

Caring

Headlines

October 4, 2007

BLS training for support staff provides life-saving skills

Patient care associate, Stacy Turnbull, saves life after participating in Basic Life Support training on Ellison 19 Thoracic Unit



Pursuing perfection: PCS executive team solidifies strategic goals

The Patient Care Services executive team has been hard at work exploring strategies and opportunities to improve care delivery and the care experience at MGH in the coming year.

The Patient Care Services executive team has been hard at work exploring strategies and opportunities to improve care delivery and the care experience at MGH in the coming year. On September 10 and 11, 2007, we held our annual strategic plan-

ning retreat, which I called, "Pursuing Perfection: Making IOM Aims a Reality." In our on-going efforts to improve systems, empower staff, and keep our patients and workforce safe, the executive team spent time reviewing our current reality, identifying shortcomings, and brainstorming about ways to create real change at the unit and organizational levels.

We were guided in our work by a number of important principals and considerations, primarily the six Aims for Improvement put forth by the Institute of Medicine's (IOM), *Crossing the Quality Chasm: a New Health System for the 21st Century*, which include:

- **Safety** — avoid injuries to patients from the care that is intended to help them. Safety must be at the forefront of patient care
- **Effectiveness** — match care to science; avoid overuse of ineffective care and underuse of effective care.
- **Patient-Centeredness** — honor the individual and respect choice. Each patient's culture, social context, and specific needs deserve respect, and the patient



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

should play an active role in making decisions about her own care

- **Timeliness** — reduce waiting for patients and those who give care. Prompt attention benefits both the patient and the caregiver
- **Efficiency** — reduce waste. The healthcare system should constantly seek to reduce the waste and the cost of supplies, equipment, space, capital, ideas, time, and opportunities
- **Equity** — Close racial and ethnic gaps in health status. Race, ethnicity, gender, and income should not prevent anyone from receiving high-quality care

We wanted to align our work with the work of Don Berwick, president and CEO of the Institute for Healthcare Improvement, and the IOM's *New Rules for the 21st Century*:

- Care is based on continuous healing relationships
- The patient is the source of control
- Knowledge is shared and information flows freely

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Recognizing that everyone at MGH is already giving 100% and doing their best to ensure the highest quality care for our patients, we concluded that, 'trying harder was not an option.' We needed to identify goals that were bold, explicit, uniform, comprehensive, and patient-centered.

- Care is customized according to patient needs and values
- Decision-making is evidence-based
- Safety is a system priority
- Transparency is necessary
- Needs are anticipated
- Waste is continuously decreased
- Cooperation among clinicians is a priority

We were fortunate to hear from Gregg Meyer, MD, the new senior vice president for MGH Quality & Safety, and MGH president, Peter Slavin, MD, who shared their thoughts and perspectives as we contemplated our goals for the future. Recognizing that everyone at MGH is already giving 100% and doing their best to ensure the highest quality care for our patients, we concluded that, 'trying harder was not an option.' We needed to identify goals that were bold, explicit, uniform, comprehensive, and patient-centered.

Discussions were thoughtful and focused. We worked in small groups and as a whole. Ideas came in all shapes and sizes. Every suggestion was measured against the IOM's *Aims for Improvement* and their *New Rules for the 21st Century*, our own guiding principals, existing programs and initiatives, and other relevant indicators that influenced our decision-making.

We discussed the importance of being able to sustain the changes we proposed through technology, a supportive management infrastructure, and our ability to enlist and engage the entire workforce in helping us achieve our goals. It takes a village.

By the end of our two-day retreat, we had the essence of our strategic plan. We had distilled our thoughts, ideas, concerns, and suggestions into five goals we deemed worthy of our time, energy and commitment in the coming year. The goals met all our quality, safety, and service criteria, and we were, I think, justifiably proud of the choices we made. Our goals for 2008 are:

- Strategic Goal #1: *Through the patient's eyes*
Seek the patient's voice to improve the experience of care
- Strategic Goal #2: *Follow the evidence*
Achieve and sustain evidence-based quality indicators
- Strategic Goal #3: *Handle with care*
Decrease patient and staff injuries through the use of safe patient-handling practices
- Strategic Goal #4: *Lean & Clean*
Provide a clean and clutter-free environment for patients and staff
- Strategic Goal #5: *Team PCS*
Enhance teamwork to achieve excellence in care delivery

We've already begun talking about tactics and mechanisms to help us succeed in this work, but we're still in the early stages. Like every strategic plan, this is a work in progress and will require our ongoing attention and commitment. I know I can count on everyone in Patient Care Services to embrace and contribute to this important work. I'll keep you informed as we move forward.

