unit service associates in the SICU paid off in a big way! No cases of nosocomial C. diff or VRE were reported in the second or third quarters of 2007, and there has been marked improvement in the overall cleanliness of the unit.

SICU unit service associates were given the coveted Excellence in Action Award, which includes movie passes and lunch for the entire SICU staff.

In his comments, Slavin acknowledged the important contributions unit service associates make to patient care. "We're an institution that provides world-class care," said Slavin, "and we couldn't do that without the dedication, support, and commitment of our unit service associates."

On behalf of his co-workers, unit service associate, Mark Hector, observed, "We're just doing our jobs."

For more information on the USA Observation/Education Project, call 4-7841.

SICU unit service associate, Alix Manigat, holds Excellence in Action Award, surrounded by his Ellison 4 colleagues, MGH president, Peter Slavin, MD (right), and members of the project team



New clinician acquires new confidence caring for stroke patient

I remember thinking, the last time I performed a neuro evaluation was when I was still in school, so this should be interesting... and it was.

My name is Hillary Kocolosky, and I am a physical therapist. When I first started at MGH, I worked as a physical therapy intern for the inpatient Cardiac team on the Step-Down

Unit. Early on in my internship, I worked with a patient who made a lasting impression on me. That experience boosted my confidence, improved my evaluation skills, and taught me to advocate for my patients.

When I received the consult to evaluate Mrs. L, I thought she was going to be a patient with a 'routine' arrhythmia, but as I reviewed her chart, I discovered she'd been admitted to the hospital after developing left-sided weakness. She had suffered a cardio-embolic stroke, and to top it off, she spoke only Cantonese.

I remember thinking, the last time I performed a neuro evaluation was when I was still in school, so this should be interesting... and it was. I discussed the case with my clinical instructor and she agreed she should observe my interaction with Mrs. L (and an interpreter) and provide guidance if needed. I was doing



Hillary Kocolosky, PT
physical therapist

okay with the logistics of working with an interpreter, making eye contact with the patient and directing my questions to her. After a few minutes the interpreter informed me that he and Mrs. L spoke two different dialects of Cantonese; he wasn't sure she understood everything he was saying.

I moved on to my physical examination, trying to determine how much Mrs. L could follow direction and perform active movement. I remember testing her limbs for spasticity and tone and thinking to myself, is that the Brunstrom or Ashworth scale? My clinical instructor said, "Don't get caught up in the PT details right now. Record what you're seeing and move on."

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In hindsight, that was good advice. It allowed me to continue with my exam, and then later on clarify the specifics when I finalized the documentation.

While working with Mrs. L, I had to problem-solve around the language barrier. Most of the time Mrs. L's daughter was present, and between the interpreter and Mrs. L's daughter, we worked out a system of demonstrations and basic feedback. When I began working with Mrs. L, she could barely initiate movement in her left upper and lower extremities, but within a couple of weeks she had progressed well, moving her limbs through almost full range of motion and sitting at the edge of the bed with contact-guard assistance.

One day, I noticed Mrs. L didn't look at me when I entered the room. I tried to get her attention by reaching out to her left hand, but I felt no grasp. I lifted her left arm to see if she could hold it up as she had the day before. It was completely flaccid. My heart sank. I knew something was definitely wrong.

I thought, okay, I'm an intern, a new clinician, but

Mrs. L will always remind me to have trust in my examination findings, to record detailed clinical data in my documentation, and to advocate for my patients. Yes, I initially doubted my findings, but sooner rather than later, I realized I knew more than I thought I did. And it was up to me to get my voice heard.

I know what my examination is telling me. I need to inform her doctor right away.

I found the resident who was on the unit and told him that there was a change in Mrs. L's condition. Her cognition was different, and her motor function had completely changed. I thought to myself, she may have had a hemorrhage or another stroke and heparin would only make things worse. The resident was skeptical at first, but I showed him the clinical data and convinced him that more tests were needed.

Mrs. L had, in fact, suffered a hemorrhage. Although this was a setback, she eventually did regain function in her left extremities and was later transferred to a rehabilitation facility.

Working with Mrs. L taught me several things. First, there is much I have to learn as a new clinician, but I've grown to realize that it's okay not to know everything. No therapist knows everything about physical therapy. What's important is that I am able to make clinical decisions in the moment, which is crucial while working in an inpatient setting. It means being able to identify the things I don't know and either look them up or ask for guidance from my clinical instructor or clinical specialist.

Second, I realize how important it is to document what I see and move on to where my examination is leading me. This was great advice early on because it helped me better manage my time while conducting evaluations.

