

Caring

Headlines

May 28, 2009

Nurse Week 2009

*Science, safety take
center stage*



Staff nurses, Danielle Dumas, RN (left), and Clara Namkoong, RN, with patient, Frank Conte, in the Respiratory Acute Care Unit

Patient outcomes 'hardwired' to Excellence Every Day

When it comes to MGH nurses, there's no bigger fan than senior vice president for Patient Care, Jeanette Ives Erickson, RN. Her annual Nurse Week presentation has become an opportunity for her to publicly thank and recognize their dedication, commitment, and contributions to patient care. And this year was no exception. In a presentation rich with photographs, video clips of nurses, and a live interview with three MGH patients, Ives Erickson left no room for doubt—MGH nurses are simply the best! The following is an encapsulated version of Ives Erickson's presentation, and the consensus is, she has good reason to be proud.

This year, like every year, the MGH community comes together to say thank-you and reflect on the important role nursing

plays in ensuring excellent patient care. Given the complex times we find ourselves in—the challenging economic situation and the national H1N1 flu outbreak, celebrating your practice is more important than ever.

a better place. Recognizing your commitment and telling your stories is what Nurse Recognition Week is all about.

This week has been filled with stories about MGH nursing excellence—stories about the

you also think of yourself and your colleagues who take personal responsibility for the patients they care for.

An important question for us is: How do we sustain excellence? How do we achieve excellence

“Employees feel valued; members of the healthcare team feel their patients are getting great care; and patients feel the service and quality they receive are extraordinary.”

Studer describes nine principles necessary to achieve exceptional care:

- Commit to excellence
- Communicate at all levels
- Align behaviors with goals and values
- Build a culture around service
- Measure the important things
- Create and develop leaders
- Focus on employee satisfaction
- Build individual accountability
- Recognize and reward success

Studer may have written the book, but you put these principles into action each and every day. Let me tell you how

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“Employees feel valued; members of the healthcare team feel their patients are getting great care; and patients feel the service and quality they receive are extraordinary.”

—Quint Studer, former hospital executive
and author of *Hardwiring Excellence*

I'm sure you've all heard what our new President thinks about nursing: “Nurses provide extraordinary care. They're the front lines of the healthcare system.” And of course, I agree.

Nurses, like all of you, are heroes. You don't expect fame for your efforts. You are compassionate and courageous, and because of you, our world is

success of one nurse, one team, one department, or one nursing service.

Today, I want to share stories of your responsibility to patients. Stories of how you live ‘Excellence Every Day.’

When I mention the word, “excellence,” what comes to mind? Olympic athletes? Grammy-award winning musicians? Nobel-prize winners? I hope

every day? What does it look like? We understand it when we see it in others, but do we understand it when we see it in health care? If we don't understand excellence, how will we create change and improve patient outcomes?

Quint Studer, author of the book, *Hardwiring Excellence*, suggests that excellence in health care is achieved when:

Nurse Week Presentation (continued)

MGH nurses are hard-wired to excellence.

Commit to Excellence

A commitment to excellence positively impacts the bottom line while allowing an organization to fulfill its mission and remain true to its values. At MGH, our mission provides alignment and unity of purpose.

We are driven by a common vision and core values. This is why we are nurses, this is why we work at MGH. In service to others we have found purpose.

We contribute to and

make a difference in the lives of our patients and families. We advance the goals of our teammates and hospital by constantly striving for excellence.

Communicate at all levels

Since articulating our vision, we've made much progress toward actualization. Today, our work is organized under the umbrella of Excellence Every Day. Excellence Every Day has become a mechanism to help us see the

power of evidence-based practice. We are embracing evidence-based regulations, changing expectations,

using research and best practices to influence, shape, and change care delivery.

Excellence Every Day has helped us understand how individuals and teams can make a difference. We call you champions: Magnet champions; hand-hygiene champions; palliative care champions; ethics champions; 65Plus champions; pain champions; and Excellence Every

Day champions. The journey toward Excellence Every Day was once just an idea. Today at MGH, it is reality. Yes, there is much to do and there are always opportunities to improve.

President Obama, says people will judge us on what we build. Excellence Every Day champions are building something wonderful. Excellence Every Day champions are

front-line clinicians across all disciplines whom we've empowered with education and resources. Each day, champions share key information about National Patient Safety Goals and other quality and safety initiatives.

Feedback from patients is key in guiding our work. HCAHPS (Hospital-

*continued on
page 26*



Senior vice president for Patient Care, Jeanette Ives Erickson, RN (left) is joined by MGH patients (l-r): Jim Massman, Angela Adinolfi, and David Wooster.

Therapeutic Touch

and its effect on bio-behavioral stress markers in vascular surgical patients

Kicking off Nurse Week with her presentation, “The Effect of Therapeutic Touch on Bio-Behavioral Stress Markers in Vascular Patients,” staff specialist, Mandi Coakley, RN, shared the results of her research study aimed at testing the effect of Therapeutic Touch on patients recovering from vascular surgery.

Coakley hypothesized that patients who received Therapeutic Touch as an intervention following surgery would have significantly lower blood pressure, pulse rate, cortisol levels, respirations, and less pain and anxiety than patients who received traditional care. She sought to determine whether those who received Therapeutic Touch would have a greater ability to sleep, report an increased sense of well-being, and have an increased number of natural killer cells (a type of cell that constitutes a major component of the natural immune system). She hoped to be able to describe the experience of patients who received

Therapeutic Touch post-operatively to better understand its effect as a healing intervention.

In reviewing the literature, Coakley found evidence that complementary therapies such as acupuncture, massage, meditation, laughter, and Reiki, showed significant improvement in bio-markers such as pain, anxiety, stress, muscle tension, fatigue and depression. They impacted mood, alertness, quality of sleep, and relaxation. However, Coakley noted a gap in the findings related to the relationship of stress-reducing interventions such as Therapeutic Touch and their impact on bio-markers specifically related to post-surgical recovery.

For the purposes of her study Coakley used the following definition of Therapeutic Touch: a contemporary interpreta-

tion of several ancient healing practices, a consciously directed process of energy exchange during which the practitioner uses the hands as a focus for facilitating healing.

The intervention is administered with the intent of en-

abling people to re-pattern their energy in the direction of health.

The specific questions Coakley hoped to answer were: Does Therapeutic Touch differentially affect behavioral and biological stress markers? To what degree does it affect them? When does it occur? How long does it last? And what are the most valid, reliable, sensitive outcomes that create the least patient burden?

Using a sample group of 21 participants, all between one and seven days post-vascular surgery, Coakley provided Therapeutic Touch to 12 participants while the other 9 received traditional care. All interventions were performed between 1:00 and 3:00pm, and all variables (blood pressure, pulse, respirations, pain, anxiety, etc.) were measured before and after the intervention was administered.

Coakley found that participants who received Therapeutic Touch had significantly lower systolic blood pressure, were better able to sleep, reported

lower levels of pain, and showed lower levels of cortisol and higher levels of natural killer cells.

As predicted, there was a significant correlation between pain and anxiety. There was no significant relationship between cortisol and natural killer cells, between cortisol and a patient’s ability to sleep, or between natural killer cells and a patient’s sense of well-being.

In response to open-ended questions, participants had an overall positive response with statements such as: “It was very relaxing.” “I loved it. I think it was really helpful.” “I didn’t know what to expect, but I found it very relaxing.”

Coakley concludes that there’s a growing body of evidence that supports the use of Therapeutic Touch as an intervention in many patient populations. While we may not understand why Therapeutic Touch works, there’s evidence to suggest it should be incorporated into nursing practice as a complementary modality to help patients relax and decrease their pain.



Staff specialist,
Mandi Coakley, RN

The wisdom of experience

an interactive session with Barbara Mackoff

Two of the most powerful sessions presented this Nurse Week were facilitated by guest author, educator, psychologist, Barbara Mackoff, in her dual presentation, “The Wisdom of Experience.” Tapping into real-life stories of MGH nurses, Mackoff demonstrated the power of storytelling as a means to improve patient safety. She compared clinical narratives to windows (allowing clinicians to see how colleagues make sense of their experiences) and mirrors (allowing clinicians to make sense and discover deeper truths about their own experiences).

Mackoff talked about narratives in terms of their ability to usher us toward what she calls, ‘sense-making.’ How can we use narratives to shape solution-based models rather than simply describe problems. Using narratives as sense-making tools helps us close the gap between knowing ‘how’ and knowing “that” (integrating skills, patterns and connections).

When Mackoff talks about safety narratives, she’s talking about stories that reveal both the dangers and opportunities embedded in clinical situations. Safety narratives can focus on interventions (instances when a near-miss was prevented); errors (an actual mistake in practice); or adverse events (when an unintended injury or complication results in disability, a prolonged hospital stay, or death).

During each of her interactive sessions, Mackoff invited nurses to read narratives that fell into one of the above categories. Following each reading, Mackoff engaged in a dialogue to help tease out the sense-making lessons contained in each scenario. She demonstrated how a blame-free examination of errors can contribute to solution-oriented thinking and a shift in practice toward a genuine culture of safety.

Mackoff recommended adopting a worst-case-scenario way of thinking in

order to project and devise interventions and safety precautions for the future. She stressed the importance of staying connected to patients and their suffering; of balancing patients’ privacy with safety interventions; and

allowing cautionary tales to become instructive practice for the future. “Never,” she said, “lose sight of the power of your own experience, intuition, and instincts.”

When writing a narrative describing an adverse event, Mackoff recommends:

- describing the setting: where were you, what could you see, hear, smell?
- describing those present: who else was involved?
- giving an account of the event: what did you do and why?
- describing what happened next: what were the immediate consequences?
- describing your inner state: what were you feeling and thinking?
- describing the impact: how were you changed by the adverse outcome?
- describing your reflection: what information could have helped avoid the situation? Are there alternatives you might have considered but didn’t? Were there small mistakes that led to a bigger mistake?
- giving the story a different ending: how could this situation have ended differently—without the adverse event you described?
- revising the situation: what relationships, systems, or choices would lead to that different ending?
- describing your wisdom: how would you behave differently if you were in that situation again?

