

Caring

Headlines

April 17, 2008

April is Occupational Therapy Month

—by Lauren Cosgrove, OTR/L; Laura White, OTR/L; Julie Burke, OTR/L; and Leslie McLaughlin, OTR/L

“Occupation is the very life of life.”

—Harold Bell Wright, American author, 1872-1944

We spend nearly every waking moment of our lives occupied. We have certain habits, routines, and roles that motivate us and structure our day. Your role as mother may require you to bring your son to hockey practice. You may have a habit of ironing your clothes every morning before getting dressed.

Your job motivates you to go to work and perform to current standards. But what happens when you're unable to engage in those habits, routines, or roles? What happens if you can no longer perform simple activities such as feeding yourself or getting dressed? You try to find ways that will allow you to engage in those activities that make you who you are.

That's where Occupational Therapy (OT) comes in. The goal of occupational therapy is to enable individuals to participate in daily activities. Occupational therapists recognize how physical and cognitive impairments impact a person's ability to function. Through the use of remediation, compensation, or adaptation techniques, occupational therapists help individuals resume participation in daily activities despite limitations.

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Occupational therapist, Julie Burke, OTR/L, teaches outpatient neurology patient, Marcis Braunfelds, how to use a rocker knife to cut food with one hand as his children look on.

Hand hygiene: a key component of excellent care, and recently, of great fiction, too

Gerritsen shows a physician... unapologetically performing gynecological exams one after another while wearing the same pair of gloves. Obviously, as a nurse, I had a visceral reaction to the scene.

My father recently recommended a book to me, a suspenseful murder mystery by best-selling author, Tess Gerritsen, called, *The Bone Garden*. The story is told in alternating story lines, one set in present day, the other in the now seemingly primitive medical world of 19th-century Boston. Among other pivotal elements of the story, Gerritsen shows a physician, a renowned and accomplished doctor of his time, unapologetically performing gynecological exams one after another while wearing the same pair of gloves. Obviously, as a nurse, I had a visceral reaction to the scene.

But I, too, recommend *The Bone Garden*, not just because it's a great book and a great mystery, but because I was struck by a passage that appeared in the Author's Note:

"In March 1833, Oliver Wendell Holmes left Boston and sailed to France, where he would spend the next two years completing his medical studies. At the renowned Ecole de Medicine in Paris, young Holmes had access to an unlimited number of anatomical specimens and studied under some of the finest medical and scientific minds in the world. He returned to Boston a far more accomplished physician than most of his American peers.



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

In 1843, at the Boston Society for Medical Improvement, he presented a paper entitled, "The Contagiousness of Puerperal Fever." It would prove to be his greatest contribution to American medicine. It introduced a new practice that now seems obvious, but which, in Holmes' day, was a radical new idea. Countless lives were saved, and miseries avoided, by his simple yet revolutionary suggestion: that physicians should simply *wash their hands*."

That was in 1843. I think you'll agree — we've come a long way. As I review the results of our most recent hand-hygiene survey, I'm thrilled to see that our first-quarter results show continued improvement and sustained success of our 2007 efforts. Twelve units attained a "90/90" or better compliance rate (90% be-

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I want to thank our physician colleagues, the managers and directors within Patient Care Services, our hand-hygiene champions, and above all, staff and support staff for your day-in, day-out, commitment to patient safety and the delivery of excellent care.

fore contact and 90% after contact with patients or the patients' environment). This upward trend in compliance is visible across disciplines and in all role groups. I think special recognition should be given to Physical Therapy for their uninterrupted record of near-perfect, hand-hygiene practice and to Respiratory Care for achieving such a dramatic improvement in their compliance rates.

No conversation about hand-hygiene success would be complete without acknowledging the incredible work of Stephanie Cooper, training and development specialist, Tom Drake, senior training and development specialist, and our amazing team of unit service associates who keep our Cal Stat dispensers full and whose own compliance rates have risen significantly.

It's gratifying to see a decrease in the number of healthcare-associated infections throughout the hospital. That tells me our hand-hygiene efforts are paying off in terms of positive outcomes for our patients. To date, our hand-hygiene program has only extended to inpatient units, but in the coming months the program will expand to include ambulatory settings and service areas, as well.

Recently, the STOP Task Force and MGH hand-hygiene champions received a Partners in Excellence Award for their outstanding contribution to hand-hygiene practice and compliance. And MGH was a recipient of the Betsy Lehman Patient Safety Award, given by the Betsy Lehman Center for Patient Safety and Medical Error Reduction for the success we achieved in improving hand-hygiene compliance.

