Caring Headlines
March 19, 2009

Building relationships in the GCRC

See story on page 5

Learning together in the GCRC are (l-r): Damian Fishel (twin brother #1); Kelly Ann Brainthwaite, patient care associate; Kathleen Egan, RN, staff nurse; patients, Sarah Dinuovo and Shanna Fishel; and Oren Fishel (twin brother #2)

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Hand hygiene: a professional commitment as well as a National Patient Safety Goal

As healthcare providers and employees interacting with patients and the clinical environment, we have the potential to transmit germs that can cause infections. Knowing this, we have a responsibility to help prevent the spread of infection by using good hand-hygiene practices.

By now, every clinician and support person at MGH understands and embraces the need for a robust hand-hygiene program. As healthcare providers and employees interacting with patients and the clinical environment, we have the potential to transmit germs that can cause infections. Knowing this, we have a responsibility to protect our patients by using good hand-hygiene practices. That is the thinking behind the Joint Commission's National Patient Safety Goal #7, requiring hospitals to reduce the risk of healthcare-associated infections by complying with current hand-hygiene guidelines established by the Centers for Disease Control and Prevention. Those guidelines include:

- use of an alcohol-based hand rub as the recommended method of hand hygiene
- minimal hand-*washing* as this can cause dermatitis
- washing hands with soap and water at these specified times: when hands are visibly soiled; after using the bathroom; and before eating
- required use of alcohol-based hand rub *before* and *after* contact with the patient
- required use of alcohol-based hand rub *before* and *after* contact with the patient's environment
- gloves may not be used as a substitute for hand hygiene (alcohol-based hand rub is required before and after glove use)
- the regular use of lotion to promote healthy skin

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

At MGH, we're fortunate to have the STOP (Stop the Transmission of Pathogens) Task Force to guide our hand-hygiene efforts in a multi-pronged, multidisciplinary approach. The group is directed by David Hooper, MD, and Jackie Somerville, RN, and led by Judy Tarselli, RN, and Heidi Schleicher, RN, of the Infection Control Unit. Our Hand Hygiene Program encompasses the widespread placement of Cal Stat wall dispensers and pump containers throughout the hospital. An assortment of posters and visual aids are created and distributed to patient care units and common areas on a regular basis.

The program uses anonymous observers to measure compliance before and after contact with the patient or the patient's environment. The results of these surveys are provided to staff on a monthly basis to help improve hand-hygiene compliance in a quick, effective, non-punitive way. Feedback is also presented at forums throughout the hospital, such as Combined Leadership meetings, staff meetings, and other venues.

continued on next page

Without a doubt, the most effective tool we have in advancing our hand-hygiene agenda are the more than 150 hand hygiene champions from every unit and discipline throughout MGH whose enthusiasm and creativity have brought real change to the culture at MGH. These champions have become peer leaders, educating, communicating, and motivating staff.

The Hand Hygiene Program employs a rewards system to recognize individuals and units that achieve exemplary compliance and to encourage hand-hygiene improvement. Pizza parties and MGH food service coupons are among the incentives.

Without a doubt, the most effective tool we have in advancing our hand-hygiene agenda are the more than 150 hand hygiene champions from every unit and discipline throughout MGH whose enthusiasm and creativity have brought real change to the culture at MGH. These champions have become peer leaders, educating, communicating, and motivating staff. They have brought their considerable talents to bear in crafting imaginative ways to inspire co-workers. From stickers and posters to full-size cutouts of celebrities to decorative bulletin boards and hand-hygiene valentines, I am continually amazed by their passion and resourcefulness. I recently enjoyed a preview of the *Cal Stat Rap*, written and recorded by Pauline Albrecht, RN, and her colleagues in the Same Day Surgical Unit—another example of the incredible ingenuity of our hand-hygiene champions.

As you know, the expectation of the Joint Commission is 90% compliance before and after contact with the patient or the patient's environment. Our goal at MGH is 100% compliance before and after contact. In January, our compliance rate throughout the hospital (including physicians) was 92% before contact and 93% after contact.

What makes these results so exciting is that we're seeing the difference it makes in terms of keeping patients safe. As hand-hygiene compliance has improved, MGH has seen a significant decrease in the occurrence of healthcare-associated MRSA infections. And that is very good news.

