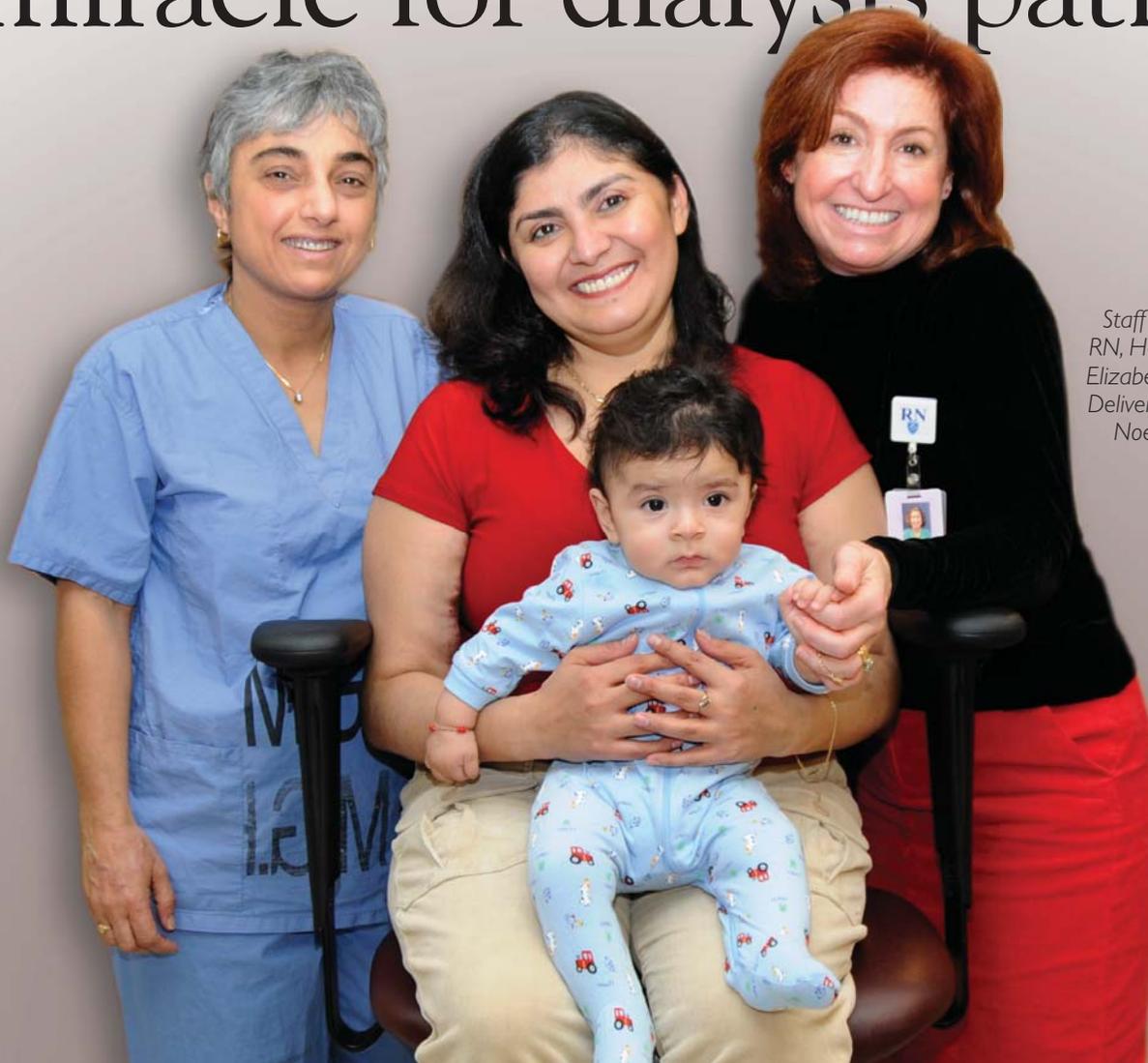


Caring

Headlines

February 19, 2009

Team effort produces small miracle for dialysis patient



Staff nurses, Karen Clark, RN, Hemodialysis (left); and Elizabeth West, RN, Labor & Delivery (right), with patient, Noemy Rivera and her son, Anthony

*See
story
on
page 5*

Medication Reconciliation:

*a critical element in continuity of care, an important
National Patient Safety Goal*

At MGH,
our medication-
reconciliation
process begins the
moment a patient
is admitted with
the creation of
a Pre-Admission
Medication List
(PAML).