So successful are our hand-hygiene efforts, we've been contacted by hospitals and healthcare facilities across the country and as far away as Australia inquiring about our program. Other organizations want to know how we've achieved and sustained such high compliance rates and how we accurately survey and measure compliance across disciplines. Our program has become a model for others.

Because transparency, accountability, and an informed public foster good practice, we offer a hand-hygiene video for patients and visitors on MGH Channel 31 and on the MGH intranet. The video is available in English and Spanish and encourages patients to take an active part in their care through heightened awareness about hand hygiene.

I want to thank our physician colleagues, the managers and directors within Patient Care Services, our hand-hygiene champions, and above all, staff and support staff for your day-in, day-out commitment to patient safety and the delivery of excellent care. Oliver Wendell Holmes had it right back in 1843 when he introduced his, 'radical new idea': healthcare providers should simply wash their hands.

Update

I'm happy to announce that Karen Murphy-Lind, RN, has been appointed the new co-chair of the Ambulatory Care Nursing Practice Committee. Karen is the unit nurse leader and practice manager for the Specialties Unit at the Charlestown HealthCare Center. She will serve as co-chair for a two-year term.

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(Cover photo by Abram Bekker)

Every year at MGH, occupational therapists see thousands of patients with a variety of diagnoses. What sets occupational therapists apart is our unique focus on participation in occupations. The following case stories show how occupational therapists help patients resume participation in their daily occupations.

Neurology

Jane was referred to outpatient OT services to address symptoms resulting from a recent stroke. She presented with impaired vision and weakness on her left side. She had difficulty with cognitive skills, including memory. Jane's goal for occupational therapy was to increase movement in her left arm and be able to dress and feed herself with less help from others.

- OT treatment focused on helping Jane find easier ways to perform her usual routines. This included:
- instruction in stretching and strengthening of her left arm and hand
 - the use of adapting techniques to enable her to dress with her non-dominant hand
 - the use of adapted equipment, such as a rocking knife to cut her food
 - the integration of a new habit—scanning her environment to compensate for her loss of vision and to avoid injury

In the Pediatric Intensive Care Unit, occupational therapist, Jennifer Cardella, OTR/L, demonstrates therapeutic positioning and calming strategies during feeding while mom looks on.



(Photo by Michelle Rose)

Now Jane can dress herself with minimal assistance. She can independently use the microwave to heat foods. She is safe moving around her home and engaging in everyday activities. Jane independently performs her exercise program to keep her joints flexible and pain-free.

Orthopaedics

Bob is a 66-year-old man who came to MGH for a hip replacement. He told his occupational therapist he wanted to, "live life again." His hip pain was so bad he couldn't put his socks or shoes on without his wife's help.

OT treatment involved issuing Bob special, long-handled equipment that allowed him to:

- put on his pants, socks, and shoes without help
- safely get in and out of the shower and wash his feet without bending over
- reach items on the floor and on lower shelves of the refrigerator

Bob told his OT, "How would I have managed at home without these? My wife is going to be happy, too!"

Pediatrics

Baby Ann was born two months premature. For months in the Newborn ICU, she required a ventilator to help her breathe. Baby Ann's mother wanted to understand the developmental needs of her child and be able to feed her before going home. OT treatment included suggestions for:

- positioning the baby and incorporating devices to help her muscles develop
- helping the mother recognize certain behaviors in her baby and use sensory strategies to calm her
- determining the best bottle, nipple, and safe feeding techniques to ensure proper nourishment

When Baby Ann was discharged, her mother was able to apply the sensory, positioning, and developmental strategies she learned to optimize her baby's ability to feed, play, and learn. These techniques gave mom a sense of confidence as they transitioned home.

Psychiatry

Karen is a 32-year-old woman who had lost her job and been severely depressed. She spent most of her time lying in bed,

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worrying about the future. She rarely changed clothes, showered, cooked, or left the house. Karen's goals were to identify ways to manage her mood changes, resume her role as an active friend, and learn appropriate ways to structure her time. Karen attended daily OT sessions that

focused on coping skills, sensory motor techniques, life skills, and self expression. Through group and individual sessions, Karen learned:

- how her energy level changes throughout the day and ways she can bring her energy to the optimal level to allow her to function
- how simple strategies such as having a cup of coffee, taking a bath, exercising, or chewing gum can affect her ability to engage in life activities
- how journaling helped her identify community supports, organize her day, and set achievable goals

Karen was discharged a week later with a new sense of purpose and direction.

These examples show how occupational therapists work with diverse patient populations, maintaining a holistic view of each patient's roles, habits, and routines. OTs work closely with individuals to ensure the recovery process centers on the client's needs and wishes. Through this collaborative process, OTs help patients resume participation in the meaningful occupations of their lives.