To ensure that proper hand hygiene is ingrained in our culture, we are enlisting the involvement of patients and visitors, as well. A patient-friendly video has been produced to help educate patients, families, and visitors about hand hygiene. The video is available on Channel 31 in English and Spanish, and posters are being placed in patients' rooms with instructions on how to access it. In keeping with National Patient Safety Goal #13 that requires hospitals to encourage patients' involvement in their own care, it's recommended that this video be shown to patients or family members within 24-48 hours of admission.

Lasting change requires the commitment and participation of every person in every role group at MGH. If you see someone who needs a friendly reminder to use proper hand hygiene, don't be afraid to speak up. Good hand hygiene is an extension of our professional commitment to ensure the safety and well-being of every patient in our care. And our 92/93 compliance rate is another example of how we achieve Excellence Every Day.

Update

I'm please to announce that Tara Tehan, RN, has accepted the position of nursing director for the Blake 12 Neuroscience ICU.

In this Issue

Creating a culture of safety

—by Lela Holden, RN, patient safety officer, MGH Center For Quality & Safety;
and Keith Perleberg, RN, director, PCS Office Of Quality & Safety

The MGH Center for Quality & Safety and the PCS Office of Quality & Safety co-sponsored an informational booth in the Main Corridor during National Patient Safety Awareness Week, March 8–14, 2009. Raffle prizes were drawn from a pool of people who contributed to a reporting culture in 2008. Thanks to all who contributed, and keep up the good work!

We often hear healthcare professionals talk about creating a culture of safety. What does that mean? One characteristic of a culture of safety is open communication. That means every member of the organization feels empowered to speak up about issues related to safety and opportunities for improvement. This environment of open communication is sometimes called a reporting culture.

One way to contribute to a culture of safety is to submit concerns through the electronic safety reporting system, which has been in effect at MGH since 2006. We've received thousands of reports on-line, and each report is reviewed by staff in the MGH Center for Quality & Safety. Events that involve Patient Care Services are sent to the PCS Office of Quality & Safety for follow-up.

For a reporting culture to thrive, more is needed than open communication. British psychologist, James Reason, who's written extensively about safety cultures, notes that reporting cultures must also focus on near-misses to ensure hospitals have the right processes in place. So, a nurse who catches a wrong drug in Omnicell and reports it, gives us an opportunity to put processes in place to prevent such an error from happening again.

Reporting cultures ensure confidentiality and safety for those who report. At MGH, we are committed to a non-punitive reporting system. Managers and leaders understand that speaking up about a problem or error is a good thing—it gives us an opportunity to investigate, begin a dialogue, and solve problems.

A reporting culture provides useful feedback to those who take the time to file a report. Individuals should know their report has been heard and have an opportunity to participate in resolving the issue. If we are to continually improve our systems, two-way communication is key.

Patients also play an important role in creating a culture of safety. Patients must feel equally empowered to communicate any questions or concerns they have.

Perhaps the most important component of a reporting culture are the changes we make based on the information we receive in safety reports. Some of the changes we've made as a result of our reporting system include the handling of medication infusion pumps, improving the consent process in operating rooms, and assessing the fall risk for patients in Radiology.

A culture of safety requires trust and a commitment by all to speak up—communicate, report, dialogue, and problem-solve. For a culture of safety to exist, everyone must participate. For more information, call the PCS Office of Quality & Safety at 3-0140.

At MGH, support comes in all shapes and sizes

—by Kathleen Egan RN, staff nurse, GCRC

My name is Kathleen Egan, I am a nurse in the MGH Clinical Research Center (GCRC) on White 13. I had no idea what Hereditary Angio Edema (HAE) was until I started working on Study Protocol # 823 in June of 2008. More than 40 research protocols were implemented by nurses in 2008, the HAE Study was one of them. HAE is a condition characterized by subcutaneous and sub-mucosal swelling in any area of the skin or respiratory and gastrointestinal tracts. Angioedema occurs as a result of a C1 protein deficiency, and there is no cure for this condition. The GCRC was chosen as a research site to evaluate the safety and efficacy of a new treatment for HAE.

I became the conduit through which they asked questions; exchanged personal histories, and shared information about what they found helpful in dealing with their illness.

My role as a research nurse is to assist patients in achieving the highest level of physical and physiological well-being and collect data in a reliable way to advance the science and treatment of (in this case) HAE.

I'd like to tell you about five women who came to be good friends during their care in the GCRC. These women had been undiagnosed for years. Many physicians never even see a case of HAE. The presenting symptoms of edema of the feet, hands, abdomen, or face are often assumed to be an allergic reaction or a condition known as 'acute abdomen.'

