

Caring

Headlines

August 20, 2009

OB Simulation Program



*See story
on page 10*

Perinatal clinical nurse specialist, Patricia Connors, RN, demonstrates how mom, Noelle, the computerized mannequin who's capable of giving birth and simulating obstetrical complications, is introduced to her new baby as part of the OB Simulation Program.

The patient experience: the driving force behind patient care

When we talk about quality of care, it all comes down to one thing—the patient experience. Regardless of how good we *think* our care is, if the patient perceives her

experience to be anything less than perfect, that's what she's going to remember. That's what's going to inform her opinion. And that's what we need to take into account as we seek to improve our systems to meet and exceed the expectations of our patients and families.

We live in an information-rich, highly transparent, data-driven world. And that's a good thing for patients and healthcare organizations. Patients have quick, easy access to current, accurate information about their care providers, and hospitals have a dashboard by which to evaluate, measure, and improve essential systems and services. And we're getting to a point in our information-gathering where we're starting to see some commonalities in the terms and definitions being used, which makes the data more meaningful for everyone.

Through the use of various tools and surveys such as the H-CAHPS (Hospital-Consumer Assessment of Healthcare Providers and Systems) and a number of other data-collection instruments, we're able to tap into a wealth of information about how patients perceive their experience of care. Questions are designed to provide specific information across a wide variety of categories. Some examples of questions (related to inpatient hospital stays) include:

- During this hospital stay, how often did nurses explain things in a way you could understand?



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

- During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted?
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
- During this hospital stay, how often was your room and bathroom kept clean?
- Did you experience any bad surprises during the time you were hospitalized? Do you recall any negative experiences that you can talk about?

The responses to these questions, begin to tell a story; certain themes and trends emerge. The data, as well as anecdotal comments, help us identify opportunities to improve. For instance, a recent (January–March, 2009) H-CAHPS survey generated a short list of issues that MGH patients felt had an impact on their inpatient stay. The most prevalent issues that emerged were:

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- communication with doctors
- communication with nurses
- the responsiveness of hospital staff
- pain-management
- communication about medications
- cleanliness of the hospital environment
- noise/quiet
- discharge information

If there's one thing I know about MGH, it's that being 'good' isn't good enough. Our commitment to Excellence Every Day means being the best caregivers and support staff we can be. For us that means ensuring that patients in our care have the kind of experience we'd want for ourselves and our loved ones.

As I said, this is useful information, as it helps us prioritize and decide where best to focus our time and resources. Moving forward, we will share this data and other current patient-satisfaction indicators. We'll select the four areas where we think we can have the greatest impact. And we'll benchmark best practices and set departmental and unit-specific goals for improvement.

But even before we begin our formal improvement efforts related to this data, we've already embarked on a number of initiatives that are significantly improving the patient experience. Some units have adopted the practice of hourly rounding, including the '7 Ps' approach. Every time clinicians check on a patient they evaluate: Person, Plan, Priorities, Personal Hygiene, Pain, Position, and partnering through Presence. We're already seeing that this approach minimizes the risk of patient falls and has a positive effect on patient satisfaction.

In TCAB (Transforming Care at the Bedside) units across the country, including our own White 10, staff are exploring the benefits of 'quiet hours,' a set time every day when televisions are turned off and distractions are kept to a minimum, giving patients an opportunity to rest in a peaceful, quiet setting. During this time, patients report a decrease in pain and stress levels, and staff observe a marked reduction in the frequency of call bells. We're exploring ways to incorporate this practice at MGH.

Through a variety of programs such as TEAM USA, Through the Patients' Ears, and PCA/OA/USA Connections, our support staff are taking an active role in influencing the patient experience. Some of our most visible team members, operations associates, patient care associates, and unit service associates, share best practices around how to make patients feel welcome and comfortable. Simple gestures, such as providing an extra blanket, adjusting the room temperature, or removing a food tray can make a big difference in the patient experience.

If there's one thing I know about MGH, it's that being 'good' isn't good enough. Our commitment to Excellence Every Day means being the best caregivers and support staff we can be. For us that means ensuring that patients in our care have the kind of experience we'd want for ourselves and our loved ones. That is the driving force behind our efforts to meet and exceed the expectations of our patients and families.

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Building bridges to peace through nursing

—by Donna Perry, RN, professional development manager

On a warm May evening in Tel Aviv, two nurses arrived at Ben Gurion Airport, each looking somewhat anxious as they waited for the other. The nurses, one Israeli, one Palestinian, had never met. One had come from Haifa, the other from the West Bank. They were about to embark on a journey together to participate in a Israeli-Palestinian nursing education collaborative in Boston.

Professional development manager, Donna Perry, RN (left) with visiting nurses, Sister Mary Subhi Yusef, RN (Palestinian; center), and Shlomit Dubovi, RN (Israeli).