And last but not least, it is so important to get to know your patient. Physical therapists have consistent interactions with patients and are able to see changes, however subtle, from one day to the next.

Mrs. L will always remind me to have trust in my examination findings, to record detailed clinical data in my documentation, and to advocate for my patients. Yes, I initially doubted my findings, but sooner rather than later, I realized I knew more than I thought I did. And it was up to me to get my voice heard.

I chose to become a physical therapist after a very positive personal experience as a patient, and because I enjoy working with people. But Mrs. L reminded me that regardless of why we chose physical therapy, in the end we're here for our patients, and we have an opportunity to make a difference in their lives.

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

What a beautiful example of the transition clinicians make as they advance in professional practice. Hillary learned to 'triage' certain information to allow her to see the big picture, something an experienced clinician may take for granted, but a big step in the evolution of a new caregiver. When Mrs. L's condition changed, Hillary correctly diagnosed it. She had a momentary lapse in confidence, which she quickly overcame and then advocated for her patient. This is a milestone in any clinician's career, one that bodes well for Hillary's future practice as a therapist.

Thank-you, Hillary.

Chaplain reflects on the human side of health care

— by MGH chaplain, Nancy Raines

A

s a Spanish-speaking chaplain, I was called to minister to a Latino family in the Pediatric Intensive Care Unit (PICU) recently. The story was grisly. A 14-year-old boy had been found hang-

ing in a doorway, the victim of an apparent failed suicide attempt. To compound the situation, family and friends described the boy as happy and well adjusted, surrounded by a strong and supportive community. As



Nancy Raines, interfaith Spanish-language chaplain

What became evident to me as the days wore on was the penetrating impact this case was having on the boy's caregivers. We were all deeply touched by this case.

far as anyone knew, he did not use drugs or alcohol. He was a jokester, beloved by all who knew him. He and his friends had been planning a party, a bash to celebrate the end of summer.

Needless to say, the boy's mother and uncle (his closest family members) were devastated. By the third day, his mother could scarcely walk, having not eaten or slept in days. Family members tried to get her to eat, bringing her food that might tempt her to force down a small bite. Everyone struggled with the fact that this child's final act was incomprehensible to those closest to him.

What became evident to me as the days wore on was the penetrating impact this case was having on the boy's caregivers. We were all deeply touched by this case.

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After caring for the family for a few hours the first day, I went back to my office and called my teenage son. "How's it going?" I asked. "Having a good day?"

In a groggy voice my son replied, "Yeah, fine."

"Okay, just wanted to check in. I love you."

"Yeah, love you too."

I thought of my younger son, safe at camp. Okay. Everyone is okay.

Each day the attending doctor's eyes had a sorrowful gaze, her shoulders seemed to sag with the burden of this case. Her sensitivity with the family was palpable. She spoke gently, carefully, slowly, giving terrible news to the family in the best possible way — quietly, and respectfully. Each day she became more aware of the probability of a negative outcome. But she remained a steadfast companion to the family, showing up every day and supporting them. The family sought her out, they trusted her.

In each of these instances, clinicians didn't hide or repress their feelings. They felt the shock and sorrow of the case and supported each other by talking about the fears it triggered. Each clinician was personally affected, yet each brought his or her professional self to every interaction with the family.

One day as I was talking to the boy's nurse, another member of the team approached us. She said the case had really affected her, she had immediately thought of her son and called him just to check in. I affirmed her feelings. Later, the same caregiver attended a family meeting and with extraordinary sensitivity explained the process of organ donation to the boy's mother. She dealt with the grieving family compassionately and professionally, putting her personal considerations aside. Afterward, I told her what a beautiful job she had done, and I thanked her.

Later, a doctor involved in the case sat down to talk. She was middle aged, foreign born, and her face had a look of shock. "You never know what your children are thinking," she said. "I wonder if it had anything to do with the fact that they're immigrants. Perhaps kids at school were cruel to him."

I asked if she had children, and she said she did. "I'm always going to make time to talk to my child," she said. "Even if I'm tired. I'll turn off the television and ask how he's doing." I realized this story had hit this immigrant woman hard, as well.

When the last scan was done and the results were clear, there was one last family meeting to communicate the news and consider next steps. A representative from the organ bank attended the meeting, as well as doctors, nurses, a social worker, an interpreter, and me. The family was heartbroken that the child had been deemed brain-dead, but adamant that they wanted his organs to go to someone else.

The process was set in motion.