Goal #8 of the Joint Commission's National Patient Safety Goals focuses on medication reconciliation. It states that healthcare organizations are responsible for accurately and completely reconciling medications across the continuum of care. Medication reconciliation simply means comparing the medications a patient *has been* taking with those that are prescribed upon or after admission to the hospital. Every care provider understands the importance of knowing what medications a patient is taking to ensure optimal outcomes, to avoid interruptions in the patient's medication regimen, and to avoid adverse drug interactions. This is the spirit and foundation of National Patient Safety Goal #8, which calls for healthcare institutions to:

- have a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization
- communicate and document the complete and reconciled list of medications to the next provider when a patient is referred or transferred from one organization to another. When a patient is discharged home, the complete and reconciled list of medications is provided to the patient's primary care provider, the original referring provider, or the known next provider of service
- provide and explain a complete and reconciled list of the patient's medications directly to the patient and/or family member (as needed) when the patient leaves the organization's care



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

- have modified medication-reconciliation processes in place in settings where medications are used minimally or prescribed for a short duration

At MGH, our medication-reconciliation process begins the moment a patient is admitted with the creation of a Pre-Admission Medication List (PAML). (Medication reconciliation is mandatory in the inpatient setting and is an essential part of many of our ambulatory practices, as well). The process is started by the physician who obtains a list of medications the patient has been taking prior to admission and enters them into the electronic PAML.

Once the PAML has been created, the nurse reviews the PAML with the patient to make sure the list is complete, including all over-the-counter medications, herbal remedies, vitamins, supplements, and cold remedies.

continued on next page

Medication reconciliation is a critical component of quality care. We are committed to meeting the standards set by the Joint Commission and to meeting our own high standards for medication safety.

From here, the list is reconciled by a pharmacist for inconsistencies or potential problems with dosages or adverse drug interactions. If any such inconsistencies are found, they're immediately communicated to the physician, discrepancies are addressed and corrected, and the PAML is updated to reflect those changes.

The PAML is reviewed at every significant juncture during the patient's hospitalization, including admission, transfer, and discharge. Every clinician responsible for a patient at the time he/she experiences a change in the level or location of services is responsible for reviewing and reconciling the PAML. Because patients' needs are constantly changing, it's imperative the PAML be kept up to date throughout the entire hospital stay.

When patients are discharged from the hospital, they're given a complete list of their medications. This list includes all the medications the patients is taking—those he/she was taking prior to admission, those that have been newly prescribed (short- and long-term), and any over-the-counter medications the patient will continue to take.

Since implementation of the electronic PAML two years ago, enhancements have been made to the program to make it easier to reconcile medications. Some of these enhancements include:

- a pictorial representation of pills to help clinicians identify certain medications when patients can't remember the names of the drugs they're taking

- the ability to sort drugs by class, making it easier to compare medications in two or more lists
- the ability to document more than one medication source (home, referring hospital, rehab, etc.) to help clarify and give context to information on the PAML

Other enhancement will be added in the near future, including:

- comparison reports for nurses and physicians
- a standardized patient medication discharge report

Patients can play a big part in ensuring accurate medication reconciliation by keeping a list of the medications they're taking (including dosage instructions and the reason the drug was prescribed). Patients should bring this list with them to every doctor's appointment and to the hospital if/when they're admitted.

Medication reconciliation is a critical component of quality care. We are committed to meeting the standards set by the Joint Commission and to meeting our own high standards for medication safety.

For more information about medication reconciliation, call Sally Millar, RN, director, PCS Informatics, at 6-3104, or consult the *MGH Clinical Practice & Procedure Manual*. For more information about any of the National Patient Safety Goals or our Excellence Every Day strategies, visit: <http://intranet.massgeneral.org/pcs/excellence/> or.

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March madness MGH style

New patient menu to roll out next month

—by Susan Doyle, RD, senior manager, Patient Food Services

Nutrition & Food Services is pleased to announce the roll-out of its new patient menu, scheduled for release in March. After months of data-collection, recipe-development, and taste-testing, the Menu Committee, chaired by Lorraine Allan, RD, senior manager for Food Production, has redesigned, revamped, and reinvigorated the patient menu.

Says Susan Doyle, RD, senior manager, Patient Food Services, “From extensive feedback throughout the MGH community, we learned what patients like and don’t like, we heard suggestions about how to

improve the look of the menu, and we heard what patients are looking for in terms of variety. We looked at patient demographics, length of stay among various patient popu-

lations, and diet restrictions, and we made changes accordingly.”

Effective next month, Nutrition & Food Services will offer a patient menu that changes every day over the course of seven days. That is, patients will see different options for lunch and dinner, and those options

will change from day to day throughout the week.

All hot entrees follow the *Guidelines for Healthy Eating* as outlined by the American Dietetic Association, the American Heart Association, and American Diabetes Association with respect to saturated fat and sodium. And all menu items are trans-fat free. The goal is to present a menu that meets the needs of the majority of patients, and more than 80% of patients at MGH are on a low-cholesterol, low-saturated-fat, low-sodium, or diabetic diets. The new menu respects the almost 200 different diet orders received by Nutrition & Food Services while recognizing the need for traditional ‘comfort foods’ and culturally sensitive selections.

The Menu Committee worked extensively with Speech, Language & Swallowing Disorders to better understand and meet the needs of dysphagia patients. The committee met with representatives from Pediatrics and other specialty areas to be sure they were addressing the nutritional needs of patient populations with distinct nutritional requirements. A special diabetic menu lists the grams of carbohydrates for each menu item to facilitate teaching and compliance with a diabetic diet.

In the spirit of perpetual quality improvement, Nutrition & Food Services is committed to the idea that satisfaction with patient menus is a journey not a destination. The Menu Committee will continue to meet regularly and seek feedback from staff and patients in an ongoing effort to give patients what they want while ensuring their diet is flavorful and nutritious.