Thank-you to the nurses who courageously read their safety narratives: Lisa Bouvier, RN; Minochy Delanois, RN; Suzanne Fitzsimons, RN; Mary McKinley, RN; Christine Murphy, RN; Alexa O’Toole, RN; Bernadette ‘Bernie’ Warren, RN; and Kerri Tyman, RN. All narratives are included in this issue of *Caring Headlines* beginning on page 14.



Author, educator, and psychologist, Barbara Mackoff

The effect of music on patients undergoing cerebral angiography

a pilot study from Interventional Neuroradiology

Presenting on behalf of her research team (Patricia Arcari, RN; Jayne Sexton, RN; Christine Swanson, RN; Joy Williams, RN; and Joshua Hirsch, MD), principal investigator, Teresa Vanderboom, RN, shared the results of their pilot study, "The Effects of a Music Intervention on Patients Undergoing Cerebral Angiography for the First Time." The study tested the effect of music on stress response, anxiety, and need for medication in patients who had a cerebral aneurysm or arteriovenous malformation and were having a cerebral angiography for the first time.

For the purposes of the study, a music intervention was considered to be the playing of patient-selected music via a stereo system in the room during the angiography.

The team hypothesized that participants who listened to music would have a significantly lower stress response (heart rate and systolic blood pressure) than those who did not listen to music; would

report significantly less anxiety (as measured by the State Trait Anxiety Inventory); and would receive fewer doses of medication (Versed and Fentanyl).

Forty-eight patients participated in the study; 9 men, 39 women, all over the age of 18. Data was collected at five pre-established intervals: upon arrival, in the procedure room (pre-procedure); after each angiographic 'run'; 30 minutes after arrival in the recovery area; and at discharge. Patients could choose the music they wanted to listen to (from a selection of jazz, classical, new age, country, pop, rock, folk, acoustic, or meditative). Music was played from the time patients entered the procedure area until they left.

Prior to the procedure, patients were asked a series of questions such as: How do you feel right now? Do you enjoy listening to music? How do you cope with stress? Following the procedure, they were asked a similar set of questions: How do you feel at this moment? What did you experience while listening to the music? Did you find the

music to be helpful? If you were to have another angiogram, would you want music to be played?

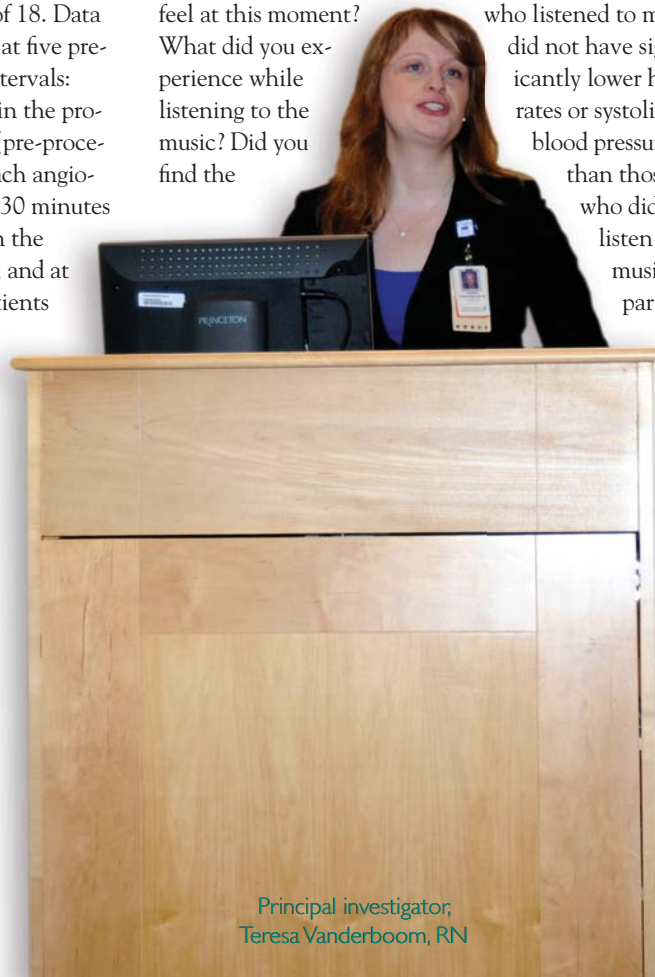
Vanderboom and her team were surprised by the results of their study. After accounting for the influence of covariance, they found that participants

who listened to music did not have significantly lower heart rates or systolic blood pressures than those who didn't listen to music; participants

who listened to music actually had *higher* anxiety scores at discharge than those who didn't listen to music; and there was no statistical difference in medication dosages between the control group and the experimental group.

The team concluded that a music intervention did not significantly influence stress response, anxiety, or medication requirements in patients listening to music while undergoing cerebral angiography. However, in thinking about re-tooling the study for the future, the team is considering using a larger sample size; limiting the music selection to one genre (or even one specific song requested by the patient); enlisting the aid of a trained music therapist; limiting the study to one diagnosis; and including cortisol analysis among other changes.

Overall, the study was well received by participants, and feedback in response to open-ended questions was that music should be offered to all patients having cerebral angiography.



Principal investigator;
Teresa Vanderboom, RN

Patients' perceptions of feeling known by their nurses

measuring the essence of the nurse-patient relationship

Associate chief nurse, Jackie Somerville, RN, has long believed in the healing power of the nurse-patient relationship. In her study, "Development and Psychometric Evaluation of Patients' Perceptions of Feeling Known by their Nurses Scale," she sought to more deeply describe, measure, and understand the phenomenon as experienced by the patient.

Following an extensive review of the literature and a qualitative study of patients' perceptions of feeling known by their nurses, items were developed guided by the four themes that emerged from the qualitative study: 1) patients' felt recognized by their nurses as a unique human being; 2) patients felt safe; 3) patients experienced a meaningful personal connection with their nurses; and 4) patients felt empowered by their nurses to

participate in their care. Somerville set out to develop an instrument to measure patients' perceptions of feeling known by their nurses (the PPFKN Scale) and to conduct a psychometric evaluation of the PPFKN Scale.

To do so, she asked the following research questions:

- How valid is the PPFKN Scale
- How consistent is the PPFKN Scale?

And to what extent can four key themes be demonstrated by analyzing the components of the Scale?

- How consistent are the sub-scales derived from the preliminary analysis?

An 85-item survey, later whittled down to 77, was crafted to reflect the themes that emerged from the qualitative study.

The survey was administered to 327 participants (surgical patients across seven general care units). Each survey was sealed in the presence of the nurse, and there were no patient identifiers on the envelopes. 296 completed surveys were collected and

analyzed. Analysis resulted in a 48-item scale with four reliable sub-scales

consistent with themes that had emerged from the qualitative study.

Somerville sees the PPFKN Scale as a valuable tool with many positive implications for the future of nursing. For instance, the Scale is a way to 'listen' to the voices of patients so nurses can begin to understand the uniqueness of each person and use this knowledge to guide

changes in nursing care and the overall healthcare experience.

Says Somerville, "The ability to measure patient's perceptions using a reliable and valid instrument will give us new insights and help us design new nursing interventions and care-delivery models. Nurse educators can influence new practitioners in understanding that the value of being known by your nurse is as important when designing nursing interventions as the results of randomized clinical trials."

Somerville sees opportunities to expand the use of the PPFKN Scale with applications across a variety of populations. Using a similar tool, research studies could explore the relationship between patients and their nurses and the impact of that relationship on recovery and healing. Research could focus on the nurse-patient relationship and the influence of organizational and environmental factors that contribute to, or detract from, patients' perceptions of feeling known by their nurses.



Associate chief nurse,
Jackie Somerville, RN

The Institute for Patient Care

the critical link in transforming patient care

If you had any questions about the purpose, goals, or make-up of The Institute for Patient Care, executive director, Gaurdia Banister's Nurse Week presentation, "The Institute for Patient Care: the Critical Link in Transforming Patient Care," put all those questions to rest. As many already know, The Institute for Patient Care is comprised of:

- The Center for Innovations in Care Delivery (located on the 4th floor of the Professional Office Building)
- The Maxwell & Eleanor Blum Patient and Family Learning Center (located off the White 1 Main Corridor)

- The Norman Knight Nursing Center for Clinical & Professional Development (located on Founders 3)
- The Yvonne L. Munn Center for Nursing Research (located on the 4th floor of the Professional Office Building)

Each of the Centers within the Institute has a distinct mission. The Center for Innovations in Care Delivery brings teams together to identify opportunities, to estimate the impact of change (including workforce demographics, new technologies and regulatory changes) and to construct innovations.

The Blum Center provides the

highest quality patient-education and health-information services to MGH patients, families and staff.

The Knight Center promotes life-long learning and clinical excellence by establishing, supporting, and fostering learning opportunities for the attainment of knowledge and skills necessary for safe, competent, compassionate, patient-centered care.

And The Munn Center advances the development, test-

ing, and utilization of knowledge to improve patient care and optimize professional nursing practice through research.

Together, these entities represent a first-of-its-kind, inter-disciplinary resource designed to foster teamwork, share



Taryn Pittman, RN

Gino Chisari, RN

Gaurdia Banister, RN

best practices, and promote creativity. These Centers serve as an infrastructure to support the development and delivery of informed, inter-disciplinary, patient- and family-centered care. Through an inclusive, collaborative approach, The Institute for Patient Care strives to:

- foster an environment of clinical inquiry and experiential learning
- create a synergy across all Centers to advance the goals of the Institute
- promote inter-disciplinary team learning to optimize safe, effective patient care
- support research and initiatives that advance safe, effective, evidenced-based practice
- seek funding opportunities to advance the work of the Institute
- advance Patient Care Services' agenda by developing, implementing, and evaluating initiatives that impact staff and patient outcomes.