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BLS training: life-saving preparation for Ellison 19 PCA

— by Marian Jeffries, RN, clinical nurse specialist, Ellison 19 Thoracic Surgery Unit

Patient care associate,
Stacy Turnbull (right)
practices Heimlich maneuver
on fellow Ellison 19 patient
care associate, Marie
Philiossaint



August 30, 2007, was a special day on the Ellison 19 Thoracic Unit. Staff had organized ‘PCA Day’ to celebrate the wonderful work of our patient care associates. It was a day of education, team-building, fun, and perhaps most importantly, it was an opportunity to practice those crucial Basic Life Support

(BLS) skills. The day began with a continental breakfast followed by a BLS re-certification class. I’m sure no one dreamed anyone in the class would be called upon to use those skills so soon.

Stacy Turnbull, a seasoned patient care associate who joined the Ellison 19 team just two years ago, was one of the participants in the re-certification class, practicing skills such as mouth-to-mouth breathing, chest compressions, and what to do in the event someone starts choking. Participants

reviewed the steps of the Heimlich maneuver and how to use it with adults and children. We specifically talked about instances where these life-saving measures had been used outside the hospital and stressed that with proper instruction and technique, anyone could be successful in helping to save a life. As it turned out, Turnbull would learn that on her own just a few weeks later.

While at the Marian Manor Nursing Home in South Boston this past weekend, Turnbull noticed a patient in distress. As the first person on the scene, she assessed that the patient was choking — unable to talk or breathe. The look of panic and the change of color in the patient’s face were signs Turnbull recognized.

Says Turnbull, “I just reacted.” To the astonishment of patients and visitors, she quickly performed the Heimlich maneuver until the patient coughed up the obstruction and was able to breathe comfortably again. Turnbull is quick to brush off any attention, saying she, “just happened to be in the right place at the right time.” But, she adds, it was pretty neat to use the maneuver she’d just reviewed a few weeks earlier and see that it worked so well!

We are very lucky on the Ellison 19 Thoracic Unit to work with such a committed team of patient care associates who routinely go above and beyond the call of duty and take the initiative to make a difference. I’d like to take this opportunity to thank them all. Stacy, Marie, Madeline, Yvonne, Lionel, Marcia and Ben... thank-you for everything you do!

Ensuring safe passage during construction of Building 3C

An interdisciplinary team has been meeting for the past year to address safety issues associated with construction of the Building for the Third Century. Safe routes and staffing requirements have been developed to ensure the safety of staff, patients, and visitors during construction.

Question: With major construction on the main campus, what plans are in place to keep patients safe as they travel near the White ramp and the old Clinics Building?

Jeanette: An interdisciplinary team has been meeting for the past year to address safety issues associated with construction of the Building for the Third Century. Safe routes and staffing requirements have been developed to ensure the safety of staff, patients, and visitors during construction.

- A security fence is now in place along the White ramp directing pedestrians (patients, visitors, and staff) along a sidewalk
- A new pedestrian 'walkway' has been established between the White and Yawkey buildings, allowing patients to travel along North Grove Street 'out of harm's way' and protected from the elements by an overhead awning

Question: Will the MGH Loop Bus run during construction?

Jeanette: Yes, the MGH Loop Bus will continue to operate around the main campus. It is wheelchair-accessible and stops at the Wang Building, the Yawkey Building, the Charles Street/MGH T station, the Massachusetts Eye & Ear Infirmary, the Cox Building, the Jackson Building, Charles River Plaza, and back to the Wang Building. The bus runs continuously throughout the day between 9:00am and 4:00pm.

Question: How are we handling pick-ups and drop-offs that used to come to the White ramp?

Jeanette: Since construction of the new building will continue to absorb space in front of the hospital, the White ramp is now dedicated exclusively to Emergency Department ambulances.

- Patients arriving for appointments and admissions may be dropped off at the foot of the White ramp. Police, Security & Outdoor Services, entrance ambassadors, and volunteers are available to assist patients, provide them with wheelchairs, and escort them to their destinations
- Patients leaving the hospital after inpatient stays or procedures may be picked up outside the Wang Lobby. Volunteers are available to wait with patients while family members go for their cars
- On weekends and evenings, patients may be picked up at the foot of the White ramp

Question: Can family members 'live-park' on the Wang driveway when picking up patients being discharged?

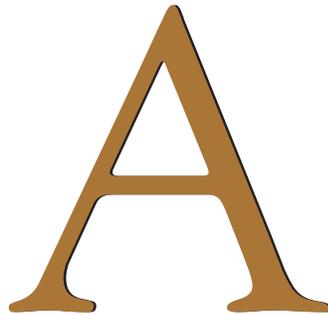
Jeanette: Traffic will be managed very carefully on the Wang driveway. Live parking won't be allowed, but family members will be allowed to park for 25 minutes free of charge in the Parkman and Fruit Street garages.