These research participants were: a new mother of twin boys; a recently married woman who had just started a new job, just moved to a new location, and just found out she was pregnant; a young woman newly diagnosed and frightened about being diagnosed with HAE; and a woman from out of state whose husband is blind so she drove herself to Boston for treatment.

With permission from each woman, as they were accepted to the study, I introduced them to one another. I became the conduit through which they asked questions; exchanged personal histories, and shared information about what they found helpful in dealing with their illness. They exchanged e-mail addresses and phone numbers. As their nurse, I had the pleasure of getting to know these women individually and collectively as they developed a support group among themselves.

Numerous efforts were made to help these women access resources not typically available in the GCRC. They became an empowered group who work to raise awareness about HAE and the special needs associated with the care of HAE patients. They worked together to ensure the support they received at MGH is afforded to others with HAE both locally and nationally.

Says the mother of twins: "I'm on the path to getting some control back in my life. The nurses in the GCRC helped me so much, administering drugs, collecting data, supporting my physical and emotional needs and my overall well-being. They've helped me gain some much needed independence. Connecting me to other HAE patients was a vital part in giving me the confidence to advocate for myself and talk about my condition. It helps knowing you're not alone."

For more information about HAE or the services provided by the GCRC, call 4-1610.

A Duck tour, a day at the museum, and honoring a sacred promise

—by Daphne Noyes, MGH chaplain

In the summer of 2008, Mrs. Collier was a patient in the Ellison 9 Cardiac Care Unit. She had been gravely ill for many weeks. During that time, despite the fact that they were from out of state, Mr. Collier was her constant companion, spending every day at her bedside. As time went on, the team realized that a crucial part of Mrs. Collier's care was making sure Mr. Collier took care of himself, too.

Knowing how much Mr. Collier loved nature, Mrs. Collier's nurse, Lauren Kelly Drew, RN, suggested he go for walks along the river. "Wear a hat," she'd remind him. "And sunscreen!"

As the chaplain providing spiritual support to this family, I encouraged Mr. Collier to attend interfaith prayer services during the day in the Chapel. On weekends, he attended services at a nearby church.

Sadly, Mrs. Collier's condition declined until even the most heroic efforts could not save her. Mr. Collier had promised his wife he would never leave her. He wanted to honor that promise by taking her ashes home with him when he left. Social worker, Marguerite Hamel-Nardozzi, LICSW, helped make these arrangements, but it meant adding three more days to Mr. Collier's stay in Boston, and Sunday would be a long day with no distractions.

Staff of Ellison 9 had grown fond of the Collier family and wanted to help Mr. Collier through this difficult time. Lauren, Marguerite, and I put our heads together and thought Mr. Collier might enjoy a Duck Tour to pass the time on Sunday. When we learned the Duck Tours offered a package with the Museum of Science, we thought, even better! It could fill the whole day for Mr. Collier. We purchased tickets with funds donated by Mrs. Collier's—now Mr. Collier's—caregivers.

That Sunday, Mr. Collier went to church in the morning, then boarded a Duck Boat and toured the city that had been his temporary home for the past few weeks. He heard historical anecdotes as he wove his way through Boston's picturesque streets. Best of all, Mr. Collier, a big baseball fan, was able to see the Baseball as America exhibit at the Museum of Science.

The following day, Mr. Collier fulfilled his promise to his wife and returned home with her ashes. In a note to staff after he left, he wrote, "We were so blessed to have experienced the care and comfort that MGH gave us. God bless you all."

Mr. Collier stands ready to take the Duck Boat tour compliments of his caregivers on Ellison 9.

(Photo provided by Mr. Collier)

The Norman Knight Preceptor of Distinction Award

—by Julie Goldman, RN, professional development coordinator

On February 26, 2009, in O'Keeffe Auditorium, staff nurse, Kathleen (Kathi) Blais, RN, of the Yawkey 8 Infusion Unit, became the sixth recipient of The Norman Knight Preceptor of Distinction Award. Said senior vice president for Patient Care, Jeanette Ives Erickson, RN, "With this award, made possible by the generosity of Mr. Norman Knight, we come together to recognize the important role of nurse preceptors. A preceptor of distinction role models excellence in patient care; is a leader among her peers; is guided by knowledge; and establishes partnerships with her preceptee, the patient, and the family."

Knight Preceptor of Distinction Award recipient, Kathleen Blais, RN (center), with nursing director, Joanne LaFrancesca, RN (left), and senior vice president for Patient Care, Jeanette Ives Erickson, RN.