- disseminate the work of PCS and the Institute through local, national, and international forums

Housed within the Institute are a number of inter-disciplinary programs and initiatives, including:

- The Awards and Recognition Program
- The Clinical Recognition Program
- Collaborative Governance
- Consultation Services
- Culturally Competent Care Curriculum
- Credentialing
- The International Nurse Consultant Program
- The Leadership Development Program
- Organizational Evaluation
- Simulation Education
- Workforce Development
- Ethical and Clinical Decision-Making

Banister cited the many factors, both internal and external, affecting health care today. From escalating costs, workforce shortages, information technology, health literacy, and access to care, to increasing patient acuity, regulatory compliance, documentation, and length of stay, there is a need for new, coordinated, far-reaching solutions.

Said Banister, "By fostering an environment of clinical inquiry and experiential inter-disciplinary group learning, innovative answers will be generated to respond to new and on-going concerns about delivering safe, timely, efficient, cost-effective, culturally sensitive, patient-centered care." She described the collaborative approach embraced by the Institute in which, supported by knowledge, education, and innovation, a problem is identified, a search of the literature is performed, experts are identified, and the ap-

propriate teams are assembled to assess the problem and propose solutions. "We are putting people together who have the vision, knowledge, and desire to tackle these issues."

Joining Banister for a discussion of some of those issues were: Barbara Blakeney, RN, innovations specialist, The Center for Innovations in Care Delivery; Brian French, RN, simulation program manager, The Norman Knight Simulation Program; Dorothy Jones, RN, director, The Yvonne L. Munn Center for Nursing Research; Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development; and Taryn Pittman, RN, manager and patient education specialist, The Maxwell & Eleanor Blum Patient and Family Learning Center.

In a passionate exchange of ideas, a question and answer session focused on evidence-based practice, the national nursing and workforce shortage, and the potential of all role groups to help shape the future of health care.

Banister closed by sharing a quote from Robert Wood Johnson Foundation senior adviser for Nursing, Susan Hassmiller, RN, who said, "Our

goal is to create a healthier nation and provide high-quality care at the exact time patients need us—from birth to death and every moment in between."



Dottie Jones, RN

Brian French, RN

Barbara Blakeney, RN

The Pursuit of Quality

17th annual Yvonne L. Munn Nursing Research Lecture

In her timely, thought-provoking, and fact-filled presentation, "The Pursuit of Quality," Claire M. Fagin professor and director of the Center for Health Services and Policy Research at the University of Pennsylvania, Linda Aiken, RN, made her point with her very first slide: "People are the most valuable asset of healthcare institutions: how they fare is an important window on the quality of patient care."

Sharing the results of her 2006–2008 research, "A Multi-State Nursing and Patient Safety Study," Aiken drove the point home. The study, conducted in four states (Pennsylvania, California, New Jersey, and Florida) was one of the largest and most comprehensive ever conducted, encompassing 80,000 nurses, 800 hospitals, literally millions of patients, and representing all nursing practice settings. The study found that nurses' dissatisfaction with their jobs is highest among nurses who work in hospitals and those who work

in direct patient care. And hospital nurses were substantially less satisfied than pharmaceutical nurses with most aspects of their jobs.

Aiken considers nurse-satisfaction and nursing burn-out rates to be important because the country is struggling economically; some hospitals report a decrease in census; according the American Hospital Association 50% of hospitals have cut staff; and long-term workforce shortages are still looming. Aiken suggests it's important to pay attention to these statistics now because nurse-satisfaction and nursing burn-out rates are predictors of patient mortality and patient satisfaction with care.

Aiken shared a number of the current quality initiatives and tools for monitoring im-

provement in care. The problem is not a shortage of data. Pay for Performance; public reporting of quality indicators; electronic physician order-entry and medical records;

the Institute
for Health
Care



Linda Aiken, RN, Claire M. Fagin professor, University of Pennsylvania

Improvement's 100,000 Lives Campaign; better identification and dissemination of best practices all make it possible to monitor and assess quality efforts. Demonstrating how easily accessible patient-satisfaction data is, Aiken included some of MGH's publicly reported HCAHPS data in her presentation.

Sharing the results of another study conducted by the National Database of Nursing Quality Indicators (NDNQI), Aiken pointed to the relationship between nurse staffing levels and patient falls on inpatient units. The study, a collaborative, inter-disciplinary project between the University of Pennsylvania, the American Nurses Association, and the University of Kansas School of Nursing, looked at the 2004 NDNQI database of 5,388 nursing units in 636 hospitals. The study focused on six types of units: critical care, step-down, medical, surgical, medical-surgical, and rehabilitation. Data was collected at the unit level and measured the num-

ber of falls per month, taking into account nurse staffing (hours per patient day) and whether or not the hospital had Magnet status.

Preliminary results of the study showed that nurses' (RNs and LPNs) daily hours were significantly associated with the likelihood of patient falls, but in different directions. RN hours were negatively associated with the likelihood of patients falling; LPN hours were positively associated with the likelihood of patients falling. One additional hour of RN care reduced the likelihood of falling by 2%; one additional hour of LPN care increased the likelihood of falling by 2.4%. And the likelihood of falls was 5% lower in hospitals that had Magnet status.

Aiken closed by sharing some other findings from the University of Pennsylvania. Research has shown that specialty certification for nurses with BSNs is associated with lower mortality. The nurse work environment is the major predictor of

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2009 Yvonne L. Munn Nursing Research Awards

patient satisfaction—not just staffing levels as suggested by the recent *New England Journal of Medicine* paper. And an interesting prediction based on a comparison of hospitals in Pennsylvania, California, and New Jersey: California hospital staff nurses care for one fewer patient, and medical-surgical nurses care for two fewer patients than nurses in Pennsylvania and New Jersey. Aiken's team estimates that hospital mortality could be reduced by 13% if Pennsylvania and New Jersey adopted the California model of nurse staffing levels.

Following Aiken's presentation, this year's Yvonne L. Munn Nursing Research awards were presented. See photos on this page.



At left: 2009 Yvonne L. Munn Post-Doctoral Fellowship recipient, Ellen Robinson, RN, with her mentor, Diane Carroll, RN. Robinson's research study, "Exploring the Basis of Surrogate Requests for Life-Sustaining Treatment when the Patient is at the End of Life," will provide evidence for nurses and other healthcare professionals to protect irreversibly ill patients from suffering while at the same time learning from surrogate decision-makers who are reluctant to authorize re-direction of care away from life-sustaining treatment. Demands by surrogate decision-makers for life-sustaining treatment for irreversibly ill patients is a common theme encountered by the MGH Optimum Care Committee.



Above: Recipients of the 2009 Yvonne L. Munn Nursing Research Award, Michelle Knowles, RN (center) and Tracey Lafferty, RN (right), with their research mentor, Laurel Radwin, RN. Knowles and Lafferty will study, "The Impact of Epidermal Growth Factor Inhibitor-Related Rash on Quality of Life for Cancer Patients."



Above: 2009 Yvonne L. Munn Nursing Research Award recipients (l-r): Anne Lamontagne, RN; Kathryn Beauchamp, RN; Brenda Miller, RN; and their research mentor, Paul Arnstein, RN. Their study will look at "Storybook versus Traditional Education for Children (aged 2–7) and their Families," comparing materials produced by the American Academy of Pediatrics with non-traditional reading materials.

Interactive nursing research poster display and doctoral consultation sessions

sharing nursing knowledge and best practices

As part of the MGH Nursing Research Expo, which included scientific sessions, poster displays, oral presentations, and doctoral consultation sessions, members of the MGH nursing research community came together to share, educate, inspire and foster interest in future nursing research.



Making the 'authentic connection'

exploring ways to build culturally sensitive relationships

In a departure from other Nurse Week presentations, Vanessa McClinchy's "Making the Authentic Connection in Service," was short on PowerPoint slides and long on inter-personal connections and self-reflection. McClinchy, an education management consultant, began by introducing herself as 'a fellow passenger,' explaining she borrowed the term from Charles Dickens' *A Christmas Carol*. Dickens described Christmas as: "...a good time: a kind, forgiving, charitable, pleasant time: the only time I know of, in the long calendar of the year, when men and women seem by one consent to open their shut-up hearts freely, and to think of people below them as if they really were fellow-passengers to the grave."

That set the tone for McClinchy's session in which she talked about MGH as a 'sacred space,' where the talented few toil to provide care to the

vulnerable. She recalled the first time she cared for a patient recounting an incident in which the doctor (in a patriarchal medical system) made a cultural faux pas, teaching her early in her career the importance of artful negotiation and cultural sensitivity.

Said McClinchy, "We're all hardwired for human connection. If the Civil Rights Movement taught me anything, it's that we're all born, we all live, and we all die. What's important is how we roll in the interim. We need to be our best so we can do our best for our fellow passengers."

McClinchy showed an image of a prism and asked attendees to think of the prism in terms of their interactions with patients and colleagues. Each of us is comprised of many facets just like a prism. How do these facets inform our core values? What facets are most im-

portant to us? What facets are still raw and need polishing? What facets would you like to see reflected in others? What facets are most important as we strive to care for the vulnerable

among us? What facets do we want to nurture and develop to make ourselves better clinicians and better people?
Food for thought.

Not a fan of the status quo, McClinchy frequently reminded attendees, "We live to rock the construct." She challenged attendees to take an introspective journey to explore their own perspectives related to power, privilege, justice, and diversity. What has each of our journeys taught us with respect to these four standards?

McClinchy guided attendees through an interactive exercise. She asked all present to identify their most significant 'facets,' to answer the questions, What makes you, you? What made you decide to take this path in life? What is important to you? What hidden talents do you possess? And how do these facets of your being inform your perceptions of power, privilege, justice, and diversity?

McClinchy got the ball rolling. She urged attendees to take these 'seeds of thought' and keep the dialogue going. Keep making that human connection.



Education management consultant,
Vanessa McClinchy

Resourcefulness, reassurance reverse need for restraints

—by Lisa Bouvier, RN, White 9, General Medical Unit

I have always felt that one of the blessings of being a nurse is our intimate exposure to people—wonderfully large volumes of diverse people, presenting like well written books given to us by luck or fate depending on your philosophy. Each one is temporarily brought to the space called, White 9, to be looked at, figured out, fixed, patched-up, made better, or made comfortable. We see so many stories that don't exist for people in other professions. Who would believe us if we shared?