For more information about logistical changes taking place during construction of the new building, call 6-8540.

A tribute to the work of CPM: 2000–2007

— remarks by David Torchiana, MD

In recognition of the numerous accomplishments and successes achieved during its brief, seven-year existence, a special celebration ceremony was held, September 18, 2007, under the Bulfinch tent.



As many of you know, the important work of the Clinical Performance Management (CPM) Program is winding down to be folded into the efforts of the new MGH Center for Quality & Safety.

In recognition of the numerous accomplishments and successes achieved during its brief, seven-year existence, a celebration ceremony was held, September 18, 2007, under the Bulfinch tent. David Torchiana, MD, chairman and CEO of the MGPO, gave an overview of achievements and paid tribute to the many people and initiatives that helped make the program a success. The following passages are excerpts from his remarks.

1992 marks the beginning of the ‘modern era’ of quality improvement at MGH. Peter Slavin was the new chief medical officer and one of his first acts was to establish a Clinical Practice Council (CPC), a group of physicians and nurses who came together to work on improving quality.

In 1995, faced with significant concerns about managed care, MGH embarked on the Operations Improvement (OI) initiative and, for the next five years, re-engineered almost every aspect of operations.

During the four years of OI activities, the hospital saved more than 125 million dollars.

While OI teams were re-engineering MGH, Specialty Care Management (SCM) was launched by the MGPO in 1997 to increase the involvement of specialists, case managers, and nurses in medical- and utilization-management efforts. These teams focused on reducing length of stay, going beyond clinical pathways and really starting team-based utilization-management efforts across all services.

Between OI and SCM, we found ourselves in a state of performance-improvement overload. By the year 2000, a number of things had become clear:

- Some form of ongoing support for performance-improvement activities was needed
- Successful improvement work is a team sport requiring many disciplines, shared leadership, and accountability
- Having talented project managers and analytic support is key to success.
- We needed to restructure to achieve the right balance between our core work, patient care, and our improvement agenda, and we wanted to reduce redundancy

In 2000, in response to the growing need for performance-improvement capabilities and our desire to streamline our improvement work, Clinical Performance Management (CPM) was launched as

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a joint MGH-MGPO program. The CPM structure maintained inter-disciplinary physician and nursing leadership and talented project staff.

A lot like OI, the initial structure of CPM was comprised of teams from the majority of clinical departments. In 2005, we began to move away from department-based teams and explore the feasibility of teams created to address specific problems.

In its seven-year run, CPM achieved some remarkable results and had an enormous impact on patients, staff, and the entire MGH community. What follows are just some of their noteworthy outcomes.

- *The STOP Task Force and Hand Hygiene Program*
David Hooper, Judy Tarselli, and Jackie Somerville worked tirelessly to educate us about the proper ways to keep patients safe from nosocomial infections resulting in a steady improvement in hand-hygiene compliance and a decrease in the transmission of some antibiotic-resistant hospital pathogens.
- *The Neuroscience Team*
The Neuro CPM team, led by Aneesh Singhal and Ann Kennedy, with Lee Schwamm's leadership on the Acute Stroke Quality Task Force, has addressed high-reliability care through the innovative use of information technology. The team implemented many interventions leveraging Provider Order Entry to collect data and drive interventions. In addition, the Acute Stroke Quality Task Force improved stroke care through innovations such as an electronic, patient-specific, quality dashboard and time-critical interventions.
- *Medication Reconciliation Project Team*
Chris Coley, Sally Millar, and Pat McCarthy, designed a truly innovative intervention, training physicians, nurses, and pharmacists in safe prescribing practices for all MGH patients. This multidisciplinary team of physicians, nurses, pharmacists and IS specialists, in collaboration with colleagues from Partners and the Brigham, designed and implemented the electronic PAML (Pre-Admission Medication List) to document and reconcile the pre-admission medication history throughout a patient's hospitalization and at discharge.
- *Patient Identification Team*
The bar code CPM team, under the leadership of Anand Dighe and Deb Burke, developed and implemented a bar-coded patient wristband for Emergency Department patients and inpatients. Soon, these

wristbands will be extended to infants and Radiology patients, as well. Already, the bar-coded wristband project has helped ensure the accurate identification of patients and reduced the error rate for point-of-care glucose testing.