For more information about the new patient menu, contact Sue Doyle, senior manager of Patient Food Services at 6-2579.

After months of data-collection, recipe-

development, and taste-testing, the Menu

Committee, chaired by Lorraine Allan, RD, senior

manager for Food Production, has redesigned,

revamped, and reinvigorated the patient menu.

Teamwork ensures safe delivery for mother and baby

—by Elizabeth P. West, RN, Labor & Delivery; and Karen J. Clark, RN, Hemodialysis

Recently, the Dialysis Unit had a rare opportunity to care for a patient who was pregnant with her first baby. Ms. Rivera, a 33-year-old, Spanish-speaking woman originally from El Salvador, had been receiving dialysis for three years due to Wegner's granulomatosis. Providing dialysis to a pregnant patient can be complicated because there are two patients instead of one, and often, pregnant women with renal disease have to deliver prematurely. Rivera was transferred to MGH during her 24th week of gestation. She came to us for out-patient dialysis hoping her baby could be delivered safely.

Rivera started receiving dialysis treatments in the Labor & Delivery Unit so the baby could be monitored for signs of fetal distress. It was exciting for staff on both the Dialysis and Labor & Delivery units to work together, to get to

know this patient, and to try to keep her well until the birth of her baby.

On Rivera's first day of dialysis, the nursing staffs of both units coordinated care while facing the challenges of learning new techniques and procedures. Throughout the days and weeks that followed, interpreters, social workers, and clinicians from other disciplines added to the continuity of care, and vigilant nursing assessment facilitated accurate identification of changes in Rivera's condition.

Dialysis patients sometimes experience extra fluid volume during the course of their dialysis treatments, and this fluid is removed based on a number of indicators. With a pregnant patient, we needed to factor in the weight-gain related to a developing fetus. If we removed too much fluid the baby could experience fetal distress; too little, and the mother could develop pulmonary edema or high blood pressure. So fetal and maternal monitoring were key.

Rivera's blood pressure had to be well-controlled. Water-soluble vitamins had to be replaced. Epogen and iron supplements were increased to prevent anemia. And Rivera's dialysis treatments were increased from three to five times per week to keep her blood chemistry, blood pressure, and fluid volume as close to normal as possible.

During Rivera's 33rd week of pregnancy, she developed worsening hypertension and an unrelenting cough. Physicians from Pulmonary and Surgery worked with nurses and physicians from Obstetrics and Hemodialysis, and Rivera was transferred to the Surgical ICU to better monitor her condition. Nurses from the Dialysis Unit continued her dialysis treatment, and nurses from Labor & Delivery continued her fetal monitoring. After one night in the SICU, it was thought that Rivera's condition might improve if her baby were delivered. With the help of teamwork and collaboration of clinicians in numerous disciplines, Rivera gave birth to a small but healthy baby boy. Weighing in at three pounds, 13 ounces, Anthony Rivera was the first baby born at MGH to a dialysis patient.

Caring for Rivera was a thrilling experience for everyone involved. It was wonderful to work with nurses and physicians from other specialties to bring a healthy infant into the world. We believe it was one of MGH's finest moments.

Baby, Anthony, weeks after meeting everyone's great expectations



(Photo provided by staff)

What you need to know about the Rapid Response Team

Question: What is the Rapid Response Team?

Jeanette: The Rapid Response Team is a team of clinicians who bring clinical expertise to the patient's bedside, quickly, when needed. At MGH, the team consists of the medical or pediatric senior resident, the clinical nursing supervisor, and the charge respiratory therapist.

Question: What is the purpose of the Rapid Response Team?

Jeanette: The purpose of the Rapid Response Team is to increase awareness around early recognition of signs of deterioration and triggers (clinical indicators that an acute or unexpected change has occurred); to provide support to staff; and to assist with patient-assessment, stabilization, and transfer.

Question: Why do we have a Rapid Response Team?

Jeanette: We know that warning signs can appear sometimes six to eight hours prior to a critical event. Recognizing significant changes in a patient's condition and activating the Rapid Response Team when additional resources are needed to respond to those changes could prevent further deterioration and improve the outcome for the patient.

The Joint Commission's National Patient Safety Goal #16 (Improve Recognition and Response to Changes in a Patient's Condition) states that: "The organization selects a suitable method that enables healthcare staff to directly request additional assistance from specially trained individual(s) when the patient's condition appears to be worsening."

Question: In what situations would we call the Rapid Response Team?

Jeanette: The patient's care team should always be informed first. If the care team is unavailable, if you have concerns that aren't being addressed, or if you feel something "just isn't right," then you should call the Rapid Response Team. It's better to call the Rapid Response Team even if they're not needed than incur serious consequences for patients by not calling. When in doubt, call.

Question: How does the Rapid Response Team fit into the existing emergency response system at MGH?

Jeanette: The Rapid Response Team is an additional resource. It doesn't replace existing emergency response systems, such as the code team, the airway consult team (RICU consult), the stroke team, and others.

Question: Is the Rapid Response Team available throughout the entire hospital?