(Photo provided by staff)

Though I have long wanted to host Israeli and Palestinian nurses together at MGH, only recently did an opportunity to fulfill that wish present itself. While attending a meeting in Jerusalem of Israelis and Palestinians working on joint healthcare projects, I met some wonderful people who were quietly working to provide health care and forge international relationships. One of these individuals was Professor Michael Silbermann, MD, executive director of the Middle East Cancer Consortium (MECC). The MECC is a unique partnership between the United States and the health ministries of Cyprus, Egypt, Israel, Jordan, the Palestinian Authority, and Turkey that sponsors collaborative research and education projects to reduce the incidence and impact of cancer in the Middle East. Its work is supported by The National Cancer Institute of the NIH (see related article on page 6).

I spoke with Professor Silbermann about the possibility of bringing Israeli and Palestinian nurses to MGH for an educational experience through our International Nurse Consultant Program. I crafted a formal proposal for a collaborative program that would involve MGH, the Middle East Cancer Consortium, the National Cancer Institute, and The Institute for Nursing Healthcare Leadership. Last November, I learned that funding for the program had been approved, and we began planning for the first visit.

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The first two nurses selected for the program were Shlomit Dubovi, RN, head nurse, from the inpatient Chemotherapy Unit of the Oncology Department of Rambam Health Care Campus in Haifa, and Sister Mary Subhi Yusef, RN, from the Education Department of the Palestinian Ministry of Health who teaches at Ibn-Sina Nursing & Midwifery College in Ramallah, on the West Bank.

During their time at MGH, Dubovi and Yusef had an opportunity to spend time with senior vice president for Patient Care Services, Jeanette Ives Erickson, RN, and executive director of The Institute for Patient Care, Gaurdia Banister, RN. Their visit coincided with Nurse Recognition Week, which allowed them to attend many of our educational events, presentations,

Those of us at MGH who spent time with them, found it enriching to hear nursing strategies from our Israeli and Palestinian colleagues. Dubovi and Yusef found their experience valuable, not only from a clinical perspective but also in terms of developing their relationship with one another.

and Research Expo. They met with leaders and clinicians from Oncology and Palliative Care. Their impressions: "Staff were so welcoming. They gave us pamphlets, booklets, guidelines, and handouts. They were so generous."

Our guests had a chance to sit in on several conversations related to diversity, cultural sensitivity, and cultural competence, including a lunch in the Chaplaincy with Imam Talal Eid; Rabbi Benjamin Lanckton; director, Mike McElhinny, MDiv; and Diversity Committee member, Firdosh Pathan, RPh. Both Dubovi and Yusef found our interfaith chaplaincy model and our efforts to support patients' spirituality very inspiring.

Following their visit to MGH, Dubovi and Yusef spent time at the Dana Farber Cancer Institute and Beth Israel Medical Center. They visited leaders at the Boston College William F. Connell School of Nursing

and had dinner with Sister Callista Roy, RN. Yusef teaches the Roy Adaptation Model in her nursing curriculum, so it was a thrill for her to meet Roy and hear about her theory first-hand.

It wasn't all work. Dubovi and Yusef got to do some sight-seeing and have some fun while in America. We spent an afternoon at Sturbridge Village and went to Maine and walked along the ocean in Ogunquit. They accompanied me to visit my family, and we enjoyed a good old-fashioned American cook-out on Mother's Day.

Everyone who participated in this collaborative program benefited from the experience. Yusef felt the program strengthened her ability to educate her students in the areas of oncology and palliative care. Dubovi said she gained knowledge she feels will enhance her leadership skills as a nurse manager. Those of us at MGH who spent time with them, found it enriching to hear nursing strategies from our Israeli and Palestinian colleagues. Dubovi and Yusef found their experience valuable, not only from a clinical perspective but also in terms of developing their relationship with one another.

This is how they described their visit:

The course helped us to grow in many areas not just in our profession as nurses but also in our relationship. Sister Mary is Palestinian from Jerusalem and Mrs. Shlomit, Israeli from Haifa. We do not know each other before. The first time that we met was in the airport. Nobody in Boston could believe because they notice that we are so close, together we shared the same beautiful comfortable apartment, eating together, going to the hospital together ... so each day our relationship increase, our respect, understanding and love increase, the two of us we believe in our same mission as nurses. To be a nurse means we should nurse everybody without looking at their religion, race, culture, belief...

Shortly after the program ended, a research project I'm working on took me to Israel and Palestine. While there, I was able to visit my new friends. I visited Shlomit in Haifa, my first visit to that beautiful city on the sea. And I spent a lovely afternoon with Sister Mary in Ramallah. It was a wonderful, enriching experience to be able to meet and share time with these two incredible nursing leaders.