- *Communication of Critical Test Results and Lab Test Utilization Projects*
Under the leadership of Kent Lewandrowski, Amanda Coakley, and Anand Dighe, the Critical Test Results Task Force was a joint effort between Pathology and Nursing. The team successfully developed procedures, monitoring systems, and goals for the efficient communication of critical results from the laboratory, Radiology, and Surgical Pathology. The team worked to improve the appropriateness of laboratory test ordering and succeeded in reducing inpatient testing nearly 20% over the past four years.
- *Surgery*
The Surgery CPM team was one of the most productive, tackling important work such as SCIP measures and generating an impressive list of team-initiated improvement ideas ranging from establishing a new trach team, to re-engineering the Pre-Admission Testing Area, and supporting the development and launch of the POD. Under the leadership of David Berger, Matt Hutter and Dawn Tenney, with project management from Suzanne Sokal, this team not only launched a number of key improvement activities, they shared their work at national conferences in the quality community and at surgical conferences.

When CPM began, we knew it would be a transitional effort. Liz Mort's contributions to this work cannot be overstated. Her organizational skill and relentless energy drove the excellence of the entire CPM effort. We anticipated we would establish incentives to reward clinical areas for achieving quality goals, and we have. We anticipated we would need to spend more energy on quality measurement and reporting, and we have. We knew we would need to put more resources into supporting the quality and safety infrastructure, and we are.

That translates into higher quality, safer, and more efficient health care for the patients we serve.

I want to thank you for all you have done and look forward to working with you on all that remains to be accomplished.

When CPM began, we knew it would be a transitional effort... I want to thank you for all you have done and look forward to working with you on all that remains to be accomplished.

Entry-level PT finds that supporting the patient means supporting and educating the family

My name is Joy Bostrom, and I am an entry-level physical therapist. On this particular day, I started to panic. It was 4:30 Tuesday afternoon, and I had less than 24 hours to ensure a safe discharge home for my patient, Mr. D. I had just come from a team meeting with Mr. D, his wife, his three children and some extended family members, his occupational therapist, his charge nurse, his nurse, and his case manager. Needless to say, it was difficult to fit everyone in his room!

The plan for Mr. D had been for him to go to an acute-level rehabilitation facility where he could receive three hours of physical and occupational therapy every day to maximize the return of his functional independence. However, that morning Mr. D's children had unexpectedly decided that rehab was not the best plan for their father. They wanted to help him return home, and not in a few days — tomorrow. The medical team had recommended a rehabilitation facility primarily for Mr. D's safety. The family was advocating for Mr. D to return home because they were concerned about his quality of life. As Mr. D's primary physical therapist, my job was to coordinate



Joy Bostrom, PT, physical therapist
entry-level clinician

family-teaching so both safety and quality of life could be achieved.

The situation was one of the most challenging I had encountered as a new graduate in the field of physical therapy. The day before Mr. D went into surgery, his family told me he had been re-arranging furniture in the garage. He was a strong man, full of life, and the head of a very large family. However, after cardiac surgery he had experienced delirium and confusion that necessitated restraints, a bed alarm, and sitters due to his high level of agitation and his attempts to pull out lines and get out of bed. Mr. D spent almost a month in the hospital after surgery due to medical complications and his impaired cognition. Mr. D is originally from Portugal, and in an attempt to help re-orient him,

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The situation was one of the most challenging I had encountered as a new graduate in the field of physical therapy.

By the end of the session, Mr. D's wife and daughter were using soft, quiet commands and light touches to help return Mr. D safely to his bed. It was an unforgettable moment; it truly was amazing to see how this family had pulled together as a team to help grant their father's wish of returning home.

the occupational therapist and I encouraged his family to bring in food, music, and activities they knew Mr. D enjoyed from home. I remember not being able to walk by his room without catching a whiff of pork stew or hearing the strains of a guitar playing popular Portuguese music. Mr. D spent his afternoons watching the Red Sox, and his daughter and granddaughter were usually there to encourage Mr. D during his physical therapy sessions. I always left each session with 'homework' for him and his family, and they always followed through on my recommendations. Over the course of a month we began to see Mr. D's cognitive level improve. His family took this as a sign that he was on his way to recovery and would be ready to come home soon.

I had been focusing my PT interventions on improving Mr. D's dynamic balance and gait. Mr. D presented with impaired motor function and was unable to complete functional skills without assistance. When I left the family meeting, I didn't know how I would facilitate a safe return home when it appeared Mr. D was so far from independence. I cleared my head and began to make a list of goals Mr. D would have to achieve before returning home. I broke it down to basics. I decided I'd need to spend a lot of time teaching Mr. D's family how to safely help him move, as it seemed unlikely he would achieve this goal on his own in the little time I had to work with him. Mr. D's family was very enthusiastic, and I have to say... love goes a long way. They went shopping that evening for a hospital bed, a commode, briefs, and other nursing supplies that would be necessary to care for him at home. They devised schedules to ensure two people would be available to assist Mr. D at all times.