Blais started her nursing career in 1983 with a strong desire to help people and effect change. Ives Erickson read from a letter of nomination submitted by Sarah Grundy, RN, a nurse who had been precepted by Blais. Said Grundy, "When I first met Kathi, I knew I would have a wonderful orientation experience. She immediately made me feel comfortable, challenged me to think things through. Her enthusiasm, compassion, and dedication were evident every day in the care she gave to patients and the support she provided to others. Kathi is someone I'll continue to look to for guidance as a young nurse."

Nursing director, Joanne LaFrancesca, RN, in her remarks about the Importance of Being a Preceptor, said, "A preceptor who brings enthusiasm, caring, compassion, and a love of nursing to her practice makes a significant contribution to patients and families."

Ives Erickson thanked Mr. Knight for his continued support of the Preceptor of Distinction Award and acknowledged the other nominees, including runner-up, Amy McCarthy, RN, staff nurse, on the White 6, Orthopaedics Unit.

For more information about The Norman Knight Preceptor of Distinction Award, contact Julie Goldman, RN at 4-2295.

On being true to yourself, your religion, and the mission of an interfaith chaplaincy

Every chaplain at MGH carries the interfaith pager several times a month to ensure uninterrupted, pastoral coverage for patients and families.

My name is Ben Lanckton. I am a Jewish chaplain and a member of the MGH interfaith Chaplaincy. Every chaplain at MGH carries the interfaith pager several times a month to ensure uninterrupted, pastoral-care coverage for patients and families. Earlier this year, I was paged to the Emergency Department. When I called to get an assessment of the situation, I was told the patient would be extubated soon, and his family was present. I went as fast as I could to the ED. When I arrived, I was greeted with, "Oh, good, you're here." I was led quickly to an urgent-care bay. I suspected I would be providing support for an end-of-life situation; I would have to establish the faith tradition once I arrived.

I found a man, intubated, surrounded by three women and a man, his daughters and son-in-law. Two of the women were crying quietly, the other was openly sobbing.

I introduced myself: "My name is Ben Lanckton, I'm the interfaith chaplain. I'm very sorry for what you're going through."

As usually happens, despite the desperate intensity of the situation, family members managed to say, "Thank-you. Nice to meet you."

Rabbi Ben Lanckton, Jewish chaplain

I learned the name and age of the patient. 'John' was 69. One of his daughters explained he'd had a massive bleed in his brain overnight, this after a year and a half of failing health following the death of their mother.

I explained why I was there: "I'm here for you and for John to provide for whatever spiritual needs you may have at this time."

Another daughter spoke up. "Can you offer prayer for him?"

"Of course," I answered.

She went on to say, "He knows he's going to heaven, because he knows we're all saved through the redeeming blood of Jesus Christ our Lord. We just want to say some prayers to go with him on his journey…" her voice trailed off as she broke down again in the arms of her sister.

continued on next page

Thanks to my chaplaincy training, including the ongoing development of a personal theology and continued exchanges about Judaism and Christianity with my fellow chaplains, I was able to offer words that met the needs of this family (and, though he was unable to perceive them, the patient).

The son-in-law asked, "Can you pray with us?" As the tallest person in the room, he may have been the only one who could see the yarmulke on my head, or perhaps he was just eager to begin the prayer.

In these kinds of situations, my role is to provide a calm, non-anxious presence. I took a breath and spoke slowly. "I just want to make sure you understand who I am and what I can do. I am a Jew, a rabbi by training. I'm here for you today as an interfaith chaplain. My role is to offer prayer for all of you and your father, respecting and honoring his faith tradition. Does that sound all right for you?"

They nodded and said, "Yes."

Respecting the family's wishes, we waited for the teenage grandchildren to arrive and get through their initial shock and grief. I suggested it might be time for a prayer. I invited them to gather in a circle holding hands around the bed. I explained that I would offer some words of prayer, and when I was finished anyone who felt moved to do so could offer some words, as well.

I paused and began: "Lord, Source of hope, and help, and healing, we ask your special blessing for John today. Be with him on this final stage of his journey. Help him feel the love and support that is both physically and spiritually surrounding him at this moment. We thank you for all the blessings that have been part of his life to this time, and we ask that he find peace with You."