The morning I first met 'Kelly,' things started off well. She had been admitted during the night after being transferred to MGH from an outside hospital. I completed her morning physical assessment and administered her medications without issue. As is often the case with house medical patients, Kelly came to us with a single-line diagnosis that hardly covered who she was and the road

she traveled to get here. Based on the information we had, the night-shift nurse had initiated a 1:1 observer to create a safe environment for Kelly. The observer was very attentive and knew when to call for assistance.

As the morning progressed, a series of small disappointments (four boxes of Life cereal instead of the requested seven) began to unravel Kelly's coping skills. The loss of control Kelly experienced coupled with her unfamiliar surroundings prompted her behavior to escalate. As Kelly's behavior escalated, it became clear that important pieces of her medical history were missing. These missing pieces led to an adverse event and prolonged hospitalization.

The team, including Kelly's nurses, physicians, Police & Security, the psychiatric clinical nurse specialist, and Kelly's psychiatrist convened to establish a plan for her immediate safety. It was quickly decided that she

would need restraints and medication to calm her and keep her and us safe. Because I had begun to establish a connection with her, I felt it important for me to remain neutral and attempt to provide comfort. I quietly reassured her that she would be safe. After much resistance, she fell asleep.

At this point in her care, Kelly was hysterical and very frightened; she was unable to process any information and needed continuous support. The care team decided that for her safety and the safety of her care providers, she should remain in restraints. In the meantime we worked to uncover the missing information from Kelly's medical history and manage her medical needs. For the remainder of my shift and the next day, Kelly remained in restraints. I had the following two days off and when I returned to work, Kelly was still in restraints. While the team had worked tirelessly to formulate a plan for Kelly's

safety, no definitive plan for how to remove the restraints was made.

While I was away, a plan to transfer Kelly to a more secure environment had fallen through. This had been the only plan to remove the restraints. Now, even though Kelly's medical needs required prolonged hospitalization, her plan of care didn't address long-term needs or alternative interventions, which led to a prolonged period of restraint.

Realizing the importance of getting Kelly out of restraints, I made it my absolute priority. I set to work gathering all the members of the team who had worked so hard to keep Kelly safe early in her admission so we could formulate a plan to remove her restraints while still maintaining her safety. Through a collaborative effort of all care providers, we determined that Kelly would be the most important participant in this plan.

With Kelly's permission, I involved her

mother in her care. Kelly was very close with her mother and talked with her daily on the phone. Having her mother reinforce with Kelly our desire to keep her safe seemed to increase her participation and compliance.

As I got to know Kelly better, I was able to recognize her stress triggers and set daily goals to maximize her success. I felt that with the right behavior plan she would be able to come out of restraints successfully. In collaboration with the psychiatric clinical nurse specialists, I typed a chart with Kelly's daily goals for remaining restraint-free, including such things as having her vital signs checked and keeping the volume of her voice contained to her room. A gold star would be placed next to each task she successfully accomplished. In order to avoid the same pitfalls we had encountered previously, and having no alternative interventions in place, the team decided

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Learning by experience takes on new meaning for Phillips 22 nurse

—by Minochy Delanois, RN, Phillips House 22, General Surgical Unit

Charlie' was a 66-year-old man admitted to Phillips House 22 for surgical intervention of an abdominal abscess. Charlie had numerous medical issues including a history of prostate, renal, bladder, and colon cancer. Charlie had Type 2 diabetes, hypertension and coronary artery disease, and had suffered an MI in the past. When he was admitted, Charlie was in fluid retention and had become extremely edematous in all extremities due to numerous DVTs that were later detected via ultrasound.

I was one of Charlie's primary nurses during his three-week admission. Due to a number of drains that had been placed, Charlie experienced back pain that radiated to the insertion sites of the drains. One particular day, he complained of flank pain and requested medication. Since I had been caring for him al-

most every day for a couple of weeks, we found a good PRN pain medication that provided Charlie with excellent pain relief. We had been giving him 5mg/5ml Oxycodone elixir by mouth as needed. When he called for his pain medication, I checked the medication administration record (the green book) to make sure this medication was still prescribed for him and to make sure he was due for it because it was a PRN medication. Once I verified everything in his green book, I went to the Med Room to pull the medication from Omnicell and did the narcotic count-back as directed. I poured the medication into a clear measuring cup and noticed that it was orange. I had given Oxycodone many times before, especially while caring for Charlie, and I knew Oxycodone was red, not orange. I immediately knew something was wrong. I smelled the medication knowing what Oxycodone

smells like. I thought perhaps the medication had expired, which might explain the difference in color and smell, so I checked the packaging for the expiration date and realized it was the *wrong* medication: Neomycin, not Oxycodone!

My first reaction was complete shock because there was a wrong medication in the narcotic drawer. I was more shocked that Neomycin came in the exact same packaging (red container with white cover) and looked exactly like the Oxycodone I had given so many times before. I remember thinking, "Oh my God, I almost gave the wrong med!" This patient had so many other medical problems, the last thing he needed was the wrong medication. I was so thankful I caught this error before giving my patient this wrong medication. I felt relieved that no harm had come to my patient. I didn't want this to

happen again, to my patient or any other patient, so I immediately went back in to the narcotic drawer that contained the Oxycodone and checked every single one to make sure they were all the right medication. I saved the Neomycin, showed it to the other nurses, and told my resource nurse and nursing director what had happened. We talked about how important it is to double-check medications because even though they're in the right drawer, they might not be the right medication.

Everyone was surprised to learn this could happen. They were all concerned about the safety issue and thankful to have learned from my experience instead of having to find out for themselves. I paged the pharmacist covering our unit and informed him about the incident. I also filed a safety report and discussed this "near-miss" incident at our monthly Quality & Safety rounds so all nurses

were aware and informed.

One of the things I learned from this experience was to trust your instincts as a nurse. Even being a somewhat new nurse myself and not having as much experience as other nurses, I knew enough about this medication to know it didn't look or smell right, which enabled me to double-check and determine it wasn't the right medication.

One of the biggest fears for a new nurse is making a mistake, but this experience showed me that incidents like these help me and other nurses (even senior nurses) learn how to prevent these mistakes from happening in the future. I learned early on from other nurses that "once a mistake is made, you'll learn from it and never make the same mistake again." I'm glad I experienced that and learned from it because it is something I will never forget.

Accidents can happen no matter how vigilant the care

—by Suzanne Fitzsimons, RN, Post Anesthesia Care Unit

It was a quiet Thursday morning in the Same Day Surgical Unit, which is typical since cases start late in the operating room on Thursdays. I was asked to have a chair set up in my area for my first patient. Mr. P arrived with the OR nurse who reported that Mr. P was a generally healthy, 75-year-old man who had had a carpal tunnel release on his left hand. Mr. P did not receive any sedation or anesthesia for this procedure. He had what we call a, “straight local,” meaning his left hand and wrist were numb at the site of the procedure. These patients don’t require an escort in order to leave the hospital; they don’t receive any mind-altering medications.

A few other nurses and I got Mr. P settled in the chair, took his vital signs, which were normal, and offered him something to

eat and drink. As I was getting his orders and discharge paperwork together, Mr. P chatted with me and a few other nurses. He was an active man who lived and worked locally. In fact, he was planning to walk to work after the procedure. He talked about his family and how much he enjoyed skiing.

After reviewing discharge instructions with Mr. P, I told him he could get dressed to leave. I let him know if he needed any help, especially with buttoning or tying, I’d be right outside the curtain. Mr. P. replied that he should be fine.

Moments later as I worked on my paperwork, I heard a loud thud. I immediately opened the curtain and found Mr. P on the floor in a sitting position. Once I confirmed that he hadn’t hit his head, I asked what happened and he told me he had sat on the arm of the chair for balance as he put his pants on. The arm of

the chair was a bit loose, and he lost his balance and fell to the floor. He had fallen on his left side and had tried to break his fall with the hand on which he’d just had surgery. I asked if anything hurt. His wrist was covered with blood. He said his left hip felt uncomfortable. I told him not to put any weight on his left leg as the nurses and I helped him up and onto a stretcher. The whole time Mr. P kept apologizing, saying how embarrassed he was. We all reassured him that it was an accident and he shouldn’t apologize. We just wanted to make sure he was okay.

I felt terrible that this had happened. I notified the surgeon about the fall and the resident came to assess Mr. P. He wrote orders for X-rays of Mr. P’s left hip, leg, and wrist. The X-ray showed that Mr. P had broken his hip and would need to have it surgically repaired. During

this time, Mr. P’s wife was notified and came to the hospital. We requested a bed on an orthopaedics unit, but unfortunately it wouldn’t be ready for several hours.

Mr. P’s wife arrived and was very understanding. She stayed by Mr. P’s side until he was ready to be transferred to the unit. We did our best to make them as comfortable as possible. We ordered lunch and offered them reading materials. Initially, Mr. P reported no pain, but as the day went on, he became increasingly uncomfortable. We started IV fluids and morphine by patient-controlled analgesia (PCA). Eventually Mr. P’s pain subsided.

Mr. P. left for the unit around 5:00pm. He was so gracious considering what had happened. He thanked everyone for their care and we all wished him a quick recovery. I wasn’t scheduled to work the following

day, but my nursing director, visited him after his surgery. Mr. P said he felt pretty good despite having spent an uncomfortable night.

In response to this incident and other falls in ambulatory surgery, a task force was assembled to look at our practice with regard to patient falls in the perioperative services. The task force is a multidisciplinary group comprised of nurses, physical therapists, physicians, case managers, and OR administrators. After investigating the incidence of falls in our area, a fall prevention program was developed to identify patients at risk for falling using the Morse Fall Scale and ambulatory-specific fall-prevention interventions. Education has begun and will be implemented in perioperative services including the Pre-Admission Testing Area and pre- and post-op settings.

Re-building relationship helps 'transform' suicidal patient

—by Mary McKinley, RN, Blake || Inpatient Psychiatric Unit

Fourteen years ago, I came to MGH with the hope of expanding my psychiatric and medical practice to include medically complex psychiatric patients, uniting my love for both nursing specialties. I've had the opportunity to work with challenging patients enabling me to grow professionally and personally while delivering the highest standard of care.