My shift had ended more than an hour ago, but Mr. D's family was in his room requesting I teach them mobility skills so they could practice throughout the night and the next day while I was still able to observe them. We reviewed how to manually cue Mr. D as he didn't consistently respond to verbal commands. I taught them the importance of working with partners to ensure safe, successful moves. I left the hospital at 7:00 that evening and spent the remainder of the night planning my teaching session for the next day to make sure every minute I spent with Mr. D before discharge was put to good use.

The next day, Mr. D's whole family was present for the teaching session. I had planned for my aide to play 'the patient' for practice purposes, but Mr. D's children were so involved, they wanted to take turns being the patient to experience exactly what it was going to be like for their dad and how it would feel to be moved a certain way. Tasks such as going from the bed to the chair or the commode were practiced over and over, as I gave feedback on body positioning and technique to keep everyone safe.

By the end of the session, Mr. D's wife and daughter were using soft, quiet commands and light touches to help return Mr. D safely to his bed. It was an unforgettable moment; it truly was amazing to see how this family had pulled together as a team to help grant their father's wish of returning home.

Often, as a therapist I look at a patient's social support system as an indicator of their ability to return to function. In this case, it truly was the reason this patient was able to return home. Mr. D's family valued their father's happiness and quality of life, and they knew how important it was for him from a cognitive standpoint to return to a familiar environment. This family taught me that a strong will goes a long way, that quality of life should be the ultimate goal, and that, though barriers might stand in the way, they can be overcome with flexibility, teamwork, and a lot of love.

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

Joy demonstrates great commitment, creativity, and a burgeoning understanding of the importance of incorporating family members into the plan of care. Joy developed a safe, effective discharge plan to help the D family meet their goal of bringing their father home to receive extended rehab therapy in a familiar setting. Though the team might have preferred a rehabilitation facility for Mr. D, Joy embraced the family's wishes and set about helping them achieve their goal. Even as a new clinician, she appreciated the importance and power of listening to the patient.

Thank-you, Joy.

Updating the MGH mission statement to reflect the work that we do

Revised MGH Mission Statement

Guided by the needs of our patients and their families, we aim to deliver the very best health care in a safe, compassionate environment; to advance that care through innovative research and education; and to improve the health and well-being of the diverse communities we serve.

In addition to patient care, research, and education, the new mission statement includes service to the community as well as some key credo and boundaries statements.

Recognizing that the scope and influence of our work at MGH is ever changing and evolving, a new mission statement has been approved by the General Executive Committee and the MGH Board of Trustees to better reflect our current reality and the work that we do. In addition to patient care, research, and education, the new mission statement includes service to the community as well as some key credo and boundaries statements.

Credo: As a member of the MGH community and in service of our mission, I believe:

- the first priority at MGH is the well-being of our patients, and all our work, including research, teaching and improving the health of the community, should contribute to that goal
- our primary focus is to give the highest quality of care to each patient delivered in a culturally sensitive, compassionate and respectful manner
- my colleagues and I are MGH's greatest assets
- teamwork and clear communication are essential to providing exceptional care

As a member of the MGH community and in service of our mission, I will:

- listen and respond to patients, patients' families, my colleagues and community members

- ensure that the MGH is safe, accessible, clean and welcoming to everyone
- share my successes and errors with my colleagues so we can all learn from one another
- waste no one's time
- make wise use of the hospital's human, financial, and environmental resources
- be accountable for my actions
- uphold professional and ethical standards

Boundaries statement: As a member of the MGH community and in service of our mission, I will never:

- knowingly ignore MGH policies and procedures
- criticize or take action against any member of the MGH community raising or reporting a safety concern
- speak or act disrespectfully toward anyone
- engage in or tolerate abusive behaviors
- look up or discuss private information about patients or staff for any purpose outside of my specified job responsibilities
- work while impaired by any substance or condition that compromises my ability to function safely and competently

For more information about the new mission statement, contact your Human Resources generalist.

Relaxation channels on MGH patient TV

— by Shelly Bazes, RN, Clinical Care Management Unit

In the summer of 2006, Shelly Bazes, RN, a nurse in the Center for Quality & Safety and nurse practitioner at the Benson-Henry Institute for Mind-Body Medicine, approached Catherine Calder, RN, staff nurse on the Ellison 10 Step-Down Unit, about potential ideas for a Making a Difference (MAD) grant. Calder's previous MAD grant entitled, "Nurture the Nurse," had funded mind-body healing sessions for patients and families on Ellison 10, which were very well received. Calder felt that offering the sessions twice a week limited the number of patients who could benefit from them. That's where the idea of using television to reach more patients was born, and a Making a Difference grant to create relaxation channels was awarded to Bazes and Calder in 2007.