I paused, as I typically do when I offer prayer with Christian patients, to note for myself (and in my own theological understanding, for God) that I had ended my shared, general prayer with the family, and I was now praying specifically for the family and the patient:

"And for John and all those who share his faith tradition, we commend him to You in the name of Jesus, whose redeeming power shields all those who share his faith. We take faith and solace in Your promise of eternal life, dwelling on high at Your right hand forever."

One of the daughters began to say the Lord's Prayer, and all, myself included, joined in. After a few moments John's primary care physician arrived. He expressed his sympathy, and familiar with the patient, was able to gently joke about John's stubbornness. He was also able to tell us definitively that John was no longer capable of voluntary movement, that he could no longer hear. Even as these facts were difficult to hear, the sensitive way in which he conveyed them made it easier for the family to adapt to the grim reality.

In fact, they so quickly accepted the inevitability of John's death that they began to discuss the details of the funeral arrangements. I listened for a few moments then suggested, "There might be time to address those issues when things feel a little less intense." They agreed.

After a few more minutes of mostly silence, I thought it was time to let them be alone as a family for this crucial time in their shared experience. But I wanted to make sure there weren't any un-met spiritual needs.

"I know it can be helpful to have someone outside the family facilitate your spiritual needs, but it can also be important to experience times like these with just the family. I'm sensing you might like to be alone together. If I'm mistaken, please let me know."

The son-in-law offered his hand. "Thank-you, Rabbi, we appreciate it." I gave him my card and reminded him the Chaplaincy can be paged 24 hours a day, seven days a week. I said good-bye to the family, and to John, and took my leave.

This was a moment when a chaplain was needed quickly to provide a meaningful prayer experience for a family wracked by confusion and grief. Thanks to my chaplaincy training, including the ongoing development of a personal theology and continued exchanges about Judaism and Christianity with my fellow chaplains, I was able to offer words that met the needs of this family (and, though he was unable to perceive them, the patient).

The Talmud says in Tractate Gittin: "We feed the hungry, visit the sick, and tend to the dead of non-Jews along with Jews for the sake of the paths of peace." I am grateful for the opportunities I have to put these words into action.

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

What a wonderful opportunity to witness the important work of our colleagues in the Chaplaincy. Despite vast differences in the religious and spiritual beliefs of our patients and families, Rabbi Lanckton showed us the power of coming together, of being present, at a time of great sorrow. Rabbi Lanckton honored John's life and passing and brought comfort to John's family while at the same time remaining true to his own theological beliefs. This narrative speaks to compassionate care, collaborative practice, cultural competence, and great sensitivity.

Thank-you, Rabbi.

Advocacy brings closure for family of homeless patient

—submitted by the Office of Patient Advocacy

It's a sad story with a happy ending, an ending made possible through the efforts of a determined MGH patient advocate and his colleagues. Recently, an unidentified homeless man was brought to the MGH Emergency Department after being found unconscious in downtown Boston. The patient was pronounced dead in the ED and transferred to the morgue. Because he had no identification, a positive ID could not be made at the time of death. With assistance from Boston Healthcare for the Homeless and the Homeless Outreach Team at the Pine Street Inn, a positive identification was made in the days that followed, and next of kin was contacted. The patient's only living relative was a sister who lived in a remote region out of state. When she learned of her brother's death, 'Mary' expressed a desire to have his body cremated and his remains returned to her. When she didn't have the financial resources to pay for cremation, she was referred to the Office of Patient Advocacy.

Members of the Office of Patient Advocacy team (standing, l-r): patient advocates, Diann Burnham, RN; Linda Kane, LICSW; Denise Flaherty, RN; and Sally Millar, RN, director. (Seated): Reardon and patient advocacy coordinator, Lani Mauricio.

Patient advocate, Steve Reardon spoke with Mary who confirmed she was the patient's only living relative. She told Reardon her brother had worked as a laborer in the ship yards of Boston for most of his adult life. She had been aware that he had struggled with alcoholism and was homeless. For this reason, they had lost touch; she hadn't spoken to him in many years.

Mary asked Reardon for assistance in getting her brother's body cremated. She was upset because time had passed since her brother died, and she felt he wasn't yet at 'eternal rest.'

Reardon spoke with a representative from the Boston Department of Health and Hospitals who informed him that limited funds are available for the cremation of individuals who don't have the resources to pay. Reardon contacted a funeral home and explained the situation. He asked if they'd be able to assist with the cremation. The owner of the funeral home was more than willing to help, agreed to cremate the body, and offered to help facilitate the return of his ashes to Mary. Needless to say, Mary was overjoyed.