Cancer consortium takes MGH nurses to Middle East

—by Mandi Coakley, RN, staff specialist

Two MGH nurses, staff specialist, Mandi Coakley, RN, and clinical nurse specialist, Anne-Marie Barron, RN, had an opportunity to travel to Larnaca, Cyprus, May 8–10, 2009, to attend the fifth annual conference of the Middle East Cancer Consortium (MECC). The conference brings together healthcare professionals from Israel, the Palestinian territories, Cyprus, Saudi Arabia, Jordan, Lebanon, Turkey, and Egypt to explore ways to ease suffering among cancer patients in the region. Created in 1996 under the Clinton administration, MECC, supported by the National Cancer Institute, meets annually on neutral ground to share best practices across borders in the hopes of improving the care of cancer patients.

The focus of this year's conference, "Psycho-oncology: alleviating fear, frustration and sense of loss through non-pharmacological treatment modalities,"

fell right into Coakley and Barron's area of expertise. They presented their work on integrating Therapeutic Touch into nursing practice on Ellison 14 and Ellison 11 and shared an overview of research being conducted at MGH. Coakley and Barron have taught many nurses how to provide Therapeutic Touch and authored the article, "Promoting the Integration of Therapeutic Touch in Nursing Practice on an Inpatient Oncology and Bone Marrow Transplant Unit," along with Ellen Fitzgerald, RN, and Ellen Mahoney, RN, that was published in the *International Journal for Human Caring* in 2008.

Conference participants had an opportunity to experience and provide Therapeutic Touch to one another. Says Coakley, "There was an openness and receptiveness among attendees that Therapeutic Touch could provide comfort at the end of life. Participants enthusiastically embraced Therapeutic Touch as an intervention that could alleviate suffering for their patients. They were very anxious to try it."

Attendees from Middle Eastern countries shared stories about the state of oncology and palliative care in their countries and described the challenges they face. They described a lack of human and medical resources, which makes caring for patients at the end of life especially challenging.

For more information, contact Mandi Coakley, RN, at 6-5334.

Staff specialist, Mandi Coakley, RN (4th from left; back row), and clinical nurse specialist, Anne-Marie Barron, RN (4th from left; front row), with attendees of the Middle East Cancer Consortium



(Photo provided by staff)

Who has a greater impact on the patient experience than we do?

—By Richard Corder, senior director, Service Improvement

Guided by the needs of our patients and their families, we strive 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.

Our ability to fulfill our promise of 'Excellence Every Day' relies on our ability to listen to our patients, hear what they're telling us, and design our care and services to meet their needs.

These words are more than just a mission statement. They are the framework, the foundation, the essence of what we do as caregivers and healthcare professionals. Without a clear understanding of the needs of our patients and families and a commitment to give the best of ourselves on their behalf, we would have a very shallow healthcare system, indeed. Our ability to fulfill our promise of 'Excellence Every Day' relies on our ability to listen to our patients, hear what they're telling us, and design our care and services to meet their needs.

But it doesn't stop there. The road to Excellence is paved with vigilance, constancy, and attention. The thing about excellence is—there's always room for improvement. We must hold ourselves to the highest standards of quality and safety and work every day to ensure we meet those standards.

Every employee at MGH is responsible for the patient experience. Every member of the organization plays a part in how patients experience the care we provide. Our patients are the first to tell us it's not always 'the big things' that have the greatest impact. Sometimes, the smallest acts of kindness and consider-

ation make the biggest difference. But good or bad, what patients tell us informs our work.

We've heard from patients that noise is an issue in some areas of the hospital. We've heard that a clean and welcoming physical environment helps ease anxiety. Anticipating patients' needs increases satisfaction. Effective communication fosters honesty and openness. Responding quickly to patients' call bells contributes to both physical and emotional well-being.

This is powerful information. This is nothing short of a blueprint for achieving Excellence Every Day. As we begin to think more personally about how each of us can impact the patient experience, let us truly be 'guided by the needs of our patients and their families.'

In the coming months, you may begin to see some patient comments in various forms throughout the hospital. If you're moved or inspired by what you see, please feel free to share your thoughts. Let me and your colleagues know what you're doing to improve the patient experience. Let us know how we can help you. We all own the patient experience.

I'm interested in hearing your thoughts, comments, and ideas. Please feel free to contact me, Richard Corder, senior director, Service Improvement at 4-2838.

Nurse's care provides joyful moments for new mom and 'nana'

Every time I talk with a parent for the first time whose baby has been whisked away for acute care, I try to present a clear and complete picture of the baby's status and plan of care. I am methodical in that respect; I always try to put myself in the parent's place.

My name is Elizabeth Warren, and I am a staff nurse in the Neonatal Intensive Care Unit. Weighing in at more than ten pounds, 'Richard' was born at a community hospital. He developed respiratory distress in his first hour of life, necessitating a transport to our Neonatal Intensive Care Unit (NICU). As Richard's admitting nurse, the first observation I made was how large he was compared to most of the other newborns. He had fair skin, light blonde hair, and beautiful blue eyes. Richard's chest X-ray was consistent with respiratory distress syndrome; his lungs needed ventilator support. He presented with transient labile blood pressures and hypoglycemia despite multiple dextrose boluses. The medical team and I had our hands full trying to determine what was causing his respiratory distress and glucose instability. Sepsis was at the top of the list—but Mom had had good prenatal care, normal glucose screening during pregnancy, normal labor, and no elevated temperatures.