Jeanette: Yes, the Rapid Response Team is available to staff, patients, and families hospital-wide and includes a pediatric team. To avoid delays, ambulatory areas are encouraged to access current systems, such as the Emergency Department, code blue, and direct admission when triggers of an acute event are identified.

For more information about the Rapid Response Team, speak with your supervisor or contact Colleen Snyderman, RN, at 4-4920.

continued on next page

The Waiting Room Reader, a little light reading for patients and families



The *Waiting Room Reader: Stories to Keep You Company*, is a collection of stories that focuses on life's gifts and pleasures. It was created to help fill the time and lift the spirits of patients and family members who spend a lot of time in hospital waiting rooms.

The introduction to *The Reader* tells us: "Like you, we too have been patients in waiting rooms of doctors' offices and hospitals. Sometimes for routine care, other times for critical care. We too have waited for X-rays or our annual physical. We too have undergone surgeries and waited long hours alone while a loved one drifted in and out of surgery-induced sleep. In all

cases, we've needed patience, laughter, and hope. In that spirit, we have gathered a collection of stories that hopefully, will make your wait seem shorter."

The Reader was made possible by the CavanKerry's GiftBooks outreach initiative, an extension of the Laurel Books: Literature of Illness and Disability imprint co-sponsored by The Gold Foundation with support from The Liana Foundation, Sandra O. Gold, president, Joan Cusack Handler, publisher.

Copies of *The Waiting Room Reader* will be available in all waiting rooms, the Gray Family Waiting Room, and the Blum Patient & Family Learning Center. For more information about *The Reader*, call 718-601-0757.

Fielding the Issues (continued)

Question: Who can activate the team?

Jeanette: Anyone can call the Rapid Response Team at any time by calling the Code/STAT line at 6-3333. State whether you need an adult or pediatric response, and provide the name and location of the patient care unit, room number, and contact person. The team will arrive within five to ten minutes.

Question: Should I call the Rapid Response Team before calling another emergency response team?

Jeanette: No. If you need a specific emergency response team, such as the Code Team, or the Acute Stroke Team, you should call them first. A code blue should always be called for cardiopulmonary arrest.

Question: Is the Rapid Response Team the same as the Central Resource Nursing Team?

Jeanette: No. The Central Resource Nursing Team, formerly known as the Rapid Response Team will continue to offer the same services, assisting staff with fluctuations in workload and acuity and providing clinical oversight for patients traveling to testing and interventional areas.

Question: Can family members call for assistance when they perceive a change in a patient's condition?

Jeanette: Patients and family members are encouraged to raise their concerns with the primary nurse. Notices are being placed on patient care units that read:

During your hospital stay we encourage you to:

- ask questions if there's anything you don't understand about your or your loved one's care
- let staff know if you're concerned about any changes in your or your loved one's condition

For more information about the Rapid Response Team, speak with your supervisor or contact Colleen Snyderman, RN, at 4-4920.

Infusion nurse a guiding presence on a healing journey

I always try to be sure my new patients aren't worrying about something specific that could easily be addressed right away. I find this allows patients more comfort and a greater ability to listen to, and understand, teaching.

My name is Helen Brandt, and I am a staff nurse on the Yawkey 8 Infusion Unit. Mr. M was a 70-year-old man who came to me for treatment of his nasopharyngeal cancer. His history was significant for a left tonsillar carcinoma which had been excised in January of 1998. At that time, he had refused post-operative radiation and instead sought and participated in alternative therapy, including interferon, chelation (a process that removes heavy metals from the body), vitamin injections, and hydrogen-peroxide infusion. Mr. M had a history of aortic valve replacement and was taking coumadin. He was accompanied by his wife, who was clearly active in his care. They were from out of state and staying in an apartment locally for the duration of his treatment.

Mr. M's disease was curable, but the treatment was rigorous. He would undergo daily proton-beam and photon therapy and weekly chemotherapy with cisplatin. Problems I anticipated Mr. M might experience included: inadequate nutrition and weight loss due to pain and swelling in the nasopharyngeal region; possible skin breakdown on the neck; nausea and vomiting due to cisplatin; dehydration related to nutritional status; constipation due to chemotherapy, anti-emetics and inactivity; and poor nutritional status.

On his first visit, after introducing myself to Mr. M and his wife, I reviewed what would happen that day. I asked if there were any questions he wanted answered up front to help relieve any anxiety he might be feel-



Helen Brandt, RN, staff nurse
Yawkey 8 Infusion Unit

ing. I always try to be sure my new patients aren't worrying about something specific that could easily be addressed right away. I find this allows patients more comfort and a greater ability to listen to, and understand, teaching.

Mr. M mentioned he had struggled with the fear that his decision to forego post-operative radiation therapy ten years earlier had led to the cancer he was now being treated for. I could tell this weighed on his mind, so I spent time responding to this concern. I knew from the doctor's note that it wasn't clear whether the present cancer was a second primary occurrence or a late recurrence of his original disease. Whatever the case, I knew Mr. M needed to be in the healthiest frame of mind possible to deal with his planned course of treatment. Mr. M had been responsible and compliant. He had conscientiously researched and chosen the treatment that to him seemed the best choice ten years ago. I supported him in that and encouraged him to be at peace with his earlier, carefully

continued on next page

thought-out decision, and to focus now on what he needed to do and know to help make the current treatment successful.