At MGH, Occupational Therapy is available in both inpatient and outpatient settings. Inpatient services are offered on all units to meet the individual goals of our diverse patient population. Outpatient services address a variety of patients' needs including developmental intervention, neurological rehabilitation, and hand therapy. Outpatient services are available on the main campus, at the Revere HealthCare Center, and at our newly expanded site at Waltham's MGH West.

For more information about services provided by the MGH Occupational Therapy Department, call 4-0140.

At right: occupational therapist, Cara Triggs, OTR/L, instructs patient in the use of adaptive equipment to assist with dressing and undressing after hip surgery.

Below: on the Psychiatric Unit, occupational therapist, Kristi Giles, OTR/L, demonstrates the use of sensori-motor activities as a coping strategy.

Below right: Taber Hilton, OTR/L, occupational therapist, makes type of splint used for patients following wrist fracture.



(Photos by Abram Bekker)

New Graduate in Critical Care Nursing Program

—by Gail Alexander, RN, clinical educator

On March 3, 2008, at a special luncheon in the Thier Conference Room, 17 nurses were recognized for completing the New Graduate in Critical Care Nursing Program. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, congratulated graduates on their accomplishment, noting the rigorous demands of the program, the expert guidance of critical care leadership, the generosity of clinicians who teach in the program, and the invaluable support and expertise of the preceptors.

Associate chief nurse, Jackie Somerville, RN, shared that 125 nurses from 11 intensive care units have graduated from the program since its inception in 2001. This was the first time nurses from the PACU and Newton Wellesley Hospital participated in the program.

Program coordinator, Gail Alexander, RN, commented on the importance of sharing clinical narratives. “Thought-

ful reflection affords us the opportunity to learn from our experiences. Hopefully, writing that first narrative is the beginning of a career of reflective practice.”

Participant, Laura Walsh, RN shared her narrative chronicling her end-of-life care of Mary, an elderly woman in the SICU (see narrative on page 8). Walsh’s ability to recognize Mary’s responses to certain stimuli allowed her to tailor her care to best meet Mary’s needs.

Walsh’s preceptors, Michele Pender, RN, and Patricia Pires, RN, spoke about the ability to create an environment where reflection can occur. They described the strategies they used to help guide Walsh through her preceptorship.

This year’s participants in the program included:

- Suzanne Bonin, RN, Surgical ICU
- Julie Crisileo, RN, Cardiac Surgical ICU
- James Gray, RN, Post Anesthesia Care Unit
- Laura Hooper, RN, Pediatric ICU
- Yulia Kubic, RN, Medical ICU
- Chrystine Kusick, RN, Cardiac Surgical ICU
- Courtney Leach, RN, Cardiac ICU
- Amanda Lewis, RN, Post Anesthesia Care Unit
- Christie Majocho, RN, Cardiac ICU
- Jenna Marchant, RN, Pediatric ICU
- Chelsea Spindel, RN, Pediatric ICU
- Meredith Stanford, RN, Cardiac ICU
- MaiAnh Tran, RN, Neuroscience ICU
- Laura Walsh, RN, Surgical ICU
- Adam Castagno, RN, Newton Wellesley Hospital
- Elaine Sue Joyce, RN, Newton Wellesley Hospital
- Elizabeth White, RN, North Shore Medical Center

For more information about the New Graduate in Critical Care Nursing Program, visit the Knight Center website at www.mghnursing.org, or contact Gail Alexander at 6-0359. For application information, contact Adrienne Robbies at 617-643- 4880.

Members of the 2008 graduating class of the New Graduate in Critical Care Nursing Program



(Photo by Abram Bekker)

PCS Diversity Program receives Rosoff Award

Once again, the PCS Diversity Program has brought pride and recognition to the MGH community as one of this year's recipients of the prestigious Rosoff Awards. Sponsored by the Boston Ad Club and the Greater Boston Chamber of Commerce, the Arnold Z. Rosoff Awards recognize businesses and individuals for their work in advancing diversity and having a positive social and economic impact on multi-cultural communities throughout the area.

At a special reception at the Fairmont Copley Plaza on March 26, 2008, the PCS Diversity Program was honored for its, "far-reaching and comprehensive initiatives, educational offerings, and cultural events de-

signed to build a diversity-centric hospital community. Since its inception in 1995, the PCS Diversity Program has systematically, strategically, and successfully embedded diversity into its cultural DNA."