Says Reardon, "If we hadn't been able to identify the body, Mary might never have known her brother passed away. This was a collaborative effort. I value the ability of our team to brainstorm together to find non-traditional solutions to situations like this one. My colleagues were tremendously helpful in working through the details that ultimately led to a resolution in this case."

Shadowing gives students inside look at careers in health care

—by Daniel Correia, program coordinator

Traditionally, Groundhog Day is celebrated on February 2nd, but on Friday, January 30, 2009, MGH got the jump on Punxsutawney Phil, by hosting its 14th annual Job Shadow Day. The MGH Center for Community Health Improvement in partnership with the Boston Private Industry Council invited students from East Boston High School and Health Careers Academy to explore potential careers in health care.

Radiation Oncology staff nurse, Kathleen Selleck, RN, (left) and her 'shadow,' Jennifer Pleitez, a student at East Boston High School, paired up for Job Shadow Day.

(Photo provided by staff)

The 52 students hosted by MGH had hands-on learning experiences in a variety of setting. MGH Job Shadow hosts spoke about the skills, responsibilities, education, and training required to enter various healthcare fields. More than 25 sites participated.

Kathleen Selleck, RN, a staff nurse in Radiation Oncology observed, "What a great experience I had with my 'shadow,' Jennifer. She was a terrific guest. Staff really opened their arms to her. I was touched by the receptiveness of my co-workers, and I think Jennifer learned a lot in the time she was here."

Some of the departments that participated in Job Shadow Day include: Nursing; Bone Marrow Transplant; the Cancer Center; Cardiac Surgery; the Emergency Department; Midwifery; Occupational Therapy; Physical Therapy; Radiation Oncology; the Same Day Surgical Unit; the Post Anesthesia Care Unit; and Speech, Language & Swallowing Disorders.

Annual participation in Job Shadow Day advances the hospital's mission to partner and collaborate with others to build healthier communities and enhance the hospital's responsiveness to those from diverse cultural and socioeconomic backgrounds.

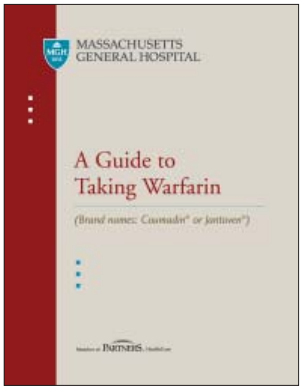
Although Punxsutawney Phil predicted six more weeks of winter, MGH is a warm and welcoming place all year round. For more information about the MGH Center for Community Health Improvement call Dan Correia, project coordinator, at 4-6424.

March is Deep Vein Thrombosis Awareness Month

—by Lynn Oertel, RN, clinical nurse specialist, Anticoagulation Management Service

Deep vein thrombosis, commonly referred to as DVT, occurs when a blood clot, or thrombus, develops in the large veins of the legs or pelvic area. An estimated 350,000–600,000 Americans develop DVT or pulmonary embolus each year resulting in upwards of 100,000 deaths. March has been designated National DVT Awareness Month. To help educate staff, patients, and visitors about the risks, prevention, and treatment of DVT, the Anticoagulation Management Service along with the Vascular Center sponsored an informational booth complete with carotid-artery screening exams in the Main Corridor, March 10, 2009. Staff were available to answer questions and demonstrate some diagnostic tools. This was also an opportunity to showcase *A Guide to Taking Warfarin*, a new booklet that provides comprehensive information for patients and families on warfarin therapy. The guide was created as a Partners-wide initiative to promote safety and consistency for this important, high-risk drug therapy.

CiCi Teixeira, office manager, Anticoagulation Management Unit (left), and Drena Root, RVT, technical director of the Vascular Lab at MGH West, demonstrate carotid-artery screening exam at the DVT educational booth in the Main Corridor.



Some of the risk factors associated with DVT include: certain heart and respiratory diseases; prior incidence of DVT; advanced age; cancer; medical illness with restricted mobility; a predisposition to clotting; obesity; and stroke, among others. Symptoms of DVT include: pain, swelling, tenderness, discoloration or redness of the affected area, and warmth of the skin.

For more information about DVT, call Lynn Oertel, RN, in the Anticoagulation Management Unit at 6-6955.

Ensuring safety in administering sound-alike, look-alike drugs

a National Patient Safety Goal

According to the Agency for Healthcare Research and Quality, about 15% of all medication errors are the result of confusion between drugs that look alike or sound alike. For that reason, the Joint Commission has made sound-alike, look-alike drugs a National Patient Safety Goal (#3).