Toward the end of my shift, I had the opportunity to meet Richard's mom via telephone. She was still a patient at the community hospital. Every time I talk with a parent for the first time whose baby has been whisked away for acute care, I try to present a clear and complete picture of the baby's status and plan of care. I am methodical in that respect; I always try to put myself in the parent's place. Richard's mom, Sharon, asked very good and appropriate questions, and naturally expressed concern about Richard's well-being. I tried to reassure her by describing how he was nestled



Elizabeth Warren, RN, staff nurse,
Neonatal Intensive Care Unit

in his bed with colorful boundaries and how comfortable he appeared even with the ventilator and IV pump at his bedside.

Toward the end of our conversation, I assured Sharon that Richard would return to the community hospital once he was successfully removed from the ventilator and his electrolytes were consistently within the normal range. That's when Sharon mentioned that her mother was an inpatient here at MGH. She explained that Helen, her mother, had T-cell lymphoma and was receiving her care here. Sharon said it would be better if Richard stayed at MGH so she could visit them both at the same time.

I could only imagine how difficult it must have been for Sharon—her mother in the hospital with cancer and her first-born son in the NICU. I wanted to brighten her spirits, so I told her I would take a picture of Richard and bring it up to his 'nana' so she could see her grandson. I could hear the surprise and appreciation in her voice.

By the end of my shift, Richard's respiratory status and blood pressure were stable, but he was still having

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blood glucose issues. Fortunately, his blood work was negative for infection. It had been a busy day, and I was tired, but I couldn't forget the promise I'd made to Sharon to bring her mom a picture of her grandson.

As I rode in the elevator and got closer to the unit where Helen was staying, I began to feel nervous and worried about what I might find. What would I say to her? But I looked at Richard's picture, his beautiful features, and realized that he would do all the talking. I stopped at the nurses' station to make sure it was okay for me to visit. I entered her room with a knock and introduced myself as the proud nurse who was taking care of her brand new grandson. Her smile glimmered, and she was instantly captivated by the picture of Richard. I told her all about his beautiful blue eyes and how big he was—the biggest boy in the NICU! We chatted for a few minutes, and I could tell how tired she was, so I said good-bye and promised to keep her posted on Richard's status.

Richard was infection-free and removed from the ventilator in a matter of days. He continued to have intermittent hypoglycemia and poor oral feeding. As it happened, Richard stayed in the NICU for five more weeks. As one of his primary nurses, I got to know Sharon quite well, and we had many long talks about his status. Richard underwent a number of genetic, neurologic, and metabolic tests that resulted in no abnormal findings—nothing explained why he wasn't taking a minimum volume of breast milk. He was receiving supplements via an indwelling nasogastric tube.

One afternoon when I came in, I found a visibly upset Sharon. She said an intern had spoken with her about the possibility of (surgically) placing a gastric tube so Richard could receive supplements after bottle-feeding. She said the intern had told her that Richard wouldn't be able to go home with an indwelling nasogastric tube. As a general rule, babies are not discharged with nasogastric tubes, however, there are exceptions to this rule, especially when parents express a willingness to learn and demonstrate competency at handling the tube. Discharging an infant home with a nasogastric tube is appropriate if the need for supplemental feeding is felt to be short term. Long-term feeding does require a gastric tube, but I didn't think Richard needed a gastric tube. I and some of his other primary nurses felt Richard would only need supplemental feeding for a short time. I thought if he went home and was fed consistently in the peace and quiet of his home, he would turn the corner. I knew from my interactions with both parents that they would be

more than capable of handling the nasogastric tube. I spoke with the attending physician who, after careful consideration, agreed that Richard could be discharged with an indwelling nasogastric tube. I spoke with the intern who had talked to Sharon and explained that, while it wasn't the norm, it wasn't out of the realm of possibility to discharge a patient with a nasogastric tube. Then I spoke to Sharon, who was *very* relieved.

Sharon had been keeping me informed about her mom's condition, which, sadly, was not improving. Helen was too ill to visit Richard in the NICU, so one day I arranged with the medical team to take Richard to visit his nana. He was totally stable and working on his bottle feeds. When Sharon and her husband came to visit, I gave them the news—Richard was going on a field trip! So off we went with Richard dressed in a handsome new outfit. Sharon walked in to her mom's room and said, "We have a special visitor, Ma!"

Helen's face lit up with sheer joy. Sharon put Richard in Helen's arms and she snuggled with him unable to take her eyes off him. It was one of the most joyful moments I've experienced as a nurse.