Catherine Calder, RN (left) and Shelly Bazes, RN, with poster publicizing the new relaxation channels on MGH patient TV



(Photo by Abram Bekker)

Launched in September, 2007, with support from the grant and Environmental Services, two channels on the MGH closed-circuit television system now offer patients free, relaxation programming.

Channel 45: the CARE Channel™ (Continuous Ambient Relaxation Environment) features soothing instrumental music and imagery throughout the day and quiet music with a starry screen from 10:00pm – 6:00am. This channel can be used:

- during a bedside procedure
- as an adjunct for patients receiving pain or anxiolytic treatments
- to help minimize external distractions or as an alternative to commercial television
- as a relaxation tool for English- and non-English-speaking patients
- to view peaceful vistas with the sound muted as a visual distraction

Channel 46: the MGH Relaxation and Humor Channel offers humorous and nostalgic programming carefully selected for its content and distractibility.

Nurses on the Ellison 10 Medical Unit have noted that agitated or confused patients find the CARE channel very calming.

Sandra Murphy, RN, an Ellison 10 mind-body group leader says, "To help a patient get through a bedside procedure we turned to channel 46 where an episode of *I Love Lucy* got the patient, the nurses, and doctors all laughing."

One patient on Ellison 16 said the CARE channel was very comforting during the evening hours.

The next step is to get the word out so staff and patients know about these new resources. Promotional bookmarks will be distributed, and the hope is that these channels will help create a healing environment for patients and staff alike.

For more information about the MGH relaxation channels, contact Bazes or Calder via e-mail.

Professional Achievements

Staples certified

Monica Staples, RN, staff nurse, White 11 Medical Unit, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center in June, 2007.

Stone certified

Amie Stone, RN, staff nurse, Thoracic Unit, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center in May, 2007.

Hill certified

Jayne Hill, RN, Radiation Oncology, became certified in Oncology Nursing by the Oncology Nursing Certification Corporation in July, 2007.

Brush publishes

Kathryn Brush, RN, clinical nurse specialist, Surgical ICU, authored the article, "Abdominal Compartment Syndrome," in *Nursing 2007* in July, 2007.

Wicker certified

Carol Wicker, RN, White 10 Medical Unit, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center in May, 2007.

Spencer certified

Lauren Spencer, OTR/L, occupational therapist, received the A-One certification from Columbia University in March, 2007.

Kuo certified

Yi Lin (Hope) Kuo, RN, Phillips 21 General Medical Unit, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center, in May, 2007.

Goode appointed

Nancy Goode, PT, clinical director, Inpatient Physical Therapy, was appointed, a member of the Editorial Advisory Board for *Today in PT* in July, 2007.

Pomerleau appointed

Mimi Pomerleau, RN, Obstetrics, was appointed a member of the Board of Directors for the Association of Women's Health Obstetric and Neonatal Nurses in Washington, DC, on August 15, 2007.

Internicola certified

Lisa Internicola, RN, Phillips 21 General Medical Unit, became certified in Medical Surgical Nursing by the American Nurses Credentialing Center, in May, 2007.

Nurses publish

Virginia Capasso, RN, clinical nurse specialist; Erin Cox, RN, clinical nurse specialist, and Sharon Bouvier, RN, nursing director, authored the article, "Carotid Artery Disease," in *Primary Care: a Collaborative Practice*, in July, 2007.

IV Nurses publish

IV nurses, Debra Guthrie, RN; Denise Dreher, RN; and Margaret Munson, RN, published their article, "What You Need to Know About PICCs, Part 1," in *Nursing 2007* in August, 2007.

Sweezey recognized

Kathleen Sweezey, RN, staff nurse, Cardiac Surgical Nursing Service, was recognized by the American Association of Critical Care Nurses for 30 years of continuous certification as a critical care nurse, in July, 2007.

Researchers funded

Patricia Dykes, RN, senior nurse informatician; Blackford Middleton, MD; and Diane Carroll, RN, nurse researcher, Yvonne L. Munn Center for Nursing Research, received a grant from the Robert Wood Johnson Foundation for \$300,000, for their study, "Translating Fall Risk Status into Interventions to Prevent Patient Falls," in August, 2007.

Researchers publish

Laurel Radwin, RN, nurse researcher; Rita Suhonen, RN; and Lee Schmidt, RN, published, "Measuring Individualized Nursing Care: Assessment of Reliability and Validity of Three Scales," in the *Journal of Advanced Nursing*, in July, 2007.

Viser and Woodbury present

Anne Viser, PT, physical therapist, and Lisa Woodbury, ATC, presented, "Strength and Conditioning for the Female Knee: an Injury-Prevention Program," at Cambridge Rindge and Latin High School, in June, 2007.