Q&As

Question: What are sound-alike, look-alike drugs?

Jeanette: Sound-alike, look-alike drugs are medications that sound similar when spoken aloud, have similar spellings, or are packaged similarly to other medications. An example of similarly spelled medications would be hydrOXYzine (an antihistamine) and hydrALAzine (a vasodilator). An example of medications that sound alike when spoken would be ZANtac and ZYRtec. The Sound-Alike/Look-Alike Medications Policy contains an updated list of MGH formulary medications that fall into these categories. The list does not need to be memorized; it is used by Pharmacy for the safe labeling and storage of drugs.

Question: Why is there so much concern about sound-alike, look-alike drugs?

Jeanette: According to the Agency for Healthcare Research and Quality, about 15% of all medication errors are the result of confusion between drugs that look alike or sound alike. For that reason, the Joint Commission has made sound-alike, look-alike drugs a National Patient Safety Goal (#3).

Question: Who develops the list of Sound-Alike Look-Alike Drugs at MGH?

Jeanette: The Joint Commission compiled a list of medications associated with errors related to similarities in their names. As part of our commitment to improve patient safety, the Medication Education Safety and Approval Committee at MGH selected a number of medications on the list and put processes in place to reduce errors, particularly during the preparation, dispensing, and administering of those medications. The list is reviewed and updated annually.

Question: What safeguards have been established to ensure patients are safe with regard to sound-alike, look-alike drugs?

Jeanette: The Pharmacy is responsible for physically separating sound-alike, look-alike drugs in Omnicell and on shelves where drugs are stored. Drugs stored on shelves are also identified by a special label that alerts pharmacists to check the drug name carefully to be sure they've selected the correct medication.

Nurses are alerted to the risk of sound-alike, look-alike drugs through the use of capital letters (or TALLman lettering). This distinctive lettering is used on labels and in Omnicell.

Question: What should nurses do to avoid errors related to sound-alike, look-alike drugs?

Jeanette: Whenever you see a string of CAPITAL LETTERS in a drug's name, it's an indication that other drugs have a similar name.

Stop. Check the spelling. Be sure you're using the right drug.

Question: Which drugs are most commonly involved in sound-alike, look-alike errors?

Jeanette: The most common drugs associated with sound-alike, look-alike errors involve opioids such as: hydromorphone, morphine, and hydrocodone; and oxycontin, mscontin, and oxycodone.

For more information about sound-alike, look-alike drugs, call the PCS Office of Quality & Safety at 3-0140.

Announcements

Jean M. Nardini, RN, Nurse of Distinction Award

The Jean M. Nardini, RN, Nurse of Distinction Award recognizes a clinical staff nurse who consistently demonstrates leadership and excellence in clinical practice. Recipient receives $1,000.
Nominees must be clinical staff nurses within Patient Care Services.

Deadline for nominations is April 9, 2009

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

Chapel Schedule for Holy Week 2009

All services held in the MGH Chapel on Ellison 1

Saturday and Sunday, April 4 and 5
4:00pm: Palm Sunday Roman Catholic Mass

Monday, Tuesday, Wednesday, April 6–8
12:15pm: Ecumenical Service and
4:00pm: Roman Catholic Mass

Thursday, April 9
12:15pm: Ecumenical Prayer Service
4:00pm: Roman Catholic Mass

Friday, April 10
11:00am: Second Day Passover/ Shabbat Service
12:00pm: Good Friday Service
4:00pm: Roman Catholic Service

Saturday, April 11
7:00pm: Roman Catholic Easter Vigil Mass

Sunday, April 12
12:15pm: Ecumenical Easter Service
4:00pm: Easter Sunday Roman Catholic Mass

Wednesday, April 15
10:00am: 7th Day Passover Service

For more information, call Rabbi Lanckton at 4-3228.

Elder care discussion group

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

Next session:
April 14, 2009
12:00–1:00pm
Yawkey 7-980

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

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.

Norman Knight Visiting Scholar Program

Judy Murphy, RN, vice president, Information Services for Aurora Health Care, is the 2009 Norman Knight visiting scholar. 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'Keeffe Auditorium
Reception to follow

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

MGH mourns the loss of Miriam 'Mim' Huggard

We are saddened to learn that long-time friend of the MGH community and veteran nurse, Miriam 'Mim' Huggard, died Monday, March 9, 2009, at the age of 99. Born in New Brunswick, Huggard graduated from the MGH School of Nursing in 1931 when she became a staff nurse in the Baker Building. In 1942, Huggard advanced to supervisor of the Phillips House Nursing Service and part-time instructor in the Staff Education Department. She was appointed director of that service in 1965 and served in the role until her retirement in 1976. She will be missed.