As I started Mr. M's IV, I explained that I'd be spending a lot of time with him and his wife, explaining the management of side-effects and how Mr. M could best take care of himself during the course of his treatment. Although Mr. M appeared very quiet and somewhat laid-back, his wife was a bundle of nervous energy with many questions. Our talk that day covered treatment and side-effects and the very human process of getting to know each other.

Mr. M's chemotherapy took approximately four hours. During that time, I sat with Mr. M and his wife several times giving them information on how to adequately care for Mr. M. The amount of information is overwhelming, so I make a conscious effort to provide the most essential information first and provide written information about what they'll need to know between now and when I see them again. I gave them my phone number and encouraged them to call me with any questions. I provided written instructions for the use of anti-emetic drugs at home. We physically looked at the bottles of prescription medications they had filled so they'd know exactly what drug I was talking about. Every time I returned, the foundation of trust was reinforced that I would be there for them throughout the course of this treatment.

We spent time talking about the possibility of infection and why it's important to be aware of that. I explained how chemotherapy affects the growth of blood cells in the bone marrow, in this case white blood cells. These cells wouldn't be as available to fight infection. Mr. and Mrs. M would need to be conscientious about good hand hygiene and not be exposed to people who were ill. They needed to know the signs and symptoms of infection, and we reviewed those. Mr. and Mrs. M were instructed to call the doctor immediately any time Mr. M's temperature went above 100.5°. I made sure Mr. M had a thermometer in his temporary apartment.

Patients in general, and this couple in particular, are usually very interested in what they can do to help themselves during treatment. When patients receive treatment with cisplatin, I stress the importance of staying adequately hydrated. I give patients a specific daily goal for fluid intake and explain the symptoms they'll experience if they begin to get dehydrated. With Mr. M and his wife, I had to intervene further. Mrs. M was so anxious to take care of her husband that, as treatment progressed, she inadvertently tried to

push him beyond his ability to take fluids. I explained that Mr. M would drink when he could but was unable to at that time. I helped Mrs. M re-focus her intervention to his feeding tube and gave her a lot of positive feedback for the excellent job she was doing.

Serious illness affects family members and those close to the patient as well as the patient himself. Although the primary focus of care is always the patient, it is extremely fulfilling to be able to assist families through the challenges of serious illness. Mr. and Mrs. M were a very interesting couple. Both musicians, they were grounded in their love of music and exuded a spirituality that was evident in every aspect of their lives. Mr. M was quiet and accepting, a gentle man. I was told he would sit down at any piano he passed and play for a while. Mrs. M, more anxious on the outside, actively sought spiritual support. I enjoyed listening to her talk about her deepening spiritual awareness throughout this experience, and I encouraged her to spend time in the healing garden, which she came to love.

When Mrs. M requested that a social worker talk to her husband because she felt he was depressed, Mr. M begged off claiming fatigue and sent the social worker away. I suggested the social worker spend some time with Mrs. M in the healing garden. When Mrs. M returned to the unit, she was more relaxed and better able to support her husband because someone had spent time with her sharing her burden.

My role as an infusion nurse is so satisfying because of the opportunities I have to form connections with incredibly courageous and complex people. The ability to enter a room where someone sits scared and doubtful, and see that person come to understand that I will be part of a caring and healing journey, is the most gratifying and energizing feeling I know. I am truly grateful that life has led me to this hospital, this unit, and this position.

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

Helen skillfully developed a therapeutic relationship with Mr. M and his wife. It was important for Mr. M to be able to put his questions about past decisions behind him. Helen helped him see beyond his fear and doubts and focus on the present. This narrative beautifully articulates the many interventions Helen performed based on her individual knowledge of Mr. M and his family. It's clear to see how Helen's years of experience have informed her compassionate practice.

Thank-you, Helen.

The ability to enter a room where someone sits scared and doubtful, and see that person come to understand that I will be part of a caring and healing journey, is the most gratifying and energizing feeling I know.

'More alike than different'

Everyone should have the opportunity to reach her full potential

The following passages are excerpts of remarks delivered by Carmen Vega-Barachowitz, CCC-SLP, chair of the Council on Disabilities Awareness, at the recent symposium, "More Alike than Different," sponsored by MGH in collaboration with the Massachusetts Down Syndrome Congress, January 27, 2009.

This conference comes on the heels of an historic event. The election of an African American President is a milestone in American history, an unprecedented event that many thought impossible. The journey to this milestone was challenging and often painful. It required unwavering dedication and a clear vision of equal rights and opportunities. I mention this because it is an example of what can be achieved when people believe. The Massachusetts Down Syndrome Congress has a vision to ensure that every person with Down Syndrome has the opportunity to reach her full potential.



Carmen Vega-Barachowitz, CCC-SLP, director, Speech, Language & Swallowing Disorders and Reading Disabilities and chair of the Council on Disabilities Awareness

Many were drawn to the Thier Conference Room for the recent symposium, "More Alike than Different."