When we returned to the NICU and Sharon was preparing to leave, she gave me a big hug and thanked me for arranging it so her mom could meet Richard. I was touched by her gratitude. After my shift, I reflected back on the day with such pride. I'm proud to be a nurse, especially in the NICU where our families' needs are sometimes as significant as their baby's.

Sharon and I have kept in touch since Richard returned home. He only needed the nasogastric tube for less than two weeks! Unfortunately, Helen passed away a few months after that visit in her hospital room. It saddens me to think that Richard will never again see his nana. But I feel extraordinarily blessed to have been part of the joy when they met for the first time.

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

Holistic care. Liz recognized the need for physical and emotional care as she tended to the many needs of Richard and his family. She provided complete and accurate information to Richard's mom right away, knowing the stress she must have felt being separated from her newborn so soon after giving birth. She advocated for Richard to receive nutrition via the least invasive option. And she sensitively and creatively arranged time and space for Richard and his parents to bond and for Richard to meet his ailing 'nana.' What a wonderful example of caring for the 'whole' person.

Thank-you, Liz.

Helen's face lit up with sheer joy. Sharon put Richard in Helen's arms and she snuggled with him unable to take her eyes off him. It was one of the most joyful moments I've experienced as a nurse.

OB simulation class gives nurses hands-on experience

—by Patricia M. Connors, RN, perinatal clinical nurse specialist

One of the advantages of simulation is that it provides a 'safe zone' where mistakes can be made and learning can occur without anyone being harmed.

Mid-way through the second year of the Obstetrical Simulation Program, many OB nurses have become intimately acquainted with Noelle, the computerized mannequin who's at the center of a number of emergency scenarios enacted in the controlled setting of the Simulation Center on POB4. Noelle, who's capable of giving birth and simulating several obstetrical complications and resuscitation emergencies, resides in a special room designed to replicate the labor, delivery, and postpartum setting. Neonatal and fetal mannequins are also part of the interactive simulation program.

Obstetrical nurses are required to participate in one four-hour simulation session per year. This includes staff of Labor & Delivery, the postpartum unit, and the Newborn Nursery. Approximately 200 nurses have attended at least one session. Simulation exercises stress the importance of teamwork, role clarity, and effective communication. Scenarios include both maternal and neonatal cardiac arrest, postpartum hemorrhage, maternal seizures, and other 'unanticipated' complications. Since maternal and neonatal cardiac arrests are rare in the OB setting, simulation is an excellent way to review and practice resuscitative measures, work with the specialized equipment, and improve communication techniques. Nurses are able to see, touch, and practice with pediatric and adult code carts and use the cardiac defibrillator. According to staff evaluations, re-enacting cardiac arrest is one of the most beneficial aspects of the program. Debriefing sessions following each scenario help determine what areas require more practice and review.

This year, a scenario addressing loss and bereavement has been added to the program, giving staff an opportunity to practice evaluating and facilitating the grieving process when a mother loses a baby. Many different scenarios are played out that explore a variety of coping situations for the grieving mother. Participants share their own feelings and experiences and offer suggestions about how to manage these challenging situations.

Simulation scenarios, by their very nature, are stressful for participants. Responding to an emergency, practicing in unfamiliar surroundings, the uncertainty of the outcome, and watching yourself on videotape can be extremely anxiety-provoking. Faculty support participants by emphasizing that no one fails. One of the advantages of simulation is that it provides a 'safe zone' where mistakes can be made and learning can occur without anyone being harmed.

The OB Simulation Program was developed by Pat Connors, RN, perinatal clinical nurse specialist, with the assistance of Maryann Columbia, RN. Kim Francis, RN, clinical nurse specialist for the Newborn & Special Care Nursery, Beth Nagle, RN, Jeanne McHale, RN, Gail Alexander, RN, and Brian French, RN of the Simulation Center participate in many of the scenarios.

At present, all roles (obstetrician, neonatologist, anesthesia, and code team members) are played by nurses, but in the future, we hope to have interdisciplinary participation to enhance the realism of the simulation.

For more information about the OB Simulation Program, call Patricia Connors, RN, at 4-4697.

KnowledgeLink: the quick, easy way to access patient-education materials

If you've been looking for a quick, easy, one-stop source for patient-education materials, look no further: KnowledgeLink is here.

If you've been looking for a quick, easy, one-stop source for patient-education materials, look no further. KnowledgeLink is here. From CAS or eMAR, just enter a topic in the Search box and select Patient Info. KnowledgeLink will automatically bring you to Care Notes or DrugNotes. Can't find what you're looking for? Choose a resource from the left side of the screen, including:

- MD Consult
- PCOI handouts
- Up to Date
- MedlinePlus
- And more...

Once you select a resource, KnowledgeLink automatically displays patient-education materials available on the subject.