When the final meeting was over, caregivers gathered around the nurses' station. I went to the attending doctor. "You were extraordinary with that family," I said. "You were so gentle and caring. It was such a difficult case. I want to honor you for that." With tears in her eyes, she leaned into me, and I hugged her. "You carry a lot here," I said. She stayed in the hug for a while then pulled away, looked at me with an exhausted face, and thanked me. It had indeed been hard on all of us.

In each of these instances, clinicians didn't hide or repress their feelings. They felt the shock and sorrow of the case and supported each other by talking about the fears it triggered. Each clinician was personally affected, yet each brought his or her professional self to every interaction with the family.

The family had gone through a terrible ordeal, but they had the expert help and care of an extraordinary group of people who, while they couldn't change the devastating outcome, offered generous, caring, professional help.

I returned home that afternoon with a heavy heart and a churning stomach. My teenage son pulled me aside, upset and wanting to talk. He was worried something he had done might impact his chance to get into college. I listened, supported, and reassured him. I helped him see what he could do to right the situation. Then I said to him, "This is something we can handle. No one is hurt. Everyone is safe. That's the most important thing."

Password self-service coming to Patient Care Services

Question: Is it true I'm going to have another password soon?

Jeanette: Yes. MGH is implementing the Password Self-Service Program so employees can create, manage, and change their Partners passwords themselves. This password is used primarily to log in from the main screen of your computer. Password self-service is an important step in increasing network security and complying with HIPAA regulations.

Question: Will it be easy to create and change my Partners password?

Jeanette: If you've ever created a password for an on-line bank account or commercial website, the Password Self-Service Program works in a similar way. You answer a few questions to verify your identity and create your own password.

Question: What happens if I don't create a Partners password?

Jeanette: After 30 days, you'll be locked out of the Partners system, and you'll have to call the Help Desk (6-5085) to be reinstated.

Question: How often will my Partners password change?

Jeanette: Your Partners password will expire every six months. You'll receive several e-mail reminders

before your password expires. But it's a good idea to change your password when you receive the first or second notification. You also have the ability to change your password at any time without assistance from the Help Desk.

Question: So, I no longer need my old password?

Jeanette: You'll still use your old password, also called your clinical 'key,' to sign orders, enter verbal orders, or complete discharge documentation. Your key doesn't go away, and it doesn't expire.

Question: How will I know when to enter my Partners password and when to enter my key?

Jeanette: Make sure you read the prompt. Most applications that require your key will provide a prompt asking for your key. Other applications will prompt you for your password. That's when you use the Partners password you selected. If you're in doubt, try both. If you run into problems, call the Help Desk (6-5085).

Question: If I forget my key, is there a way to look it up?

Jeanette: Yes. Go to the Partners Applications menu and select Utilities. Click on Partners Key Lookup. Type in your user name and Partners password. Your key will be displayed for 30 seconds.

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MGH is implementing the Password Self-Service Program so employees can create, manage, and change their Partners passwords themselves. Password self-service is an important step in increasing security and complying with HIPAA regulations.

Best practices, lab specimens, and two patient identifiers

Question: What do caregivers mean when they say, 'two patient identifiers'?

Jeanette: All nurses learn the five 'rights' of medication administration:

- right drug
- right time
- right dose
- right route
- right patient

The term, two patient identifier, expands on the right patient step for all testing. With labs at MOH processing more than 20 million samples a year, the first step in getting a specimen processed correctly, is making sure the sample belongs to the correct patient. Making this a National Patient Safety Goal for 2007, the Joint Commission requires a process by which two pieces of information connect the identity of a patient to a lab sample to ensure there is no mistake as to whom the sample belongs.

Question: Does it matter which two identifiers we use?

Jeanette: For all inpatients, the two identifiers are printed on the patient's wristband. They are the patient's name and the patient's medical record number. This ensures that inpatients who have the same or similar names will not be confused. It's a way to double check the patient's identity, confirming the medical record number throughout the entire process. Transposed digits in the medical record number could be fatal.

Question: Do the two patient identifiers only apply to medication administration?

Jeanette: No. In addition to checking the two patient identifiers before administering medications, two identifiers should be used at all times when collecting laboratory specimens. Since the blood-drawing process involves matching, then attaching, the correct label to the correct collection tube, the best place to do this is in the presence of the patient at the bedside. Labeling specimen tubes in the presence of the patient is another component of the National Patient Safety Goals for 2007. Simple clerical mistakes, like attaching the wrong patient's label to a collection tube, can result in catastrophic errors. The safest practice is to match the label to the information on the patient's wristband at the bedside before affixing it to the tube.

The safest practice is to match the label to the information on the patient's wristband at the bedside before affixing it to the tube.