The theme of the National Down Syndrome awareness campaign is, "More alike than different." We all know people with a wide range of abilities and talents. People with Down syndrome are no different. They are

creative, love to dance, play instruments, have pets, friends and jobs. They cope with everyday challenges and have big dreams just like everyone else. And like everyone else, they should have the opportunity to reach their full potential.



Disabilities Awareness (continued)

With dreams come responsibilities. For healthcare professionals, our responsibility is to partner with adults and families of children with Down syndrome, to seek true collaboration, which begins by recognizing the patient and the family's expertise.

Families are big, small, extended, nuclear, multi-generational, single-parent, same-sex, and a variety of other adjectives. 'Family' can be as temporary as a few weeks or as permanent as forever. At the core of every family is the recognition that these are the people who are important in one's life. We begin to plant the seeds of partnership when we elicit a person's story, acknowledge his or her preferences, respect his or her values, and validate his or her feelings. Patients and families turn to us for unbiased information, current knowledge, and support, trusting that we have their best interests at heart. Achieving our vision requires an environment of mutual respect and a recognition of one another's strengths.

With our common vision in mind, patients, families, and healthcare providers enter into a partnership to establish common goals. Setting common goals requires us to act with integrity, honesty, effort, patience, curiosity, cooperation and most importantly, compassion and care. As we enter this partnership with our patients and families and they enter this partnership with us, we see how everyone contributes talent and interests. Everyone has something to teach. Everyone has something to learn.

Fulfilling our vision requires the unwavering dedication of millions of believers like you and me, believers with a vision of equal opportunities for every person.

The faces of diversity as seen at the recent symposium, "More Alike than Different," sponsored by MGH in collaboration with the Massachusetts Down Syndrome Congress, January 27, 2009.



(Photos by Abram Bekker)

Human Family

by Maya Angelou

I note the obvious differences
in the human family.
Some of us are serious,
some thrive on comedy.

Some declare their lives are lived
as true profundity,
and others claim they really live
the real reality.

The variety of our skin tones
can confuse, bemuse, delight,
brown and pink and beige and purple,
tan and blue and white.

I've sailed upon the seven seas
and stopped in every land.
I've seen the wonders of the world,
not yet one common man.

I know ten thousand women
called Jane and Mary Jane,
but I've not seen any two
who really were the same.

Mirror twins are different
although their features jibe,
and lovers think quite different thoughts
while lying side by side.

We love and lose in China,
we weep on England's moors,
and laugh and moan in Guinea,
and thrive on Spanish shores.

We seek success in Finland,
are born and die in Maine.
In minor ways we differ,
in major we're the same.

I note the obvious differences
between each sort and type,
but we are more alike, my friends
than we are unlike.

We are more alike, my friends,
than we are unlike.

We are more alike, my friends,
than we are unlike.

Nursing Research Committee Journal Club

Sharing knowledge to improve care

—submitted by the Nursing Research Committee

The Journal
Club meets
on the second
Wednesday of
every month from
4:00–5:00pm,
hosting notable
researchers who
share their findings
with the MGH
community.

At a recent meeting of the Nursing Research Committee Journal Club, Patricia Reid-Ponte, RN, presented a summary of her article, “Using an Executive Coach to Increase Leadership Effectiveness.” Reid-Ponte had been invited by the *Journal of Nursing Administration* to write an article for a special edition on succession planning, published in June, 2006. For her article, she interviewed four coaches and four nurse leaders who had been coached. The leaders commented on the effectiveness of coaching as a tool in developing leadership and offered recommendations for others interested in the coaching method. Reid-Ponte shared aspects of her experience conducting interviews and preparing the manuscript. The discussion focused on pros and cons of coaching as a tool for succession planning.

At another meeting of the Journal Club, Angela Nannini, RN, shared her extensive research examining the records of more than 100,000 women in Massachusetts who suffered injuries during pregnancy. Her article (co-authored with other public health nurses), “Injury: a major cause of pregnancy-associated morbidity in Massachusetts,” reported the results of a year of data-collection and can be found in the *Journal of Midwifery & Women’s Health* (Jan/Feb 2008). Most injury visits were reported through the Emergency Department. A higher risk for injury was seen in adolescents, black

non-Hispanics, those who had public insurance, and those with less than a high-school education. Clinically, the authors concluded that guidelines should include recommendations for assessment of injury history and prevention counseling. Further research could focus on the development of evidence-based interventions to decrease the frequency of injuries.

Earlier this year, Roseanna Demarco, RN, presented, “Refinement of the Silencing the Self Scale-Work for Registered Nurses,” which was published in the *Journal of Nursing Scholarship* in 2007. The subject is a timely one as the Joint Commission is focusing on lateral violence in the workplace. Demarco has been working on her research regarding communication in the workplace for more than ten years. Her research confirmed the validity and reliability of the Silencing the Self Scale-Work for Registered Nurses but it would need to be tested in other geographic areas to be used nationally or internationally as Demarco concentrated on Massachusetts nurses. Demarco’s research revealed differences in how men and women communicate, and she is now applying this concept to how nurses interact with others in the workplace, especially their peers and doctors. As a result of confirming the reliability and validity of the scale, the goal is to design interventions to change present situations.