Last year, along with a nursing student, I volunteered to admit a transfer patient from a local rehab hospital who would challenge me to a higher level than I have known in my 23 years of nursing. After reading the discharge summary, I quickly prioritized the plan of care, reviewed the many medical and psychiatric diagnoses, and made a tentative list of treatment goals. All this would change after I completed the admission.

'Sonya' is a 39-year-old woman, mother of two boys, ages 9 and 6, with a past psychiatric history of

major depression and borderline personality disorder. She had also harmed herself by setting herself on fire earlier last year.

This was determined to be probable psychotic depression resulting in burns over 35% of her body on her face, neck, chest, arms, and trunk, with permanent scarring of her vocal chords resulting in a permanent tracheotomy. She also suffered scarring that resulted in subglottic stenosis requiring a nasal gastric tube for nutrition. Hepatitis C and *c-diff* colitis were listed as ongoing problems.

While at a local rehab hospital, Sonya expressed suicidal ideation and attempted to discontinue her tube feeds and the antibiotics for her pneumonia and *c-diff* infection. Her parents were conflicted about Sonya's wishes to stop treatment and allow her to die. Her major emotional support was her friend, Joan, who was described as somewhat intrusive and interfered with Sonya's treat-

ment, according to her hospital records.

During the interview, I had to sit close to hear her, as Sonya was only able to speak in a whisper due to the laryngeal scarring. This required tremendous effort on my part to keep a non-expressive manner as Sonya was quite disfigured, and I had never seen anyone so severely burned. Asking the reason for her self-injury was difficult but necessary. Sonya spoke about the events leading up to the incident in which she reported depression with insomnia, increased suicidal ideation, verbal abuse from her boyfriend, and threats to have her children removed by the Department of Social Services. She said her boyfriend taunted her by saying she was an actress and was afraid to do anything. Her response after the event was, "I thought he would rescue me."

I reviewed the safety contract we ask all of our patients to sign. I reviewed the statistics of

suicide in families and asked if this was the legacy she wanted to leave her children. This statement was viewed as threatening by Sonya, prompting her to tell the psychologist she didn't like me.

In the next few days, it was decided that Sonya would need a primary nurse for continuity of care and future treatment planning. Although I had volunteered to admit Sonya, I was reluctant to be her primary nurse because her illness was close to home for me for personal reasons. My father, now deceased, had lost his voice to cancer 13 years ago. My brother had died from burns sustained when he was 18 months old. Growing up, my parents had instilled a fear of fire and burns in us and insisted we perform regular fire drills at home. I couldn't see myself as Sonya's primary nurse. However, as no one else volunteered, I saw the need and accepted the challenge.

This began my relationship with Sonya with its many twists and turns. First, there was a disagreement with Sonya's friend, Joan, about being present during wound care and negative comments she made about staff and quality of care. I politely asked Joan to leave the room and when she refused, there was a verbal altercation resulting in Joan crying and leaving upset. While meeting with the social worker, Joan admitted to feeling burdened. She was trying to be Sonya's spokesperson but felt overwhelmed and ultimately decided not to visit for three weeks. I apologized to Sonya and asked if she thought we might be able to work together and move beyond this incident. For the next few weeks, we began to feel more comfortable with each other and a bond formed between us.

The weeks progressed, and as her primary nurse I became invested in her recovery and emotional

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‘Near miss’ leads to heightened awareness and safer nursing practice

—by Christine Murphy, RN, White 12 Neuroscience Unit

Being a relatively new nurse, I try to be very cautious, ask questions, and refer to senior staff if I need help. Well, on this particular day, I came into work, started my day as usual, got report, looked in on my patients, and checked labs. One of my patients had a hematocrit of 23. The doctor was aware of this and was trying to reach the family to obtain consent for a possible blood transfusion. At the time, the patient had only procedure consent, and the doctor wanted to touch base with the family. The doctor wrote an order that read, “Type and Screen/2 units packed RBC,” followed by an order for “Crossmatch.” When I looked at the order for further clarification, the instructions read, “Crossmatch (RBCs) 2 units Start ASAP.” The order seemed confusing, so I asked a senior

nurse nearby to look at the order with me. We both interpreted the order as, “Type/screen/cross-match and transfuse 2 units ASAP.” So I called for the blood to be sent to the unit. When the blood arrived, the same senior nurse agreed to assist me in verifying the order, verifying the consent and sample type, and hanging the blood.

After completing the process, we brought the blood into the room and got everything ready. The senior nurse and I went through the whole verifying process again and one unit packed RBCs (red blood cells) was hung. There I was thinking, “This day’s going okay. All medications are out, patients are bathed and up in their chairs, blood hung. Great job!” Little did I know that things were about to come to a screeching halt.

About an hour later, the doctor approached me and asked me something.

(I don’t remember the specific question, but it was something that made me realize that he hadn’t intended for the blood to be hung.) I remember thinking, “Oh my God! How could you! I’m quitting!” My heart stopped. After the blood returned to my vital organs, I ran to the patient’s room and shut off the blood. I didn’t know where to begin or what to do. I remember thinking I was never going to be a nurse again after this. I kept re-playing the incident in my head trying to figure out where I went wrong. When I told the doctor about the incident, he said he only put in the order so everything would be ready *if they decided to transfuse*, not to actually transfuse the patient.

So, what did I learn? No matter how long you’ve been a nurse, you’re going to make mistakes. The mistake, or misinterpretation, was not only made by me but also by the senior nurse and

the doctor. One order was interpreted in two ways by two different people, putting the patient at risk for harm. Fortunately, this patient was fine. Because we went through the correct verification process, the patient received the correct blood type and no harm came to her.

After completing a safety report and notifying my nursing director and clinical nurse specialist, the clinical nurse specialist notified the Center for Quality & Safety. They agreed that the order had been unclear. The directors of the Blood Transfusion Service and IV Therapy were notified. After reviewing this situation with others, I learned that ordering and obtaining blood is a three-step process: first, type and screen; second, type and cross; and third, an order to transfuse.

The notation, “Start ASAP” had confused not only me but also my senior nurse colleague. We

shared our feelings about the incident with the medical director of the Blood Transfusion Service for further follow-up and raised awareness among nurses on the unit for the potential for misinterpretation. This experience reinforced how important it is to read everything carefully and double check before you proceed whenever you have doubts.

So what I had thought was going to be the last day of my short-lived nursing career actually turned out to be a learning experience that made me a better nurse. I realize that even though a mistake was made, what’s really important is what we learned and that the patient wasn’t harmed. It’s so important when a mistake is made to ask ourselves, What did we learn from this, rather than blaming ourselves or looking for someone else to blame.

Trusting your instincts can help avert adverse events

—by Alexa O'Toole, RN, Blake 13 Newborn Nursery

I was in a postpartum mother's room at about 1:00am taking vital signs on a baby when I noticed the baby was jaundiced. The mom had opted for early discharge, and the baby had had a transcutaneous bilirimeter screening (TCB) to test for jaundice about four hours earlier. I turned the lights on to make a better assessment. The infant was jaundiced to the abdomen, which is more than you'd expect for an infant 24 hours old.

The mother asked if the baby's vital signs were normal. I reassured her that they were, but the

baby's skin looked a little yellow and I was concerned about jaundice. I wanted to do another screening before the baby went home. I let the mother know I was going to need to measure the baby's bilirubin again and I'd be right back with the screening tool. I told the mother that the TCB results were high and I'd need to draw blood to verify the reading. I asked mom if she'd like to accompany me to the nursery, but she preferred to wait in her room.

When I brought the baby to the nursery, the nurse

and resource triage nurse were assessing another infant. I discussed my baby with them and let them know I had performed an early TCB. (All newborns routinely have a TCB at 36 hours of life.) They thought this was appropriate. The TCB was 10.9, and our policy states that anything over 9 requires a serum bilirubin. I paged the neonatologist and we drew a serum bilirubin. The serum bilirubin was 14.9 which placed the infant at high risk for developing severe hyper-

bilirubinemia. Hyperbilirubinemia occurs due to a baby's inability to metabolize bilirubin. The lack of metabolism causes an excessive amount of bilirubin to accumulate in the baby's blood, which can result in brain damage or a number of other disabilities.

I paged the pediatrician and let her know the results. The neonatologist wanted the baby admitted to the Transitional Care Nursery. The neonatologist discussed with

the mother that her baby would

need to be placed in an isolette under phototherapy lights. The mother came to the Level I Nursery. Mother and baby were brought into the Transitional Care Nursery (Level II) where the baby had serial serum bilirubins to monitor for an increase in bilirubin.

The infant did well and continued to progress normally. After three days the bilirubin decreased to normal levels, and the baby was discharged. I learned that as a nurse you need to trust your instincts and assessment skills.

Barbara Mackoff (back left) with nurses who read safety narratives (Front row l-r): Mary McKinley, RN; Christine Murphy, RN; Alexa O'Toole, RN; Lisa Bouvier, RN; and Suzanne Fitzsimons, RN. (Back row): Minochy Delanois, RN; Bernadette Warren, RN; and Kerri Tyman, RN.