Question: What password do I use to access my Outlook e-mail from home?

Jeanette: Once you've created it, your Partners password will be the password you use to access your e-mail from home.

Question: Where can I find more information on the Password Self-Service Program?

Jeanette: There is an excellent website with plenty of good information. Go to: <http://helpdesk.partners.org/passwordselfservice>.

Announcements

16th Annual Deb Wing, RN, Memorial Conference

"Neurological Consequences of Stimulant Use and Abuse: Acute Care Implications"

Speaker: Susan Krupnick, MSN, APRN, BC, CARN

November 7, 2007
4:00–5:00pm

Haber Conference Room
Reception to follow

Lunchtime Seminars

"Working and Breastfeeding"

a free, informational seminar presented by Germaine Lambers, MGH lactation consultant

November 6, 2007
Bulfinch 222 Conference Room
12:00–1:00pm

Feel free to bring a lunch
For more information, call 6-6976

Sponsored by the Employee Assistance Program

Call for Nominations

The Norman Knight Nurse Preceptor of Distinction Award recognizes a clinical staff nurse who consistently demonstrates excellence in educating, mentoring and coaching nurses.

Nurses may be nominated by nurse colleagues familiar with the nominee's practice.

Nomination forms are available on inpatient units and in The Center for Clinical & Professional Development on Founders 3.

Nominations are due by November 20, 2007.

For more information, call Julie Goldman, RN, at 4-2295

Correction

In the October 4, 2007, issue of *Caring Headlines*, the article entitled, "Relaxation channels on MGH patient TV," should have included Catherine Calder, RN, as co-author: Shelly Bazes, RN, is a nurse practitioner in The Center for Quality & Safety.

Call For Proposals

Yvonne L. Munn Nursing Research Awards

Proposals are due by January 15, 2007

Guidelines for proposal preparation are available at: www.mghnursingresearchcommittee.org under, "Resources"

For questions and guidance, contact Virginia Capasso, RN, at pager: #2-5650 or by e-mail

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

CarePages

CarePages is a free, simple-to-use, interactive, on-line service that helps patients and families stay in touch day and night while a loved one is hospitalized. Patients and family members can send and receive messages from their entire network of friends simultaneously at their convenience.

Start a CarePage by visiting www.carepages.com/mgh.

For more information, call 4-9865

Global health seminars

The MGH Center for Global Health is launching its global health seminar series. Seminars are designed to introduce salient global health topics and build a shared community around improving health in international, resource-poor areas.

"Health, Human Rights, and Social Justice"

presented by Paul Farmer, MD, Maude and Lillian Presley professor of Social Medicine, Harvard Medical School, and founding director, Partners in Health

Thursday, November 1, 2007
5:00–6:30pm
in the Ether Dome
(space is limited)

"Global Implications of Human Trafficking and Modern Day Slavery"

presented by Kevin Bales, president, Free the Slaves, and author of *Disposable People: New Slavery in the Global Economy*

Thursday, November 15, 2007
5:00–6:30pm
O'Keefe Auditorium

Seminars are free and open to the MGH community

For more information, contact Roy Ahn at rahn@partners.org

Published by

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

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For more information, call: 617-724-1746

Next Publication

November 15, 2007

Educational Offerings – 2007

November

7 & 14

Phase II Advanced Wound-Care Education Program

Training Department
8:00am – 4:30pm
Contact hours:
6.6 for each day

November

9 & 19

ACLS Provider Course

Day 1: 8:00am – 3:00pm
O’Keeffe Auditorium
Day 2: 8:00am – 3:00pm
Thier Conference Room
No contact hour

November

12

CPR Re-Certification

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

November

13

BLS Certification for Healthcare Providers

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

November

13

CPR Re-Certification

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

November

14

CPR Re-Certification

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

November

14

New Graduate RN Development Seminar I

Training Department
Charles River Plaza
8:00am – 2:00pm
Contact hours: 3.6
(for mentors only)

November

14

Nursing Grand Rounds
“Talking with Teens about Taking Care of Themselves”

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

November

14

OA/PCA/USA Connections
“The Medical Record”

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

November

14

Nursing Research Committee’s Journal Club

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

November

15

CVVH Core Program

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

November

16

Creating a Therapeutic and Healing Environment

O’Keeffe Auditorium
8:00am – 4:00pm
Contact hours: TBA

November

16 & 30

End-of-Life Nursing Education Curriculum

Founders 325
8:00am – 4:00pm
Contact hours: 7 (for each day)