The Nursing Research Committee Journal Club meets on the second Wednesday of every month from 4:00–5:00pm. For more information, visit www.mgh-nursingresearchcommittee.org.

Some changes to EMAPPS

Roll-out still on schedule

For more information about EMAPPS, contact Rosemary O'Malley, RN, at 6-9663.

Question: Is EMAPPS on schedule to roll out as planned?

Jeanette: The Electronic Medication Administration Process for Patient Safety (EMAPPS) is scheduled to go live on White 6 and Blake 13 the week of March 9, 2009. The roll-out will continue with two or three more inpatient units every two weeks through November, 2009.

Question: I've heard there are going to be changes to the Unit Census Monitor and POE. Why is that?

Jeanette: As a result of switching to an electronic medication administration record (eMAR), changes were necessary to ensure the three information systems are in agreement. Orders must be entered into POE in order for them to flow to the Pharmacy informa-

tion system and the eMAR. Two columns have been added to the Unit Census Monitor (UCM)—'RN Assigned' and 'eMAR Cues'— and an eMAR Tools button has been added, as well. These will be enabled as each unit goes live on EMAPPS.

Question: What changes will occur in POE for the prescriber?

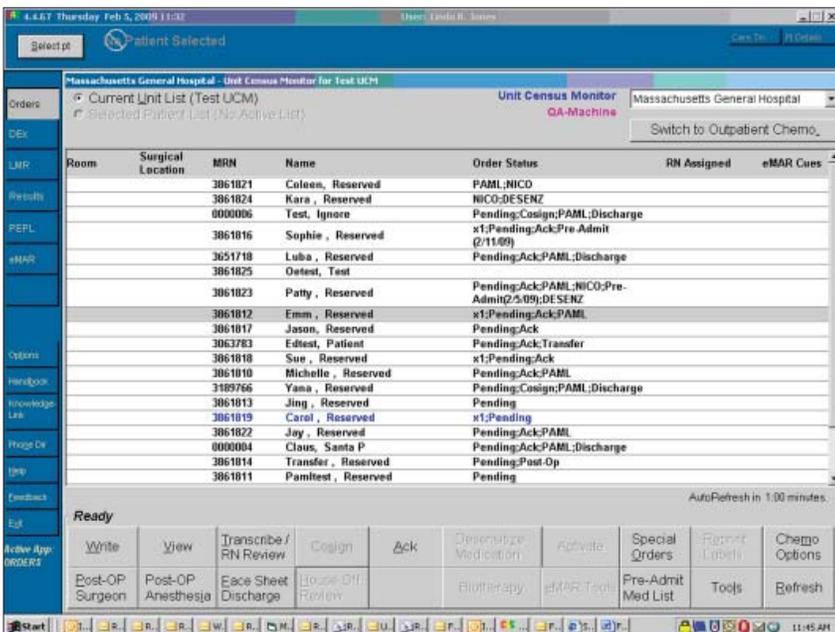
Jeanette: The screen presented to the ordering prescriber will now allow for the continuation of certain orders including: Medications, IV, Respiratory, Blood Products, Labs, Food and Nutrition, Restraints/Code Status, General Care: Wound Care, Precautions, Diagnosis, Vascular Access Devices, and Anti-Embolicism. Other orders will be available to view and can be re-written, but won't be continued on the screen.

Traditionally, when transfer orders were written, the prescriber was presented with current active orders at which time he/she selected the orders to be continued. With the new system, current active orders are automatically continued, and the prescriber is prompted to provide the appropriate parameters.

Question: How will nurses and respiratory therapists scan and document medications?

Jeanette: Hardware is currently being installed which will allow clinicians to scan and document medications at the bedside. I'd like to thank staff on patient care units as well as staff of Buildings & Grounds and Information Systems for their efforts in facilitating this installation. Bedside computers will be attached to an adjustable arm to minimize ergonomic injuries.

For more information about EMAPPS, contact Rosemary O'Malley, RN, at 6-9663.



Announcements

Norman Knight Visiting Scholar Program

Judy Murphy, RN, vice president, Information Services for Aurora Health Care in Milwaukee, will visit MGH as the 2009 Norman Knight visiting scholar. A nationally recognized expert on system methodologies, automated clinical documentation, and technology supporting evidence-based practice, Murphy will meet with staff and present at grand rounds:

"The Copernican Shift: the Patient as the Center of the Universe"

Tuesday March 31, 2009,
2:00–3:00pm
O'Keefe Auditorium
Reception to follow

For more information, contact Mary Ellin Smith, RN, at 4-5801.

Ash Wednesday February 25, 2009

Services in the MGH Chapel on Ellison I

- Roman Catholic Mass at 11:00am and 4:00pm
- Ecumenical Service at 12:15pm
- Ashes will be distributed in the Chapel between 9:00am and 5:00pm.
- Every effort will be made to bring ashes to patient units some time between 8:00am and 4:00pm.

All services are broadcast on Channel 16 on the in-house television system.