The nomination specifically cited PCS director of Diversity, Deborah Washington, RN, for her outstanding leadership of the Diversity Program; Carmen Vega-Barachowitz, SLP, director of Speech, Language & Swallowing Disorders and Reading Disabilities, for her many contributions as co-chair of the Council on Disabilities Awareness; and Pat Rowell, director of Volunteer and Interpreter Services, Information Ambassadors, and General Store Services, for the advances she spearheaded in making medical interpretation available to all patients. Selection of the PCS Diversity Program as an award recipient was a unanimous choice by a panel of more than a dozen judges.

Some of the many accomplishments of the PCS Diversity Program include:

- increasing the minority nursing staff by 207% between 1996 and 2006 while the overall nursing staff grew by 81%
- more than tripling the number of minority nurses on staff since 1996
- influencing the hiring of minority leadership in the roles of nurse managers, clinical educators, and directors of clinical and administrative programs
- creating a curriculum for managers to help enhance their skill in leading a multi-cultural, multi-ethnic workforce
- creating pipeline programs with local nursing schools, providing tuition support, mentoring, and leadership-development

Patient Care Services joins the entire MGH community in congratulating Washington, Vega-Barachowitz, and Rowell on this well-deserved honor.

(L-r): Pat Rowell, Deborah Washington, RN, and Carmen Vega-Barachowitz, SLP, accept Rosoff Award on behalf of PCS Diversity Program.



New nurse learns important lesson about patient-centered care

Mary, a 79-year-old woman, had had complications after unscheduled surgery and came to our unit 'skating' on the edge of sepsis.

My name is Laura Walsh, and I am a new graduate nurse. This narrative chronicles my care of a patient during my preceptorship in the New Graduate in Critical Care Nursing Program from which I recently graduated. I met Mary one Monday morning in the Surgical Intensive Care Unit (SICU). Her room was at the end of the corridor where soft light filtered through windows that looked out at building a few yards away. Mary, a 79-year-old woman, had had complications after unscheduled surgery and came to our unit 'skating' on the edge of sepsis. In the week Mary had already spent in the hospital, she had ruled in for a small MI (minor heart attack), her labs had shown multiple bacteria, and she had required units of blood, vasopressors, and mechanical ventilation. Her condition had somewhat improved over the weekend, but she was still ventilated and on pressors.

By this time, Mary's sister, who was also her health-care agent, had changed Mary's code status three times from Do Not Resuscitate, to full code, to various places in between. In report that morning, I learned that Mary's comfort was of utmost concern to her family. This, I understood. But I was still unclear as to what



Laura Walsh, RN, new graduate critical care nurse

the current plan was—where we were going with this woman, or rather, where she would take us.

Mary was sedated on a small amount of propofol and lay silent, half asleep in her bed. The tubing from the ventilator looked enormous around her small frame, and the lines filled with antibiotics, pressors, and IV fluid appeared heavy against her body. My preceptor and I decided to turn Mary's sedation off to get a sense of how she was doing. It took Mary a while to come around, but as she did, I saw the fear and confusion in her eyes. I tried to re-orient Mary as often as I could, but there were times I wondered if she was truly "there." More experienced team members and my preceptor felt she was not.

I was determined to make Mary as comfortable as possible, and it was immeasurably frustrating when I felt I was missing something she might need. I couldn't let go of the fact that this woman could die, and I had to do everything in my power to ensure her comfort.

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I was somewhat distracted by other tasks... titrating her pressor, administering her meds, and rushing to change dressings that needed changing. By the end of my first day with Mary, I was disappointed in myself, feeling I hadn't succeeded in doing everything I could for her. My preceptor reminded me that you can't expect to achieve perfection with very sick patients who've been confined to a hospital bed for an extended period of time.

The next day when I returned to take care of Mary, the situation became more complicated. Mary's sister was very upset about everything Mary had been through and wanted to speak with the team. The team explained that they were unsure what would happen if Mary was extubated because she was so weak and deconditioned and had already suffered a cardiac insult. An official family meeting was scheduled for the following day when more of Mary's family could be involved in the decisions that Mary herself was no longer able to make on her own.

I returned to work to care for Mary two days later. At the family meeting with the SICU team, the social worker, and Mary's primary care physician, the team and Mary's family had decided to extubate Mary and provide comfort measures only if she should fail. I sat in report that morning, ready to cry, my mind racing. Why did everyone think she would fail? Maybe they were wrong. The pressure was on. I was responsible for ensuring the comfort and dignity of this woman and her family while her life could be ending on our unit. I did not want to mess it up.

With reassurance from my preceptor, I went about my normal daily routine with Mary. When Mary's sister and brother came in to visit before she was extubated they seemed almost chipper. I thought this could be due to nerves combined with a sense of relief that a final decision had been made. They asked to be called back in as soon as the breathing tube was removed. Mary's sister put a religious memento around Mary's neck and asked that we play a CD of Mary's niece singing during the extubation. I grew more nervous with these gestures and requests but reminded myself that Mary's outcome was not entirely known as it might be in other cases.