Nurses present

Chelby Cierpial, RN, clinical nurse specialist; Sioban Haldeman, RN, clinical nurse specialist; and Judy Silva, RN, nursing director, Cardiac Interventional Unit, presented their poster, "Improving Safety for the Anti-Coagulated Patient, Fall-Prevention, and Medication Administration," at the National Teaching Institute of the American Association of Critical Care Nurses, in Atlanta, May 20 – 24, 2007.

Tyer-Viola presents

Lynda Tyer-Viola, RN, clinical nurse specialist and nurse scientist, Blake 14 Obstetrical Unit, presented, "The Doctoral Forum: a Strategy to Advance Nursing Science in the Clinical Setting," at the Sigma Theta Tau International Research Congress, in Vienna, in July, 2007.

Radwin and Mallory publish

Laurel Radwin, RN, nurse researcher; The Yvonne L. Munn Center for Nursing Research, and Gail Mallory, RN, Oncology Nursing Society, authored the article, "Watch for the Implementation of the Patient-Reported Outcomes Measurement Information System," in the ONS/Advanced Research Special Interest Group on-line newsletter, in August, 2007.

Tyer-Viola also presented, "Nursing's Social Responsibility for Global Health," a focused discussion group with Dr. Inge Corless and Dr. Patrice Nicholas.

Researchers present

Laurel Radwin, RN, nurse researcher; The Yvonne L. Munn Center for Nursing Research; Howard Cabral; and Leslie Chen, presented their poster, "Factor Structure of Four Scales to Measure Outcomes of Patient-Centered Nursing Care," at the Academy of Health's annual meeting in Orlando, Florida, June 4, 2007. The study was funded by the Agency for Health Care Research and Quality.

Friends of the MGH Cancer Center support patient education

— by Mary Elisabeth Field

The Friends of the MGH Cancer Center is an organization that works closely with the MGH Cancer Center helping patients and families through support, education, and amenities to relieve the stress, anxiety, and effects of cancer treatments. Every spring, the Friends award grants to groups and individuals to fund projects to advance this mission. Grants fund a variety of projects from educational materials, to renovations, equipment, books, and

Providing grant money to advance the education and understanding of cancer and its various treatments is one of the many ways the Friends of the MGH Cancer Center support the care of cancer patients and their families.

many other creative initiatives proposed by those who work closely with cancer patients.

The Cancer Resource Room is one area where educational materials and resources funded by the Friends can be found. Earlier this

year, the Friends of the MGH Cancer Center celebrated its tenth anniversary working with the Cancer Resource Room.

This year, the Friends received a number of proposals aimed at supporting and developing cancer education through films, CDs, literature, and lectures.

One proposal began, “Our Friends grant allowed us to initiate many new programs and projects that are valued by the Cancer Center and incorporated into staff’s clinical practice.”

Some of those projects include: a database used by nurses to provide important information to patients and families; and a mechanism for consistent distribution of patient-education materials to inpatient and outpatient areas.

The Friends have supported educational advances in other areas, too. In May of 2007, grant money was given to the Melanoma and Pigmented Lesion Center to fund the book, *Understanding Melanoma*. A grant was given to Chemotherapy to translate an educational video into Spanish, and grant money went to Cancer Resource Health Communications to create a Spanish resource brochure.

“I came to the Cancer Resource Room when it first opened to learn about my mother’s brain tumor,” said one Cancer Resource Room visitor. “Recently, due to my own breast-cancer diagnosis, I’ve spent many hours reading through books and pamphlets. The information is empowering. Thank-you.”

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For more information about the Friends of the MGH Cancer Center, call 6-1063.

Pastoral Care Week

Come celebrate
Healing Faith

Chaplaincy display tables
Tuesday, October 23, 2007
Main Lobby
11:00am – 1:00pm

The Blessing of the Hands
Thursday, October 25, 2007
MGH Chapel
6:30 – 8:00am; 11:30am – 1:00pm;
3:00 – 5:00pm

Patients, families, staff, and visitors are invited to participate in this special blessing that offers affirmation and appreciation for the many tasks our hands do to provide comfort and care for one another.

For more information, call the Chaplaincy at 617-726-2220.

4th Annual Women's Health Research Lecture

The Women's Health Research Committee invites you to attend the 4th annual Improving the Health of Women through Research at MGH lecture.

Wednesday, November 7, 2007
12:00 – 1:00pm
O'Keefe Auditorium
A light lunch is included

Guest speaker, Dr. Susan F. Wood, served as assistant commissioner for Women's Health and director of the Food and Drug Administration Office of Women's Health from November 2000 – August 2005. She resigned because of the delay of approval of emergency over-the-counter contraception (Plan B) by the FDA. She is currently a research professor at the George Washington University School of Public Health and Health Services where her work and advocacy focuses on the use of scientific knowledge in public policy.