For more information, call the MGH Chaplaincy at 6-2220

Hand hygiene video available

A patient-friendly video has been produced to help educate patients, families, and visitors about the MGH Hand Hygiene Program. Produced by the STOP (Stop Transmission of Pathogens) Task Force, the video is available on Channel 31 in English and Spanish. Over the next few months, posters will be placed in patients' rooms with instructions on how to access the video.

For more information, contact Judy Tarselli, RN, at 6-6330.

Career Information Day

Healthcare practitioners provide insight into their disciplines at the 6th annual Career Information Day

March 25, 2009
10:30am–3:40pm
Thier Conference Room

40-minute sessions will include a 20-minute presentation followed by 20 minutes of questions and answers.

Careers will include:

- Nursing, 10:30–11:10am
- Medical Imaging (Radiography), 11:15–11:55am
- Medical Technology, 12:00–12:40pm
- Surgical Technology, 12:45–1:25pm
- Professional Billing Office and Medical Coding, 1:30–2:10pm
- Electrodiagnostic (Sleep) Technologists, 2:15–2:55pm
- Respiratory Therapy, 3:00–3:40pm

Sponsored by MGH Training and Workforce Development. For more information, contact John Coco at 4-3368.

Elder care discussion group

Elder care monthly discussion groups are sponsored by the Employee Assistance Program.

Next session:
March 10, 2009
12:00–1:00pm
Yawkey 7-980

All are welcome. Bring a lunch. For more information, call 6-6976.

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.

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

Next Publication

March 5, 2009

Educational Offerings – 2009

February

24

PCA Educational Series

Founders 325
1:30–2:30pm
No contact hours

February

25

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
7:00–11:00am
Contact hours:TBA

February

26

Psychological Type & Personal Style: Maximizing your Effectiveness

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

February

26

Nursing Grand Rounds

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

February

27

Intermediate Arrhythmia

Simches Conference Room 3120
8:00–11:30am
Contact hours: 3.5

February

27

Pacing Concepts

Simches Conference Room 3120
12:15–4:30pm
Contact hours: 3.75

March

2

BLS/CPR Re-Certification

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

March

2 & 16

ACLS Provider Course

Day 1: 8:00am–4:30pm
O'Keefe Auditorium

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

March

**2, 4, 9, 16,
18 & 24**

Greater Boston ICU Consortium Core Program

BMC (and MAH)
7:30am–4:30pm
Contact hours: TBA

March

3

Pediatric Simulation Program

Founders 335
12:30–2:30pm
Contact hours:TBA

March

5 & 12

Phase II Advanced Wound-Care Education Program

Simches Conference Room 3-120
8:00am–4:30pm
Contact hours:
6.6 for each day

March

5

CVVH Review and Troubleshooting for the Experienced CVVH Provider

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

March

10

BLS/CPR Certification for Healthcare Providers

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

March

10

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

POB 448
11:00am–3:00pm
Contact hours:TBA

March

10

Chaplaincy Grand Rounds:
"On Spiritual Growth"

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

March

11

Nursing Grand Rounds

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

March

11

OA/PCA/USA Connections

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

March

11

Nursing Research Committee's Journal Club

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

March

13 & 27

Pain Relief Champion: State of the Art and Science

O'Keefe Auditorium
8:00am–4:30pm
No contact hours

March

16

Diabetic Odyssey

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

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

The smallest acts can make the biggest difference

—by Stephanie Cooper, educational development and project specialist

A cancer diagnosis is among the worst fears a family can face. Bob Paolillo, operations associate on the Hematology/Oncology Unit, has experienced this first-hand and believes he was meant to be behind the desk on Ellison 14, doing what he can to comfort patients and families. Several years ago after a long career in another industry, Paolillo applied to MGH. When he sat down with nursing director, Ellen Fitzgerald, RN, he knew he had come to the right place. He possessed a great respect for customer service and the position of operations associate offered him an opportunity to put that respect into practice in a meaningful way.

Transcribing orders, maintaining patient records, ordering supplies and equipment, and handling numerous phone calls were only part of his many responsibilities. It's the positive impact he has on patients that makes his work so fulfilling.

Paolillo arrives at work early, dropping by patients' rooms to introduce himself, explaining his role and letting patients know that he and his co-workers are available to help if they need anything. He wants to be more than just a voice on the other end of the phone.

Says Paolillo, "There's a real sense of teamwork on the unit. If there's something I can do to help, I do it. Whether it's bringing a patient a warm towel, ice chips, a blanket, help with the TV—it's all part of the Ellison 14 experience."

At a time when patients and families can feel overwhelmed, Paolillo tries to let them know they're in good hands. When patients are re-admitted to Ellison 14, Paolillo greets them as if they're old friends.

He shows them to their room, orients them, and lets them know who their nurse will be. At discharge, he's been known to say, "Don't take this the wrong way, but I hope you never have to come back!"

"The job is very fulfilling," says Paolillo. "We all help each other as a team. What we give to patients, we give with no ulterior motive. The essence of our lives meet in those simple, shared moments. We can't always say everything will be fine, but we can say, 'You're in the best place in the world,' and really mean it."



Bob Paolillo, operations associate

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