Once Mary was extubated, I called her family back in. Her sister and brother hovered over her, repeatedly asking how her vital signs looked, if she'd received pain medication, insisting I give more pain medication, but also expressing concern about her respiratory rate. I verified the parameters of my written order, checked

with my preceptor, and gave Mary more pain medication. I re-positioned her numerous times at the request of her family, putting off other basic-care tasks as I had done the first day I cared for her. As my frustration with the family grew, I tried to put myself in their place and imagine what they were feeling. I began to wonder if this family was feeling guilty about the decision they had made. As I watched them ask Mary different questions over and over again, I noticed she seemed restless. I realized that if Mary's comfort was their greatest concern, I needed to ask them to step out. I told them there were a few things I needed to do with Mary and I'd call them back in when we were ready for them. As I continued with her necessary care, Mary seemed to calm down. I didn't hover or hound her with questions. I re-positioned her once more, turned the lights down, and let her rest.

I think seeing Mary's family relate to her the way they did made me realize I had been doing the same thing a few days earlier. There are things I can control in this environment, and things I can't. Ultimately, I can do my best to keep patients comfortable, which means different things for different patients and families. Unfortunately, for a time, I felt as if I'd catered more to the interests of Mary's family than to Mary herself. But I realized that by doing a few simple things, then leaving her alone, I was doing what was best for Mary. I was finally giving her the comfort and dignity I'd been so intent on providing from the beginning.

Mary died two days later. Her family had been in that day to see her, and according to the nurse on duty, it had been a very good day. I wasn't there when Mary died, but I was told that when she started to decline, her family was called, and they decided not to come in. Perhaps they realized the same thing I had and opted to let Mary rest in peace.

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

Laura's ability to observe Mary's responses to her family's well-meaning but ultimately overwhelming actions changed the way she cared for Mary. It reminds us that sometimes stepping back can be one of the most powerful interventions we provide. Benner talks of the nurse as, 'compassionate stranger.' Bearing witness at the end of a patient's life is an act of courage and compassion. Laura learned this lesson early in her practice; I'm sure it will serve her well as she advances in her career as a critical care nurse.

Thank-you, Laura.

But I realized that by doing a few simple things, then leaving her alone, I was doing what was best for Mary. I was finally giving her the comfort and dignity I'd been so intent on providing in the first place.

Tips and teaching tools for medication safety

—by Nancy Davis, RRT; Anne Gavigan, RN; Angelica Tringale, RN; and Laura White, OT

What may seem simple to us may feel unfamiliar and complex to our patients. Taking the time to thoroughly review medications with patients is critical to their well-being, especially if their medications have changed during their hospitalization.



An important aspect of our practice is teaching patients about medication safety. Reviewing a patient's medications, including dosage, indications for usage, and in some cases, techniques for self-administration, is vitally important. What may seem simple to us may feel unfamiliar and complex to our patients. Taking the time to thoroughly review medications with patients is critical to their well-being, especially if their medications have changed during their hospitalization.

A major barrier to patient-education can be the patient's readiness to learn. Information may be ineffective if a patient is unable or unwilling to participate in the educational process. Barriers can include fatigue, pain, memory-loss, anxiety, and confusion caused by mind-altering medications. Language barriers and illiteracy can also be a factor. Clinicians should try to resolve any barriers before engaging in patient-teaching.

One of the best ways to approach patient-education is to ask the following types of questions:

- How do you best learn new information?
- What information is important to you when learning how to take a medication?

- Is there anything I can do to make this information more understandable?

Patients need to know the names of the medications being prescribed, both trade names and generic names, so they can identify substitutions made by the pharmacist. This helps patients feel confident questioning any errors they feel may have been made.

Patients should have a basic understanding of what conditions are being treated by medications. For instance, Lopressor (metoprolol) is used to treat high blood pressure; Prilosec (omeprazole) is used to treat acid reflux disease; Lipitor (atorvastatin) is used to treat high cholesterol. When patients understand the purpose for a medication, they're better able to report medical history.

Common side-effects should be disclosed during the teaching session. Patients need to know what to expect when taking a medication. They should be told both the mild and adverse effects. Information on side-effects can be printed out and given to patients to supplement the information they receive from the pharmacist.

Always give patients an opportunity to ask questions. If they're being discharged, they should be given a schedule of when to take their medications, and be sure to highlight any new medications or changes to existing medications to avoid confusion.

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Numerous patient-education tools are available at MGH, including printed materials, videos, websites, and the Blum Patient & Family Learning Center; and many specialty areas offer unit-specific resources, as well.