November

19

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

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

November

20

Ovid/Medline: Searching for Journal Articles

Founders 334
11:00am – 12:00pm
Contact hours: 1

November

21

Oncology Nursing Concepts

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

November

28

New Graduate RN Development Seminar II

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

November

29

Preceptor Development: Learning to Teach, Teaching to Learn

Training Department
Charles River Plaza
8:00am – 4:30pm
Contact hours: 6.5

November

30

Basic Respiratory Nursing Care

Bigelow Amphitheater
12:00 – 4:00pm
No contact hours

November

30

Promoting Women’s Health: the Role of the Nurse

O’Keeffe Auditorium
8:00am – 4:00pm
Contact hours: TBA

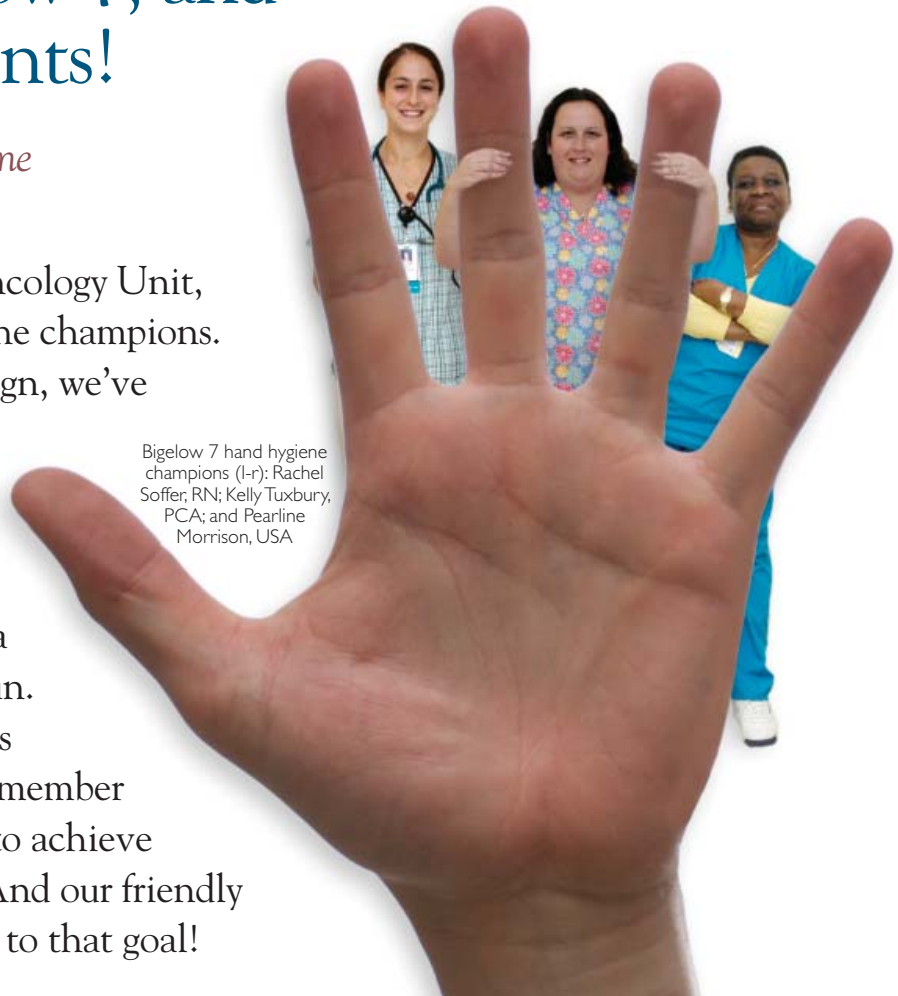
For more information about educational offerings, go to: <http://mghnursing.org>, or call 6-3111

Bugs Bunny, Bigelow 7, and big improvements!

*Rachel, Kelly, and Pearline
want you to know...*

On the Bigelow 7 Gynecology-Oncology Unit, we take pride in being hand hygiene champions. As part of our hand-hygiene campaign, we've put iridescent, hand-shaped stickers on all our Cal Stat dispensers. To make sure doctors feel included in our efforts, we hung pictures of Bugs Bunny saying, "What's up Doc? Just a friendly reminder to Cal Stat!" It's fun.

It's cheerful. And it gets people's attention. On Bigelow 7, every staff member has made a personal commitment to achieve our hand-hygiene goal of 100/100. And our friendly reminders are bringing us closer to that goal!



Bigelow 7 hand hygiene champions (l-r): Rachel Soffer, RN; Kelly Tuxbury, PCA; and Pearline Morrison, USA



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