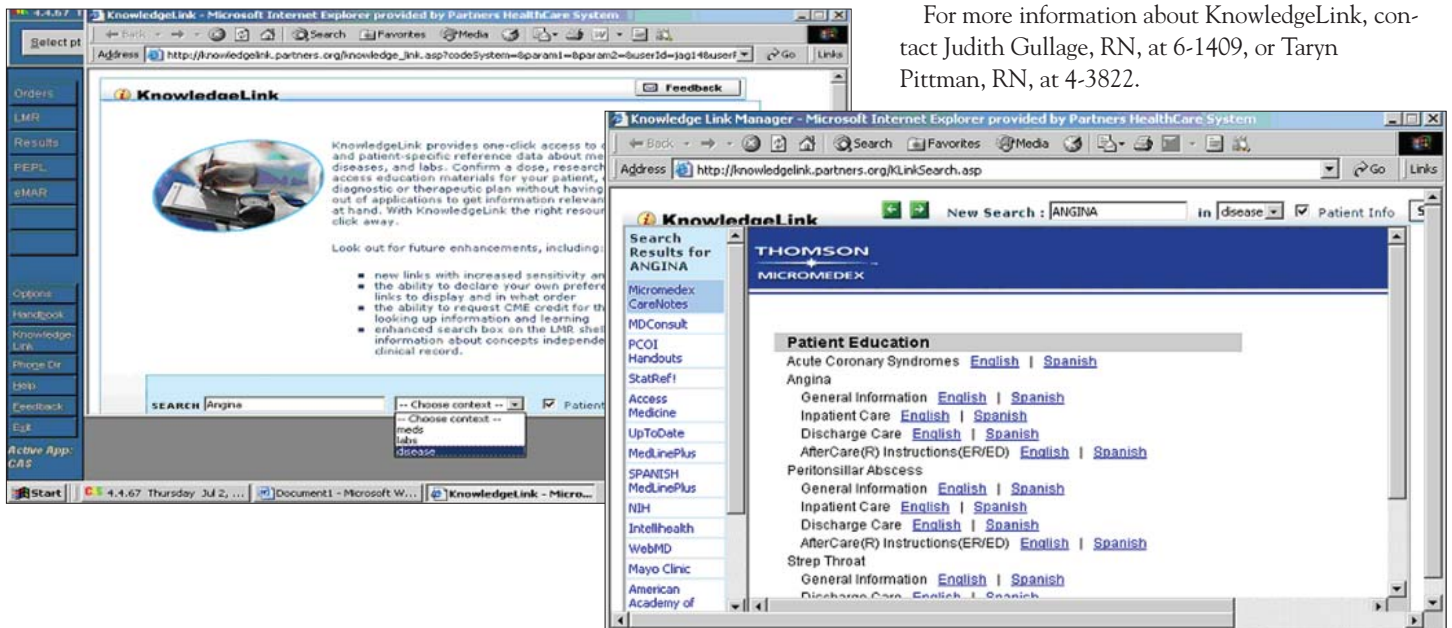
To access KnowledgeLink in CAS:

- Select the KnowledgeLink tab on the left side of the screen
- Type in a search word
- Choose Meds, Labs, or Disease from the drop-down menu
- Click the Patient Info box, then hit Search
- CareNotes or DrugNotes will be displayed. If you select a new resource from the left, KnowledgeLink will show patient-education materials on that subject.

In eMAR:

- Click on any KnowledgeLink icon
- Type in a search word
- Choose Meds, Labs, or Disease from the drop-down menu
- Click the Patient Info box, then hit Search

For more information about KnowledgeLink, contact Judith Gullage, RN, at 6-1409, or Taryn Pittman, RN, at 4-3822.



'Happenings' with The Knight Nursing Center

—by Gino Chisari, RN, director,
The Norman Knight Nursing Center for Clinical & Professional Development

I'm young enough to vividly remember the 1970s, but old enough to recall them with a romanticized fondness. It was during the 70s that I launched my nursing career, so for me, the era will always hold a special place in my heart. This was around the time I first saw the rock musical, *Jesus Christ Superstar*. Productions like *Jesus Christ Superstar*, *Hair*, and *Tommy* were considered revolutionary approaches to traditional theater.

One song that has stayed with me from that era is, *What's the Buzz, Tell Me What's Happening*. It's an upbeat song that was used to capture the audience's attention and sweep us into the fabric of the story.

I often think of this song when I hear the word, 'happening' or 'buzz' in the context of something new

and exciting. Recently, MGH has been 'abuzz' with the launching a new program called, Happenings with the Knight Nursing Center. Created by staff of The Norman Knight Nursing Center for Clinical & Professional Development, 'Happenings' are focused, unit-based presentations providing need-to-know information regarding practice, policy, and procedure changes. These presentations are not a substitute for annual required training or in-service programs, but they are a great way to stay informed about changes related to safe, high-quality, patient-centered care.