The MGH Learning Channel is a convenient way for patients and families to access information without having to leave their hospital rooms. Channel 31, the Learning Channel, offers two videos on medication safety: *Wise Use of Medications* and *Partners in Care: You and Your Medications*.

Drug Notes and Lexi Pals are resources available to clinicians for medication information. These resources describe the proper way to take medications and include possible side-effects and cautions. Lexi Pals

is available in 18 languages, including, Spanish, French, Italian, Russian, and Vietnamese.

From the MGH website (<http://www.mass-general.org/library/default.asp>) clinicians can link to on-line patient-education sites, such as, Medline Plus Easy-to-Read. The medication section of this site lists articles such as, "How to Give Medicine to Children," "Medication and

Older Adults," and "Safe Use of Medications: Take Your Medicine the Right Way Each Day," many available in Spanish. Medline Plus also offers interactive tutorials and current health news.

Following are some suggestions on how to ensure a safer patient-education experience.

Before a medical appointment

- Encourage patients to come prepared, no matter how simple or quick they expect the appointment to be.
- Ask patients to bring a notebook listing all their current medications, dosages, and administration instructions. The notebook should include any negative reactions or allergies they've experienced, as well as vitamins and/or supplements they may be taking.
- Suggest that patients write any questions or concerns they may have in the notebook as a reminder to discuss them with their doctor.

During the appointment

- Patients should write down the answer to each question in the notebook.
- Clinicians should ask patients to paraphrase the information they've been given and encourage them to ask for clarification if necessary. (It's helpful to provide the proper spelling of medications and any other unfamiliar words.)
- Clinicians should give patients their business cards or make sure their contact information is included in the notebook.
- Keeping a calendar in the notebook can help patients keep track of appointments and remind them when to have lab work and other tests done.
- Having a family member or friend present during an appointment can help patients remember important information. Loved ones can provide emotional support as well as serve as 'a second set of ears.'

When patients go home

- Suggest to patients that they keep the notebook in an easily accessible place. Encourage them to let a family member or neighbor know where it is in case of an emergency. In that event, the family member or neighbor should be advised to bring it to the hospital or have it accompany the patient.
- Suggest that patients use a pill organizer to keep track of their medications. Organizers are available in daily, weekly, and monthly sizes, are inexpensive, and provide an easy way to see if medications have been taken and/or if refills are needed.
- Alarms, timers, and written notes can help remind patients when to take pills. Cell-phone alarms can be set to remind patients when to take medications. A number of low-cost medication alarms are available on the market, and some pharmacies offer a refill plan.
- If mobility is an issue for patients, they should make arrangements for their medications to be picked up by someone else or delivered to their home.

Many educational tools and resources are available to clinicians. By using these tools in our patient-teaching sessions, we ensure that patients know how to take their medications safely, and we promote better overall compliance and health care.

For more information about medication safety, contact the Patient Education Committee at mghpatienteducomm@partners.org.

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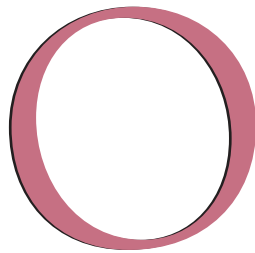
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11th annual collaborative governance grand rounds

—by Susan Lee, RN, clinical nurse specialist, The Institute for Patient Care

Executive director of The Institute for Patient Care, Gaurdia Banister, RN (top center), with collaborative governance participants at 11th annual collaborative governance grand rounds.



On Thursday, March 13, 2008, at the 11th annual collaborative governance grand rounds, Patient Care Services celebrated the outcomes achieved by the seven collaborative governance committees in 2007. Susan Lee, RN, co-leader of collaborative governance, described some of the work going on in response to the 2006 assess-

ment, calling this, 'a new era of accountability.' Lee shared that MGH collaborative governance best practices were presented at three national conferences in 2007; applications for membership are now electronic; up-to-date, on-line information provides greater transparency; and there's increased emphasis on committee members disseminating important information throughout the hospital.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, introduced Gaurdia Banister, RN, executive director of The Institute for Patient Care, who spoke about, "Collaborative Governance: Impressions from a Newcomer and Looking to the Future." Banister shared drawings that had been done at the collaborative governance leaders' retreat earlier in the year. The drawings may have looked like children's artwork, but they were actually the result of a group exercise to get attendees to use the right side of their brain, the creative side, to answer questions such as, What core factors give 'life' to collaborative governance?

At the retreat, a technique called, 'appreciative inquiry,' was employed to help attendees recognize and affirm the strengths, successes, and potential of collaborative governance. Banister encouraged attendees to work with and across committees to support our strategic goals, to promote teamwork, and to enhance patient care.