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.

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

Publisher
Jeanette Ives Erickson, RN
senior vice president for Patient Care

Managing Editor
Susan Sabia

Distribution
Ursula Hoehl, 617-726-9057

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

Next Publication
April 2, 2009

Educational Offerings – 2009

March 23

CPR Mannequin Demonstration

Founders 325
Adults: 8:00am and 12:00pm
Pediatrics: 10:00am and 2:00pm
No BLS card given
No contact hours

March 24

BLS/CPR Re-Certification

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

March 26

Nursing Grand Rounds

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

March 27

PCA Educational Series

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

March 30 & 31

Advanced Trauma Care for Nurses

Founders 3
Day 1: 7:00am–7:00pm
Day 2: 7:00am–7:00pm
Contact hours: TBA

March 30

Oncology Nursing Concepts

Yawkey 2-220
8:00am–4:00pm
Contact hours: TBA

March 30

Anticoagulation: Focus on Thrombosis-Prevention and Treatment

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

March 31

BLS Instructor Program

Founders 325
8:00am–4:30pm
No contact hours

April 1

BLS/CPR Re-Certification

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

April 6

ACLS Instructor Course

O'Keeffe Auditorium
8:00am–3:00pm
No contact hours

April 7

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

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

April 7

Code Blue: Simulated Cardiac Arrest for the Experienced Nurse

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

April 8

BLS/CPR Certification for Healthcare Providers

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

April 8

Pediatric Simulation Program

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

April 8

Nursing Grand Rounds

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

April 9

BLS/CPR Re-Certification

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

April 10

On-Line Electronic Resources for Patient Education

Founders 334
9:00am–12:00pm
Contact hours: 2.7

April 10

PALS Re-Certification

Simches Conference Room 3110
7:45am–4:00pm
No contact hours

April 13

CPR Mannequin Demonstration

Founders 325
Adults: 8:00am and 12:00pm
Pediatrics: 10:00am and 2:00pm
No BLS card given
No contact hours

April 13 & 14

Oncology Nursing Society Chemotherapy Biotherapy Course

Day 1: Yawkey 2-220
Day 2: Yawkey 7-920
8:00am–4:30pm
Contact hours: TBA

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

March 19th first annual Certified Nurse Day

If you are a nurse certified in any of a number of specialty areas, you'll be pleased to learn that March 19, 2009, has been designated the first National Certified Nurses Day. Certified Nurses Day was created to recognize and celebrate the contributions of board-certified nurses to the advancement of the nursing profession and to ensuring the highest standards and outcomes in patient care. Certified Nurses Day originated over a year ago as the idea of a member of the American Nurses Credentialing Center (ANCC).

Certified Nurses Day was created to recognize and celebrate the contributions of board-certified nurses to the advancement of the nursing profession and to ensure the highest standards and outcomes in patient care.

The American Nurses Association, which strongly supports certification, joined the ANCC in endorsing the creation of Certified Nurses Day. March 19th was chosen because it's the birthday of Margretta 'Gretta' Madden Styles, known as the mother of nurse credentialing. Styles was the architect of the first comprehensive study of nursing credentialing in the 1970s; she served as president of the American Nurses Association, the International Council of Nurses, the California Board of Registered Nursing, and the American Nurses Credentialing Center. A recipient of numerous international honors, Styles recognized the powerful role board certification plays in ensuring high standards of patient care.

The American Board of Nursing Specialties and the National Organization for Competency Assurance, who accredit the nation's leading nursing certification bodies, have joined in making March 19th Certified Nurses Day, and an effort is under way to seek Congressional recognition of the observance. Magnet-recognized healthcare facilities around the country strongly support Certified Nurses Day. The Magnet Recognition Program encourages healthcare organizations to promote continuous learning and certification among their nursing staff.

For more information on the newly created Certified Nurses Day, visit www.certifiednursesday.org.

Caring Headlines
March 19, 2009

Returns only to:
Bigelow 10 Nursing Office,
MGH, 55 Fruit Street
Boston, MA 02114-2696

First Class
US Postage Paid
Permit #57416
Boston, MA