Recognizing mistakes as opportunities to enhance patient care

—by Bernadette 'Bernie' Warren, RN, Same Day Surgical Unit

It was a typical day in the Same Day Surgical Unit. Mr. C arrived and checked in with the operations associate at the reception desk at 9:30am for a right carotid endarterectomy scheduled for 11:30. All patients having surgery who aren't inpatients come through the Same Day Surgical Unit to be admitted the day of their surgery. Depending on the operating room schedule, the volume of patients entering the unit can vary (up to 60 patients at a time) and the waiting area can get crowded. On arrival to the unit patients check in, complete paperwork, and are often asked to be seated until a patient care associate can escort them to the dressing room to change into a hospital gown. Sometimes patients need additional tests on the day of surgery. The normal process is to have the order, patient labels, and lab slips in the patient's chart so the patient care associate can

complete the phlebotomy. Usually one patient care associate is assigned to draw blood for the day, which is done in an area on the unit where there's a reclining chair and phlebotomy supplies. On this day, Mr. C met patient care associate, Cindy, who

modates four stretchers and one chair. One role of pre-op nurses is to interview and perform a complete admission assessment on patients prior to surgery. Usually, the nurse goes to the waiting room and meets the patient and completes a pre-operative

On this day, pre-op nurse, Marianne, interviewed Mr. C by reviewing his health history, completing a nursing assessment, and confirming that the ordered blood work had been drawn. The patient noted how 'busy' it seemed with a

This can be stressful as patients anticipate their surgical procedure and see other patients taken to the operating room. At 12:15, pre-op nurse, Julie, received a phone call from the operating room letting her know that Mr. C was on call and the surgeon was requesting a STAT PT/INR. Julie collected the appropriate lab slips while a third patient care associate, Kristy, went to get Mr. C. He said goodbye to his family and Kristy brought him back to the pre-op area. Kristy proceeded to draw his blood for the second time. After the blood was sent, Mr. C asked if there had been a problem with the blood that had been drawn earlier. Kristy, appropriately, asked Julie to see if Mr. C had had blood drawn already. During this discussion, Marianne returned from lunch and overheard the conversation. She confirmed that Mr. C did have a STAT PT/INR drawn upon ad-

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Now, each pre-operative patient is assigned a primary nurse who attends to all aspects of his or her care in the pre-operative setting until transfer to the operating room. In the event the primary nurse is not available, an associate nurse is assigned to the patient, as well.

wrote down his escort information and assisted Mr. C in changing into his hospital gown. A lab slip for a STAT PT/INR was in the front pocket of the chart. Mary, the patient care associate who was assigned to do blood work that day, took Mr. C to the lab area to draw his blood. After the blood was drawn Mr. C returned to the waiting area to sit with his family.

The Main Operating Room pre-op area is a small room that accom-

modates four stretchers and one chair. One role of pre-op nurses is to interview and perform a complete admission assessment on patients prior to surgery. Usually, the nurse goes to the waiting room and meets the patient and completes a pre-operative assessment in one of the interview rooms. After the admission assessment is completed, the patient usually returns to the waiting room until they're put 'on call' to limit overcrowding of the pre-op area. When a patient is put on call, he's escorted to the pre-op area either by a patient care associate or a pre-op nurse. The patient is then put on a stretcher and the transporter from the operating room transports him to the operating room.

very crowded waiting area. Marianne confirmed that it was a high-volume area with anywhere from 100 to 120 patients every day. She reassured him that if he felt he might need anything or had questions he could speak to the operations associate and the liaison nurse would be called to assist him.

Mr. C returned to the waiting area with his family. It's common for patients to spend up to two hours in the waiting area.

Near-miss scenario points to need for better communication

—by Kerri Tyman, RN, Medical Intensive Care Unit

My name is Kerri Tyman and I am a staff nurse in the Medical Intensive Care Unit (MICU). Since 2007, I have assumed the role of resource nurse on both the day and night shifts. The resource nurse works in collaboration with the medical team's on-call junior resident, the nursing triage supervisor, staff nurses, and support staff to coordinate patient admissions and discharges from the unit. If the MICU were a playing field, the resource nurse would function as both a team captain and a mid-fielder as she leads the team to accomplish a goal while at the same time backing up her teammates.

When I am the resource nurse, I don't have a patient assignment. I spend the majority of my time supporting nurses caring for the sickest patients, answering clinical questions, and trou-

bleshooting clinical issues. As you can imagine, good communication skills are necessary to effectively execute the responsibilities of a resource nurse and maintain a safe and efficiently run environment. During a recent

completed their work were helping co-workers who had admitted a sick, young woman at 2:00am.

When I found the night-shift resource nurse she said, "Boy, am I glad to see you! I hope you wore your roller skates be-

tient's room to see how I could help her nurse. The young patient was an otherwise healthy, active mother of two who was inexplicably in septic shock and fighting for her life. As several nurses, doctors, and I worked to

age supervisor about Mr. 'Jones,' a 72-year-old man who wasn't doing well on a medical unit and needed to come to the MICU immediately. The supervisor explained that Mr. Jones had recently undergone radiation, chemotherapy, and surgery to treat laryngeal cancer. He was in respiratory distress and being supported on BiPap (a type of non-invasive, positive pressure oxygenation and ventilation). The doctors and nurses on the medical unit were concerned that Mr. Jones might require intubation or insertion of a breathing tube to maintain an adequate airway. Given Mr. Jones' treatment for laryngeal cancer, there was a high likelihood that he would be difficult to intubate due to anatomical changes in his airway from radiation and surgery. I told the supervisor that our unit was full and I would only be able to admit Mr. Jones after a patient who was being moved to another medi-

This scenario taught me to slow down and take the time to think. I need to look at the big picture and communicate my needs to others while paying close attention to clinical details. In the struggle to prevent near-miss errors, the best communication is 'over-communication.'

day shift, I was the resource nurse when a series of miscommunications led to a near-miss error and a delay in the delivery of a patient's care.

I walked through the doors of the MICU at 6:50 on a Tuesday morning, and right away I knew it had been a tough night. The nursing station was deserted, and the computer stations were empty. No one was working on their shift notes. Nurses were finishing up their work in patients' rooms and those who had

cause you're going to be busy." As I took report from her, I learned that four of our 16 patients were critically ill requiring 1:1 nursing care. Several patients were scheduled to have invasive procedures at the bedside and several more were scheduled to travel off the unit for CT scans. I glanced at the roster of nurses for the day and was reassured that I would be working alongside a dream team of MICU nurses. As soon as report ended, I went straight to the new pa-

stabilize her, a surgeon examined the young woman and announced that immediate surgical intervention was necessary. Instantly, we prepared her for the operating room and she was whisked away.

With the most critically ill patient off the unit, I sought out each nurse and asked if I could help with anything or if they had any questions or concerns I could follow up on. As I talked to the nurses and looked in on their patients, I received a call from the nursing tri-

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Bouvier Narrative
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that frequent checks by Police & Security would reinforce our desire to keep her safe and demonstrate our commitment to enforce the new plan.

I felt it was important that Kelly's care be delivered by the same staff who would be able to remain calm despite her challenging behavior. If my nursing intuition was correct, Kelly would succeed. I shared my thoughts with a hesitant medical team—they didn't want a repeat of the events that led to Kelly's prolonged hospitalization. With all team members on board, the details of the plan were explained to Kelly and we moved forward.

With the involvement of Kelly's mother, the care team began to feel more comfortable with Kelly and came to know some of the details of her life. She liked to draw and loved to sing loudly to soft rock music. She enjoyed laughing and telling us funny stories (albeit with a slight twist). She confided that she had a friend at her group home and she wanted to go back. Kelly was delighted to tell us of her plan to buy a new blue comforter and

posters for her room. She actually laughed and became very animated with her nurses.

As it turned out, gold stars were the driving force behind Kelly's success. She quickly accumulated a plethora of gold stars, her restraints were removed, and she was soon discharged from White 9.

Sometimes our success is marked by nothing more than simply giving witness to someone's journey and providing a safe place to be acknowledged and cared for. Sometimes our success is lined with lessons learned through our mistakes.

After many years in nursing, I've come to believe there is no invisible barrier between me and my patients. Our life circumstances could be interchangeable. We're all moving together in the same quick forward flow of life toward something most of us haven't yet figured out. And if my hunch is true, if we haven't figured out where we're flowing, then the way we travel on this journey has to be open-ended and subject to personal interpretation.

McKinley Narrative
(continued from page 17)

well-being. With the help of our psychologist, we developed a treatment plan to address Sonya's suicidal ideation using dialectical behavioral skills. This included making a list of statements that all staff could use when speaking to her to help with her emotional dysregulation. The treatment plan, which was developed with input from Sonya, included set times for meals, medications, burn care, and group activities. This helped provide consistent care and build a trusting relationship. I reviewed the plan with staff (including off-shift staff) to increase everyone's comfort when working with her. This helped Sonya become more comfortable working with a variety of nurses.

Sonya's medical needs were a constant issue on our unit. Sonya became increasingly uncertain about "wanting to live looking like this." She would say, "I don't know if I have what it takes to do what I need to do." Her suicidal ideation was always 'the elephant in the room.'

Sonya experienced several pneumonia infections, elevated temperatures, persistent *c-diff* infections and nutritional setbacks. In the past, Sonya had struggled with an eating disorder and the need to be thin. While on the unit, she had two revision surgeries; her acuity of care was high, often physically and emotionally exhausting for both Sonya and me.

Sonya's nutritional status was dependent on her tube feeding and protein drinks. The idea of introducing other foods and eventually discontinuing the tube was introduced by her dietician and speech-language pathologist. I made protein shakes and brought Sonya soft-serve ice cream. After nine months, her nasal gastric tube was removed and her weight was stabilized by eating soft solid foods.

As Sonya began to feel more comfortable and started to accept her appearance, we took daily walks off the unit to get her used to being around people, to accept herself with distress tolerance, and to start thinking about living outside the hospital. During this time,

I arranged for Sonya's dog to be brought to the hospital for a visit. Interacting with her dog outside, laughing and smiling, was very therapeutic for her. As we sat watching cars go by, I realized that she knew enough about cars to be a car salesman! She was able to forget her fears for a short time and be at ease.

Five months after being admitted, Sonya's medical needs have stabilized and she has had two successful plastic surgeries. Though she continues to talk about fleeting suicidal ideation, she has not acted on these. She continues to work in therapy on emotion regulation, improving her coping skills, re-uniting with her children, and transitioning to an outpatient facility with psychiatric follow-up.

As Sonya has grown, I have been amazed by her endurance, self-reliance, and capacity to manage her feelings. As her physical appearance has changed, she has started to receive compliments and this brings a big grin to her face. When this happens, I feel a warm glow knowing I was a part of her transformation.

cal unit was transferred. The supervisor explained that Mr. Jones was “tiring out” after being placed on BiPap roughly four hours ago at 8:00am. I agreed that Mr. Jones needed to come to the MICU right away. I told her I would take nursing report from the medical unit and admit Mr. Jones myself until another MICU nurse was able to transfer our patient off the unit.