Ives Erickson invited committee members to share their accomplishments for 2007 and thanked them for their invaluable participation in preparing for the recent Magnet re-designation site visit.

For more information about collaborative governance, contact Susan Lee, at 4-3534.



(Photos by Abram Bekker)

Quality and Safety: looking at serious reportable events

The NQF defines serious, reportable events, as unambiguous (clearly identifiable and measurable), usually preventable, and extreme enough to result in death, loss of a body part, disability, or more than a transient loss of a bodily function.

Question: I'm hearing the term, 'never events,' being used in conversations about quality and safety. What is a never event?

Jeanette: Believing that having reliable information about healthcare errors would both increase accountability and lead to improvements in patient safety, in 1999 the Institute of Medicine recommended that adverse healthcare events be reported in a systematic manner. To help facilitate the reporting of adverse events, the National Quality Forum (NQF) was asked to compile a standardized list of serious, preventable, adverse events, which it first published in 2002 under the heading, 'Never Events.'

Question: What differentiates a serious, reportable event?

Jeanette: The NQF defines serious, reportable events, as unambiguous (clearly identifiable and measurable), usually preventable, and extreme enough to result in death, loss of a body part, disability, or more than a transient loss of a bodily function. Never events are adverse in nature, indicative of a problem in the organization's safety systems, and/or have an impact on the organization's credibility or accountability.

Question: Can you give us an example of a serious, reportable event?

Jeanette: The NQF identifies 28 serious, reportable events and divides them into six categories: surgical (such as surgery performed on the wrong body part); product- or device-related (such as death or disability associated with the use of a contaminated drug or device); patient protection (such as an infant being discharged to the wrong person); care-management (such as severe pressure ulcers acquired after admission); environmental (such as a death associated with a fall); and criminal (such as the abduction of a patient). A complete list of serious, reportable events is available in the PCS Office of Quality & Safety (3-0140) or on the NQF website: www.qualityforum.org.

Question: What is our current focus related to serious, reportable events?

Jeanette: We are working to craft a meaningful definition of serious reportable events (for example, what constitutes serious disability?) And we're developing systems for publicly reporting these events at the state and national levels. The highest priority of the PCS Office of Quality & Safety is ensuring that staff in all disciplines and role groups have the information they need to keep patients, families, and themselves safe while achieving the best possible outcomes. This applies to serious reportable events and all other issues related to quality and safety.

For more information, please call our Office of Quality & Safety at 3-0140.

Announcements

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.

"The Role of Academic Medical Centers in Improving Community Health"

The MGH Community Benefit Program invites you to celebrate our renewed commitment to community health. MGH president, Peter Slavin, MD, welcomes keynote speaker, David Satcher, MD, former US Surgeon General, who will talk about, "The Role of Academic Medical Centers in Improving Community Health." Governor Deval Patrick is an invited guest.

Tuesday, June 3, 2008
12:00–1:30pm
Under the Bulfinch Tent

For more information contact Alys Myers at: amyers6@partners.org

Make your practice visible: submit a clinical narrative

Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

EAP Work-Life Seminar

"What to do with Your Next \$100"

April 23, 2008
12:00–1:00pm

Thier Conference Room

What is more important, paying down debt or building up savings?

Presented by Amy Perry, consumer finance educator, this seminar looks at saving and investment strategies, financial choices, and debt-management.

For more information, call 6-6976.

EAP Work-Life Seminar

"Keeping Your Kids Safe"

May 28, 2008
12:00–1:00pm

Thier Conference Room

Be an informed parent. Join John Driscoll, assistant director, MGH Police, Security & Outside Services to learn preventative measures and strategies to ensure your kids grow up in a safe, secure environment.

For more information, call 6-6976.

Nurse Recognition Week

Sunday, May 4, 2008
Staff Nurse Breakfast
7:00–9:00am
Trustees Room

Monday, May 5, 2008
"Magnet Hospitals: the Inside Story"
co-presented by Margaret McClure, RN, professor, New York University, and Muriel Poulin, RN, professor Emeritus, Boston University
1:30–2:30pm
O'Keefe Auditorium

Tuesday, May 6, 2008
"Celebrating Nursing: a Legacy of Healing and Hope"
co-presented by Diane Carlson Evans, RN, and Mary "Edie" Meeks RN, of the Vietnam Women's Memorial Foundation
2:00–3:00pm
O'Keefe Auditorium

Wednesday, May 7, 2008
Nursing Research Scientific Sessions
10:00–11:30am
O'Keefe Auditorium

Annual Yvonne L. Munn Nursing Research Lecture, presentation of Munn Nursing Research Awards, and dedication of The Yvonne L. Munn Center for Nursing Research
1:30–3:30pm
O'Keefe Auditorium

Thursday, May 8, 2008
Staff Nurse Breakfast
7:00–9:00am
Trustees Room

"Teams that Work"
presented by Jeanette Ives Erickson, RN, chief nurse
1:30–2:30pm
O'Keefe Auditorium

Friday, May 9, 2008
MGH Nursing Research Fair
10:00am–2:00pm
Bulfinch Tent

For more information about Nurse Week presentations and activities, call 6-3100.