Latino Nurse Day

Celebrating Diversity

October 29, 2007
O'Keefe Auditorium
8:30am – 12:00pm

Storytelling and Latino dancing

Reception to follow
Trustees Room Bulfinch 2
Sponsored by PCS Diversity Steering Committee

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

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.

October is Domestic Violence Awareness Month

"The Good, the Bad and the Ugly: Profiles of Abusive Men"

presented by David Adams, EdD, and sponsored by the MGH Domestic Violence Working Group

Adams will discuss batterer intervention programs and their positive outcomes in rehabilitating abusive men, common traits of abusers, and the essential differences between abusive and controlling behavior in intimate relationships.

Thursday, October 4, 2007
11:45am–1:00pm

Thier Conference Room
Lunch included

For information, contact Donna Kausek at 6-8963

"Domestic Violence Information Tables: Night Shift Outreach"

sponsored by Police, Security & Outside Services in collaboration with the MGH Domestic Violence Working Group. Stop by to learn about the dynamics of domestic violence and services available at MGH.

Tuesday, October 16, 2007
6:00–8:00am and
9:00pm–11:00pm
Main Corridor

Light refreshments
For information, contact
Matthew Thomas at 4-3838

"A discussion with Stephen Durant, co-author of *Whose Game is it, Anyway?*"

sponsored by the MGH Men Against Abuse, in collaboration with the MGH Domestic Violence Working Group. Durant will talk about male aggression in sports

Monday, October 29, 2007
11:45am–1:00pm
Yawkey 10-660
Lunch included

For information, contact
Jim Heffernan at 6-2684

Published by

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

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Submissions

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

Next Publication

October 18, 2007

Educational Offerings – 2007

October

12&29

ACLS Provider Course

Day 1: 8:00am – 3:00pm
O'Keefe Auditorium

Day 2: 8:00am – 3:00pm
Thier Conference Room
No contact hours

October

15

Special Procedures/Diagnostic
Tests: What You Need to Know

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

October

15&22

Care of Patients with Vascular
Disease

Simches Conference Room
8:00am – 4:00pm
Contact hours: TBA

October

17

Workforce Dynamics:
Skills for Success

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

October

17

Intermediate Arrhythmia

Yawkey 10-660
8:00 – 11:30am
Contact hours: 3.5

October

17

Pacing Concepts

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

October

18

Nursing Grand Rounds
"Nursing Documentation"

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

October

18&19

PALS Certification

Training Department
Charles River Plaza
8:00am – 5:00pm
8:00am – 3:00pm (Day 2)
No contact hours

October

23

Ovid/Medline: Searching for
Journal Articles

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

October

24

New Graduate RN
Development Seminar II

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

October

24

Congenital Heart Disease

Haber Conference Room
7:30am – 12:00pm
Contact hours: TBA
(for mentors only)

October

25

Nursing Grand Rounds
"Case Management"

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

October

25

A Symposium on Evidence-Based
Nursing Practice

O'Keefe Auditorium
12:00 – 4:00pm
Contact hours: TBA

October

27

Hip Pain: Diagnosis
and Treatment

Haber Conference Room
8:00 – 11:30am
Contact hours: TBA

October

29

Intra-Aortic Balloon Pump

Day 1: NEMC
Day 2: Burr 5
7:30am – 4:30pm
Contact hours: TBA

October

30

CPR Re-Certification

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

October

30 and

November

**13, 19, 20,
26, 27**

Greater Boston ICU Consortium
Core Program

Faulkner Hospital
7:30am – 4:30pm
Contact hours: TBA

October

31

Basic Respiratory Nursing Care

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

November

2

Assessment and Management
of Psychiatric Problems
in Patients at Risk

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

November

7&14

Phase II Advanced Wound-Care
Education Program

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

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

On Bigelow 14 Vascular Unit, hand hygiene is 'easy!'

Kris, Cathy, and Tricia want you to know...

On the Bigelow 14 Vascular Unit, our hand-hygiene motto is: "That was easy!" Our goal has been to raise awareness and increase compliance with fun and humorous reminders. We put Staples 'easy' buttons atop Cal Stat dispensers, award instant-cash coupons, distribute fun 'anti-germ' stickers, and place creative posters strategically throughout the unit. Staff-meeting discussions and interdisciplinary reminders of our commitment to achieve a 90/90 compliance rate are making our hand-hygiene goals a reality. Cal Stat. Now that was 'easy!'



Hand hygiene champions, Kristine Cote, RN (sitting), Catherine Weaver, RN (standing), and Patricia Bergschneider, RN

Caring
Headlines
October 4, 2007

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Boston, MA 02114-2696

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Boston, MA