I knew the MICU was a bit chaotic that day, but I felt I needed to help triage Mr. Jones to an ICU environment quickly. When the medical nurse called to give me report, she said that although the doctors had written an order for Mr. Jones to be placed on BiPap at 8:00am, due to a miscommunication between the medical residents, respiratory therapists, and nurses, Mr. Jones had not actually started BiPap until 11:00. Mr. Jones was struggling to maintain oxygenation above 85% on a 100% non-rebreather mask. The nurse told me that as Mr. Jones had worked harder to breathe, his mental status had declined and he had become lethargic. Mr. Jones was now nearly un-

responsive and his family was on their way and not able to be reached by telephone. The nurse and I reviewed Mr. Jones’ vital signs and laboratory information. She told me Mr. Jones’ most recent blood sugar was 65 and the medical team didn’t want him to receive any IV glucose as they worried additional fluid in Mr. Jones’ vascular system might overload his lungs and make his breathing worse. I asked the nurse if the medi-

meter) and brought it to the room Mr. Jones would soon occupy, I worried I wouldn’t be available to help the critically ill woman’s nurse settle her patient in upon return from the operating room. A moment later, one of the nursing supervisors and a senior resident rolled through the double doors of the MICU with Mr. Jones. Mr. Jones looked awful. His chest heaved violently with every breath.

blood sugar on the medical unit and worried it might be contributing to his poor mental status. The supervisor said she was unaware of Mr. Jones’ most recent blood sugar. The patient care associate announced that Mr. Jones’ blood sugar was 60. The MICU resident asked me to give Mr. Jones an amp of 50% dextrose in water via IV push. As soon as the dextrose was delivered intravenously, Mr. Jones opened his eyes slightly

with us. Although his wife was his healthcare proxy, we had been unable to reach her by phone. It was very important that we knew whether or not Mr. Jones would want to be intubated and/or receive other life-sustaining measures. Mr. Jones confirmed that he would want to be intubated for a short period of time for treatment of his pneumonia.

Next, Anesthesia was called to evaluate Mr. Jones for intubation. The anesthesiologists decided it would be safer to intubate him in the operating room and I accompanied Mr. Jones to the operating suite.

Reflecting back on this day, I see several examples of near-miss errors. A series of seemingly isolated actions was brewing to create a “perfect storm” of errors. First, the MICU was exceptionally busy that day, and I had volunteered as the resource nurse to admit a patient myself. I felt tension between my need to support my fellow MICU nurses in their clinical assignments and the need to transfer Mr. Jones from the medical unit. Though I felt just-

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cal resident would order a concentrated intravenous push of dextrose so Mr. Jones could receive some sugar without additional fluid. The nurse replied, “No, the doctor says it’s fine. The MICU can deal with his sugar and fluid issues when he gets there.”

I hung up the phone and looked at the clock. It was 12:30. The critically ill young woman would soon return from the operating room. As I grabbed a glucometer (blood sugar

I tried to put him at ease. “Hello Mr. Jones,” I said. “My name is Kerri and I am going to be your nurse here in the Medical Intensive Care Unit. How does your breathing feel?”

Mr. Jones didn’t answer me or open his eyes when I spoke to him. Right away, I asked one of our patient care associates to check his blood sugar.

The nursing supervisor asked why I was getting a finger stick. I told her about Mr. Jones’ low

and was able to answer some questions. Less than 15 minutes later, Mr. Jones was more alert and had a blood sugar of 145.

After assessing that Mr. Jones was oriented to himself, his surroundings, and his situation, the MICU resident and I explained that we thought he had an aspiration pneumonia and he would likely need a breathing tube inserted. I was very relieved that Mr. Jones was able to communicate

mission. Unfortunately, Mr. C had received an unnecessary second venipuncture due to a lack of communication and a lack of 'hand-off' reporting.

Mr. C grew increasingly anxious and concerned about his care. He began to question his confidence in a large system. Marianne apologized for putting Mr. C through an unnecessary blood draw. She assured him that both his blood tests showed his PT/INR were within normal limits. Mr. C was satisfied that his blood tests were normal, but disappointed he had had to endure an unnecessary blood draw. Mr. C proceeded to the operating room without any further incident. Marianne felt badly that Julie hadn't known that Mr. C's lab work had already been completed. Julie felt she had been following the doctor's orders while providing appropriate patient care. In this case, care involving more than six staff members resulted in unnecessary additional testing and dissatisfaction for both patient and staff.

As a result of this situation, Marianne organized a group of nurses along with our team leader and nursing director to investigate continuity-of-care issues among pre-op patients. It seemed natural to adopt a practice model that promotes accountability, streamlines care, and ensures effective communi-

cation such as the primary nursing model.

I was excited to assist in developing and implementing the primary/associate nursing model for our pre-op unit. Primary nursing helps achieve consistent, comprehensive, holistic care and facilitates communication among all team members. Now, each pre-operative patient is assigned a primary nurse who attends to all aspects of his or her care in the pre-operative setting until transfer to the operating room. In the event the primary nurse is not available, an associate nurse is assigned to the patient, as well. The associate nurse receives a full report from the primary nurse prior to assuming care.

Prior to implementing these measures, several staff members interacted with each pre-op patient. This often required patients to repeat their story as information wasn't communicated from one provider to the next. Our new practice model has had a positive effect on accountability, continuity of care, and patient- and staff-satisfaction. We are better able to "know" our patients and their needs. This is a good example of clinicians taking risks to turn a sub-optimal patient-care situation into an opportunity to enhance patient care.

tified in admitting Mr. Jones to the MICU, I also felt guilty that I wouldn't be available to adequately help my fellow nurses.

Second, Mr. Jones' treatment with BiPap had been delayed several hours due to a perceived miscommunication among caregivers on the medical unit. During this three-hour lapse, Mr. Jones' condition deteriorated and he eventually had to be intubated in the operating room. I can't help but wonder if Mr. Jones might have staved off intubation if he had been 'rested' on BiPap sooner. While some practitioners assumed Mr. Jones' decline in mental status was related only to his worsening oxygenation and ventilation, it seems that his low blood sugar was also a major contributing factor. In fact, the nursing supervisor who transported Mr. Jones to the MICU followed up with me later to say she was disturbed that there hadn't been an earlier intervention to correct Mr. Jones' hypoglycemia. We both speculated about what would have happened if Mr. Jones had remained unresponsive and unable to tell us his wishes around intubation.

This situation will affect my clinical practice in several ways. Overall, Mr. Jones received the appropriate treatment and therapy for his clinical diagnosis; however, I'm troubled by the thought that perhaps he could

have avoided intubation. I am also bothered by the delay in correcting his blood sugar. What if the scenario had been different and Mr. Jones hadn't wanted to be intubated? What if he had received a breathing tube because neither he nor his health-care proxy was available to argue otherwise? I think Mr. Jones' journey from the medical unit to the MICU could have been improved with more explicit communication among the interdisciplinary team. I believe Mr. Jones should have been fitted for a BiPap mask in a timely manner. I should have communicated my feelings of being overwhelmed to the nursing triage supervisor so she could have sent additional staff to support the other nurses in the MICU. In rushing to move from one critical epicenter to the next, there is a danger that we miss details, such as overlooking a low blood-sugar value. I should have informed the nursing supervisor or the medical resident of the lab value prior to Mr. Jones' transfer from the medical unit.

This scenario taught me to slow down and take the time to think. I need to look at the big picture and communicate my needs to others while paying close attention to clinical details. In the struggle to prevent near-miss errors, the best communication is 'over-communication.'

2009 Nursing Spectrum Nursing Excellence Awards

This year, two MGH nurses received regional Nursing Excellence awards from *Nursing Spectrum*, making them eligible to be considered for *Spectrum's* National Nurse of the Year in the fall. Grace Good, RN, nurse practitioner and leader of Team 5, was selected in the category of Clinical Care Excellence, and Adele Keeley, RN, nursing director of the Medical Intensive Care Unit, was recognized for Excellence in Management.

Nursing Spectrum Excellence Awards recognize the extraordinary contributions nurses make to patients, to one another, and to the profession of nursing. Nurses from throughout New England are nominated in six categories: Advancing and Leading the Profession, Clinical Care, Community Service, Management, and Mentoring and Teaching.

In Good's letter of nomination, colleagues

wrote, "Grace is an extraordinary person and clinician. She is a highly-skilled, compassionate, critical thinker, a collaborator who consistently displays the highest ethical standards, and the ultimate patient advocate. What defines Grace is her commitment to the disenfranchised. She has the ability to look beyond complex diagnoses and life circumstances to establish a level of trust with patients that fosters positive outcomes.

"Several years ago, Grace envisioned a multidisciplinary team that would specialize in the care of psycho-socially complex patients. Now a reality, 'Team 5' provides early intervention, ensures continuity of care, and brings a unique expertise to the care of this specialized patient population. Grace has shared her innovative Team 5 model with colleagues around the country."

Colleagues described Keeley as, "A calm, cool, compassionate profes-

sional whose manner and clinical judgment complement a managerial practice grounded in patient- and family-centered care.

"Adele recognizes the importance of bringing patients, families, and caregivers closer together. Before it was 'fashionable,' Keeley did away with formal visiting hours giving families 24-hour access to their loved ones and the care team.

"Recently, the MICU was one of four national sites to receive funding from the Robert Wood Johnson Founda-

tion to merge palliative and critical care cultures in a quality demonstration project. Part of their charge was to communicate their findings to national workgroups and begin to address challenges in traditional care models. Adele and the principal investigators from the other three sites presented their findings and developed a strategy to disseminate best practices to the larger critical care community. Some of the practices they shared included open visiting hours, Ethics Rounds, and the work of palliative care nurse champions as change agents. Adele made a con-

certed effort to challenge, empower, involve, and engage her staff nurses as leaders and drivers of change."

Patient Care Services congratulates Good and Keeley as well as the other New England regional finalists from MGH: Diane L. Carroll, RN (Mentoring); Lin-Ti Chang, RN (Community Service); Stephanie Ennis, RN (Clinical Care); Joanne Kaufman, RN (Management); Amanda Stefanczyk, RN (Advancing and Leading the Profession); and Kerri Tyman, RN (Mentoring).