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Submissions

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

Next Publication

May 1, 2008

Educational Offerings – 2008

April

21 & 25

Medical-Surgical Nursing
Certification Prep Course

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

April

23

New Graduate RN
Development Seminar II

Charles River Plaza
8:00am–12:00pm
Contact hours: TBA

April

24

Workforce Dynamics:
Skills for Success

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

April

24

Intermediate Arrhythmia

Simches Conference Room 3-120
8:00–11:30am
Contact hours: 3.5

April

24

Pacing Concepts

Simches Conference Room 3-120
12:15–4:30pm
Contact hours: 3.75

April

24

Nursing Grand Rounds

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

April

30

A Creative Approach to
Communication: the Moon
Balloon Project

Burr Conference Room
9:30am–3:30pm
Contact hours: TBA

May

5

ACLS Instructor Course

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

May

6

BLS/CPR Certification for
Healthcare Providers

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

May

6

Ovid/Medline: Searching for
Journal Articles

Founders 334
9:00am–11:00pm
Contact hours: 2

May

**7, 8, 12, 13,
27 & 28**

Greater Boston ICU Consortium
Core Program

BWH
7:30am–4:30pm
Contact hours: TBA

May

12

Diabetic Odyssey

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

May

13

BLS/CPR Re-Certification

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

May

13

Chaplaincy Grand Rounds:

Yawkey 2-220
11:00am–12:30pm
No contact hours

May

14

New Graduate RN
Development Seminar I

Charles River Plaza
8:00am–12:00pm
Contact hours: TBA

May

14

Simulated Bedside Emergencies
for New Nurses

POB 448
7:00am–2:30pm
Contact hours: TBA

May

14

Nursing Research Committee's
Journal Club

Yawkey 2-210
4:00–5:00pm
Contact hours: 1

May

14

Nursing Grand Rounds

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

May

14

OA/PCA/USA Connections

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

May

15

CVVH Review and
Troubleshooting for the
Experienced CVVH Provider

Founders 311
8:00am–2:00pm
or 4:00–10:00pm
No contact hours

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

New program an OASIS of patient safety and customer service

—by Stephanie Cooper, training and development specialist

Training and development specialist, Stephanie Cooper, and senior training and development specialist, Tom Drake, facilitate OASIS program for operations associates.

February saw the inaugural session of the new program, OASIS (Operations Associates' Services Insure Safety) a collaborative effort sponsored by The Norman Knight Nursing Center, the PCS Office of Quality & Safety, and PCS Systems Improvement. The sessions are an opportunity for operations associates (OAs) to learn, share ideas, and stay

abreast of current issues related to customer service and patient safety.

Addressing the first session, director of the PCS Office of Quality & Safety, Keith Perleberg, RN, spoke about the six aims of the IOM for improving care, defined 'never events,' and shared the 2008 strategic goals for Patient Care Services. More than 50 OAs attended, reporting a renewed sense of pride in the contributions they make to patient care.

The second session, entitled, "Welcoming new OAs with effective precepting," was held March 26, 2008, and touched on topics such as orientation tools, precepting skills, best practices, and how to deviate from standard operating procedures when necessary. The experience level of attendees ranged from a few weeks to more than a decade of service at MGH.

April OASIS sessions will continue with Part 2 of, "Welcoming new OAs." Forums will be held, April 22nd from 5:00–6:00pm, and April 24th from 10:00–11:00am.

For more information, contact Stephanie Cooper at 4-7841, or Tom Drake at 6-9148.



Evening OASIS
"Welcoming New OAs with Effective Precepting" Part 2
Tuesday, April 22, 2008
5:00–6:00pm
Founders 325

TEAM USA
"Precautions"
Wednesday, April 23, 2008
2:30–4:30pm
Ruth Sleep Hall, Room 280

ORACLE
"Ergonomics"
Thursday, April 24, 2008
7:00–8:00am
Founders 325

OASIS
"Welcoming New OAs with Effective Precepting" Part 2
Thursday, April 24, 2008
10:00–11:00am
Founders 325



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