Happenings with The Knight Nursing Center are currently being held for off-shift and weekend nurses and support staff. They typically last 20–30 minutes and are scheduled by nursing directors or clinical nurse specialist to ensure appropriate timing for staff. Topics have included, documentation, restraints and documentation, point-of-care-testing, high-alert medications, universal protocol, National Patient Safety Goals, and HealthStream for our patient care associates and unit service associates.

Happenings have been well received by staff. Nurses and support staff have expressed enthusiasm and appreciation for educational programs offered at times convenient for them.

Staff of The Knight Center continually challenge themselves to think of new ways to deliver high-quality educational programs. In the future, Happenings will expand to include weekday staff, and a 'nice-to-know' component will be introduced over and above the current 'need-to-know' topics. Nice-to-know sessions will focus on attaining new or additional nursing competencies.

So, that buzz you hear is Happenings with The Knight Nursing Center. Stay tuned, and for more information, call 3-6530.

Professional development specialist, Sheila Burke, RN, and senior educational development & project specialist, Tom Drake, present recent 'Happening' with the Knight Nursing Center.



(Photo provided by staff)

New code of conduct seeks to avoid conflict of interest

Effective July 1, 2009, pharmaceutical and medical device manufacturers are subject to new regulations. The Massachusetts Pharmaceutical and Medical Device Manufacturer Code of Conduct is designed to limit the interactions medical and pharmaceutical companies can have with healthcare providers. The new law requires companies to report payments for sales and marketing activities to the Department of Public Health, which posts the names of the recipients as well as the value, nature, and purpose of the payments on a public website.

Question: Who is affected by the code?

Jeanette: This new law affects healthcare practitioners who are authorized to prescribe or dispense prescription drugs or medical devices, and who are licensed to provide health care in Massachusetts. Advanced practice nurses, certified nurse-midwives, psychiatric nurse specialists, physician assistants, physicians, partnerships or corporations, such as an office practice and employees of office practices, are all considered healthcare practitioners under the new law. Payments given to recipients such as hospitals, nursing homes, and pharmacists will be reported to the Department of Public Health.

Question: What do we have to report?

Jeanette: Companies must report payments, fees, compensation, subsidies, or any other economic benefit valued at \$50 or more. Companies are required to identify the names of the recipients, the amount paid, and the nature and purpose of the payment. Some examples of reportable payments include:

- reimbursement for expenses in connection with product training
- speaking on behalf of a company if the company pays you directly
- compensation for services such as consulting
- donations to recipients

Question: Do all payments need to be reported?

Jeanette: Companies do *not* have to report money given for research projects, prescription drug samples, demonstration units exclusively for patient use, or items used for charity care.

Question: How often do we have to report payments?

Jeanette: Companies have to start tracking these payments as of July 1, 2009. The first report is due July 1, 2010, and reports will have to be filed every July 1st thereafter.

Question: Are there other provisions of the code we should know about?

Jeanette: Companies may only provide meals as part of informational presentations, not for entertainment purposes. Companies are prohibited from distributing promotional items such as pens, coffee mugs, etc. Partners is in the process of reviewing its policies pertaining to gifts, meals, and entertainment, and is likely to prohibit Partners staff from receiving these sorts of items in the future.

For more information about this new code of conduct, go to the Massachusetts Department of Health and Human Services website at www.mass.gov/dph/pharmamed or contact John Belknap at 4-9725.

Announcements

New Perspectives on Mind and Body

2009 MGH Nurses Alumnae Fall Reunion Educational Program co-sponsored by the MGH Institute of Health Professions School of Nursing

Friday, September 25, 2009
Simches Auditorium
8:00am-4:30pm

\$20 before July 1, 2009
\$30 after July 1, 2009

6 nursing contact hours

Must register by
September 11, 2009

For more information,
call 6-3114.

Jeremy Knowles Nurse Preceptor Fellowship

Call for Applications

Applications are now being accepted for The Jeremy Knowles Nurse Preceptor Fellowship. The fellowship recognizes exceptional preceptors for their excellence in educating, inspiring and supporting new nurses or nursing students in their clinical and professional development.

The one-year fellowship provides financial support to pursue educational and professional opportunities.

Applications are due
by September 8, 2009.

For more information, contact your clinical nurse specialist or Mary Ellin Smith, RN, at 4-5801.

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.

First National CNS Week September 1-7, 2009

Celebrating 72,000 clinical nurse specialists across the nation

Clinical nurse specialists work:

- at the bedside to improve outcomes and evidence-based practices
- with other nurse colleagues to establish best practice models, create and monitor policies, and design nursing practice standards
- with other hospital leaders to enhance quality and patient safety

A clinical nurse specialist is:

- a nurse leader with a master's degree or doctorate in clinical nursing
- a clinical expert in a specialty area
- a vital link in translating new research into nursing practice at the bedside
- a pioneer in hospital programs that enhance quality and patient safety
- an essential resource to colleagues across disciplines
- an innovator who drives improvements in a complex environment
- a "systems thinker" who looks at the big picture

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.