Adele Keeley, RN
nursing director, Medical Intensive Care Unit



Grace Good, RN
nurse practitioner and leader of Team 5

Consumer Assessment of Healthcare Providers and Systems) data shows a less than 80% approval rating of care provided. Those scores are good, but being 'good' isn't good enough. We want to be great.

Align behaviors with goals and values

This past year, we wanted to move from good to great in the area of cleanliness of our environment. We went to our unit service associates and operating room associates and they accepted the challenge. They showed us they want to provide excellent patient- and family-centered care; they want to have an environment of care they can be proud of.

Studer tells us, "This great work, these great outcomes, start with a commitment to purpose, worthwhile work, and making a difference." I was struck by the connection between our outcomes and the feedback you provided in our recent Staff Perceptions of the Professional Practice Environment Survey. Your scores around motivation were exceptional.

One very motivated group worked tirelessly this past year on EMAPPS. Working with project

leader, Rosemary O'Malley, RN, nurses, physicians, Information Systems staff, and Pharmacy colleagues came together to enhance patient safety with the implementation of our new electronic medication system.

Build a culture around service

Building a culture around service involves connecting organizational values to actions. One area of improvement identi-

and partnership through Presence. Using this proactive, multi-faceted intervention we can minimize the risk of patient falls and adverse events.

Measure the important things

Measuring supports the achievement of desired behaviors. It is exciting when goals are achieved. Measuring promotes individual accountability and helps us know when systems are working. We

"A nation, as a society, forms a moral person, and every other member of it is personally responsible for his society."

—Thomas Jefferson

fied in our patient-satisfaction survey was responsiveness. Patients want us to be more attentive in addressing their pain and comfort. They want more assistance with personal care and they want to be involved in their medications and treatment plans.

To better serve our patients, we have devised a plan to improve responsiveness. We call it The 7 Ps. When clinicians check on patients, every interaction should include an evaluation of: Person, Plan, Priorities, Personal Hygiene, Pain, Position,

measure to align leadership and employee behaviors and drive outcomes.

Our Hand Hygiene Program is a perfect illustration. Hand-hygiene data gives us the ability to develop strategies for ongoing improvement. No one understands that more than Pauline Albrecht, RN, and her colleagues in the Same Day Surgical Unit who created *The Cal Stat Rap*, a truly original, fun, and inspirational video that literally 'sings' the praises of good hand hygiene. Thank-you, Pauline.

Create and develop leaders

In order for an organization to be great, it has to have great leaders. We are fortunate at MGH that every nurse takes his or her leadership role seriously.

We are committed to providing opportunities to develop leadership skills. One shining example of that is our own Deb Washington, RN, director of PCS Diversity. Deb began her career as a staff nurse. The first day I met her, I knew she was a great leader. She has been instrumental in advancing our diversity agenda, and just last month, she was the inaugural recipient of the Boston Ad Club's Change Agent Award.

Let me read an excerpt from her acceptance speech:

"Diversity is where each of us sees our individual self worth in others. Where our efforts are not just process... but outcomes. Where we understand what it means to have equal opportunity to hurdle obstacles of the same philosophical height.... obstacles that have not been constructed or defined by one group's social experience. The idea of inclusion is about the art, not the want of dreams."

Focus on employee satisfaction

It's no secret that satisfied employees are motivated to do a better job. Satisfied employees want:

- to believe the organization has the right purpose
- to know their job is worthwhile
- to make a difference

We know from talking to MGH nurses that they support the MGH mission, vision, and values; they feel valued and appreciated; and they *know* they're making a difference in the lives of our patients.

Build individual accountability

How do you create a sense of ownership within an organization? It's amazing what people will do when they feel the power that comes from the alignment of their beliefs and actions with those of everyone else in the organization.

One example of the large-scale impact individuals and teams can have is the work of our Tiger Teams. The Laundry and Linen Tiger Team, for instance, identified opportunities to be more efficient in our handling of linens. Co-led by nursing director, Sara Macchiano, RN, and operations man-

continued on next page

Ives Erickson Nurse Week Presentation (continued from previous page)

ager, Lori Powers, this team's recommendations are saving time and money as well as supporting a healthier environment.

Recognize and reward success

Acknowledging great work is important. Everyone appreciates positive feedback.

At MGH, we're fortunate to have a robust reward and Clinical Recognition Program. I can't underscore enough the importance of positive recognition and the power of simply saying, 'Thank-you.' Just recently, I received a letter from a grateful patient sent to the staff of the Blake 12 Neuro ICU.

About three years ago, the patient had surgery for a brain aneurysm. During her hospitalization, her son, who was 14 at the time, spent hours at her bedside. In her letter, she shared an essay her son had written about the impact his time in the Neuro ICU had on his life. I'd like to share a portion of that letter with you:

In the days following my mother's surgery, my family and I traveled to Boston to visit her... As I sat in the room gazing at the various machines and monitors, I thought what a difficult job these people have. I thought how rewarding it must be when they breathe new life into someone. The ones I took the most interest in were the nurses. Even with all the tasks they had to

accomplish and people to take care of, they still came into my mother's room and treated her like she was his or her only patient. How people who deal with dying and wounded people all day can keep such a pleasant outlook was beyond me. It was in that room in the Intensive Care Unit that I realized what I wanted to do for the rest of my life. Be a nurse.

"Nurses provide extraordinary care. They're the front lines of the healthcare system."

—President Barack Obama
March 5, 2009

In his book, Studer refers to individuals who make a difference in the lives of others as 'firestarters.' Firestarters are committed to transforming healthcare through compassion, imagination, and often, nothing more than sheer determination. I want to thank each and every MGH nurse for being a firestarter in the lives of our patients and families. Thank-you for transforming care at MGH.

Following Ives Erickson's prepared remarks, she invited three members of MGH patient and family advisory councils to join her in an informal discussion.

Jim Massman from the Mass-General Hospital for Children's Patient & Family Advisory Council; Angela Adinolfi from

the MGH Cancer Center Patient & Family Advisory Council; and David Wooster from the MGH Heart Center Patient & Family Advisory Council spoke openly with Ives Erickson about everything from their diagnoses to their honest feelings about MGH nurses.

Said Massman, "To use a baseball analogy, excellence isn't the

result of stepping up to the plate one time. It's what you do every day. It's one thing to get your house in order for an inspection or what-not, it's another to sustain excellence for the long run. And that's what you do. Keep up the good work."

In response to Ives Erickson's question, "How can we make you feel more safe?" Adinolfi responded, "I've never felt more safe than I do when I'm right here. We trust you with our lives. Nothing you do goes unnoticed—everything you say and do makes a difference."

Wooster observed, "You know when you come here that this is a teaching institution. What you realize after you arrive is that it's also a learning institution. I can honestly say, I wouldn't be alive today without MGH nurses. There's so much I'd like to say; 'Thank-you' just doesn't seem like enough."

Indeed. Thank-you doesn't seem like nearly enough.

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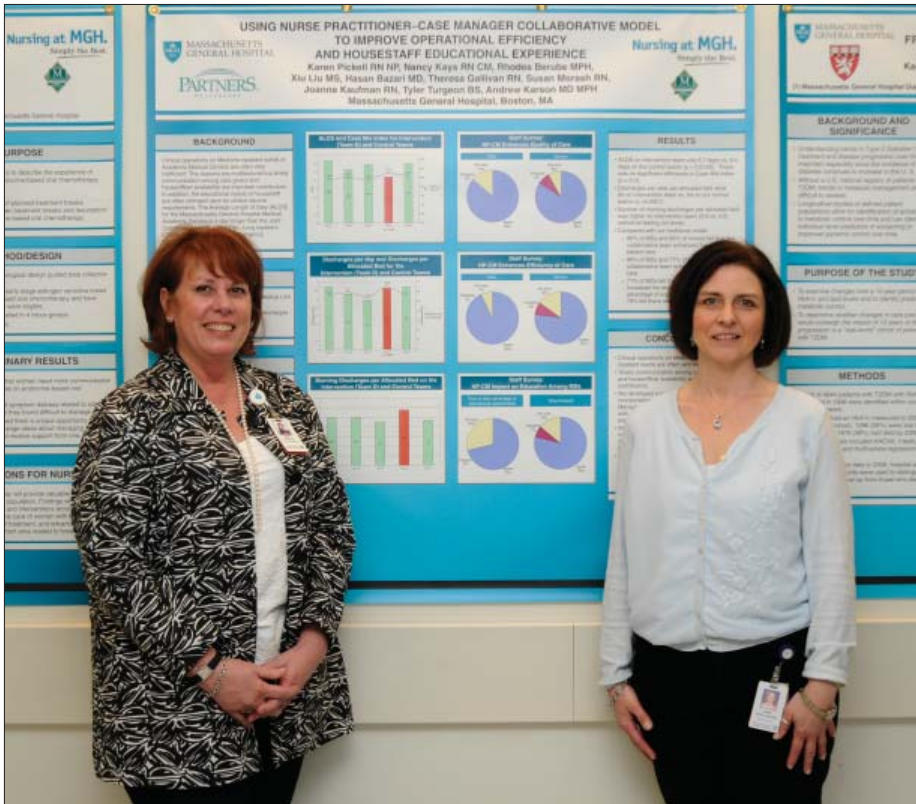
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Poster receives honors at national Case Management conference



Case manager, Nancy Kays, RN, and nurse practitioner, Karen Pickell, RN, received the Best Display of Topic Award from the American Case Management Association for creating a poster with the best clarity of concept. Kays and Pickell received the award at the national conference of the American Case Management Association in April.

Their poster entitled, “Using a Nurse Practitioner-Case Manager Collaborative Model to Improve Operational Efficiency and the House Staff Educational Experience,” described the collaborative work between Kays, Pickell, and the department of Medicine.

The award marks the first time a member of the MGH Case Management Department has received an award for best poster presentation at the national conference.

Nancy Kays, RN (left), and Karen Pickell, RN, with their award winning poster, “Using Nurse Practitioner Case Manager Collaborative Model to Improve Operational Efficiency and House staff Educational Experience.”

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