Clinical pastoral education fellowships for healthcare providers

The Kenneth B. Schwartz Center and the department of Nursing are offering fellowships for the 2010 MGH Clinical Pastoral Education Program for Healthcare Providers

Open to clinicians from any discipline who work directly with patients and families or staff who wish to integrate spiritual caregiving into their professional practice.

The Clinical Pastoral Education Program for Healthcare Providers is a part-time program with group sessions on Mondays from 8:30am-5:00pm. Additional hours are negotiated for the clinical component.

Deadline for application is
September 1, 2009.

For more information, call
Angelika Zollfrank at 4-3227.

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Submissions
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For more information, call:
617-724-1746

Next Publication
September 3, 2009

Educational Offerings – 2009

August

27

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

September

1

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

September

2

Neuroscience Nursing
Certification Course
Day 1: Simches Conference Room
3-120
8:00am–4:30pm
Contact hours TBA

September

3

CVVH Review and
Troubleshooting for the
Experienced CVVH Provider
Founders 311
8:00am–2:00pm
Repeated: 4:00–10:00pm
No contact hours

September

9

BLS/CPR Certification for
Healthcare Providers
Founders 325
8:00am–12:30pm
No contact hours

September

9

Pediatric Simulation Program
Founders 335
12:30–2:30pm
Contact hours: TBA

September

9

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

September

9

Nursing Research Committee's
Journal Club
Yawkey 2-210
4:00–5:00pm
Contact hours: 1

September

10

BLS/CPR Re-Certification
Founders 325
7:30–10:30am and 12:00–3:00pm
No contact hours

September

10

Phase I Wound-Care Education
Program
Simches Conference Room 3-120
8:00am–4:30pm
Contact hours: 6.6

September

11, 14, 15,
21, 25 & 29

Greater Boston ICU Consortium
Core Program
Faulkner Hospital
7:30am–4:30pm
Contact hours: TBA

September

14 & 21

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

September

15

Code Blue: Simulated Cardiac
Arrest for the Experienced Nurse
POB 448
11:00am–3:00pm
Contact hours: TBA

September

16

Simulated Bedside Emergencies
for New Nurses
POB 419
7:00am–2:30pm
Contact hours: TBA

September

17

Preceptor Development: Learning
to Teach, Teaching to Learn
Charles River Plaza
8:00am–4:30pm
Contact hours: 6.5

September

17

Nursing Care for Respiratory-
Compromised Patients
Bigelow Amphitheater
12:00–4:00pm
No contact hours

September

21

Assessment and Management
of Psychiatric Problems
in Patients at Risk
O'Keefe Auditorium
8:00am–4:30pm
Contact hours: TBA

September

21 & 22

Intra-Aortic Balloon Pump
Day 1: VA Boston HealthCare
System, West Roxbury
Day 2: Founders 311
7:30am–4:30pm
Contact hours: TBA

September

22

Simulated Critical Care
Emergencies
POB 448
7:00–11:00am
Contact hours: TBA

September

23 & 24

PALS Certification
Simches Conference Room 3-120
Day 1: 7:45am–4:00pm
Day 2: 7:45am–3:00pm
No contact hours

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

Grass-root efforts are always greener...

—by Stephanie Cooper, educational development and project specialist

Operations associate, Holly Moulton's, interest in the recycling efforts at MGH began on Earth Day, 2008, when she stopped by a table in the Main Corridor to ask a question about recycling. A member of the Raising Environmental Awareness League (REAL), a grass-roots organization founded in 2002 to educate and inform employees around environmental issues, answered her question and mentioned that the committee was open to all members of the MGH community.

A few months later, Moulton attended a meeting and became a member of REAL. Soon after, she joined the Recycling Subcommittee. Says Moulton, "I've always wanted to contribute to the well-being of the planet, and recycling is an easy way to do that every day. Through REAL, I learned that not only do our efforts help the planet, but they help MGH, as well. Last year, the hospital saved a hundred thousand dollars by recycling pa-

per and other products rather than disposing of them. We also saved twelve thousand trees and eighty thousand cubic feet of landfill. That's pretty impressive."

Recently, Moulton invited OR nurse, Ida Aiken, RN, chairperson of the Recycling Subcommittee to attend a session of the OASIS (Operations Associates Services Insure Safety) program to share some information with her colleagues about the recycling efforts underway at MGH. Aiken shared that we're only recycling about 25% of what we could be recycling. MGH has been recycling paper for many years, and began recycling plastic in March of 2008. But, said Aiken, there's a lot more we can do.

MGH is committed to helping preserve the environment.

For more information about these efforts, contact Mary Ellen Halliwell at mhalliwell@partners.org. For information on how to obtain recycling bins and to learn what items can be recycled, go to the Environmental Services website on the MGH intranet and click on 'Greening MGH.'

Ellison 4 Surgical Intensive Care Unit
operations associate, Holly Moulton



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