

Caring

Headlines

April 15, 2010

The Gil Minor Nursing and Health Professions Scholarship to Advance Diversity

See story on
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Gil Minor, former CEO of Owens & Minor (second from right), with executive director of The Institute for Patient Care, Gaurdia Banister, RN (right); and scholarship recipients (back row, l-r): Ana Duarte, RN; Devona Bailey; and Franz Edouard. (Front row): Van Abreu, RN, and Nida Lam, RN.

Understanding the use of restraints in patient-centered care

No matter what the situation, restraints should always be used as a last resort — when less restrictive measures have been attempted, when potential benefits outweigh potential harm — and at the least restrictive level to ensure safety.

Questions about the use of restraints never go away. And that's exactly as it should be. We should *always* question the need for restraints whenever it arises for every patient, in every setting, in every situation. There's no place for complacency in health care, especially when it comes to restraining patients to keep them and others safe.

The Joint Commission defines restraint as, "any method (chemical or physical) of restricting a client's freedom of movement..." Restraints are used for behavioral reasons (for example, when a patient threatens a caregiver or exhibits violent or self-destructive behavior) or to protect patients from harming themselves (for instance, by dislodging IV connections critical to their care). No matter what the situation, restraints should always be used as a last resort — when less restrictive measures have been attempted, when potential benefits outweigh potential harm — and at the least restrictive level to ensure safety.

In addition to meeting standards set by regulatory agencies such as The Joint Commission, the Centers for Medicare and Medicaid, the Department of Public Health, and the Department of Mental Health, we have our own policies for ensuring the safe, respectful, and responsible use of restraints.

Any hospital committed to delivering patient-centered care must also be committed to a meaningful and robust examination of restraint use. At MGH, direct caregivers are oriented to the safe use of restraints dur-



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

ing orientation, and demonstration of competency is required annually. Audits of restraint use and related documentation are performed by unit leadership in patient care areas and by staff specialists in the PCS Office of Quality & Safety. A multi-disciplinary team was recently formed to ensure that MGH policies and procedures regarding the use of restraints protect patients while at the same time contribute to best outcomes.

I'd like to take this opportunity to clarify and reinforce the standards for medical orders and nursing documentation related to the use of restraints.

Medical orders:

- The type and location of restraint being used must match the type and location specified in the order
- Restraint orders should not be interpreted as, "if needed." If restraints are ordered, they should be applied unless removed for treatment or for other patient interactions (such as a visit with family members)

continued on next page

When it comes to restraining a patient, we need to listen to our heart, our brain, and our conscience. Decisions about whether, when, and how to restrain a patient should always be made with the patient's best interest in mind and never for the ease or convenience of the caregiver.

- Medical orders should be written:
 - before initiating non-behavioral restraints
 - for behavioral restraint, within one hour of initiating restraints and then every four hours for patients over age 18, every two hours for patients age 9–17, and every hour for patients under age 8
 - for each new episode of restraint use even if a previous order has not expired (for example, when restraints are removed for two hours, but behavior requires re-application of restraints)
 - for patients restrained prior to surgery. If the need for restraint persists post-operatively, a new order must be written
- Nursing documentation must include:
 - Progress Notes
 - Each shift should include:
 - specific behaviors requiring restraint
 - consideration of least restrictive alternatives
 - type and location of restraint(s)
 - description of discussion with the patient and family regarding the need for restraint
 - Problem List
 - Check each shift to individualize and update as needed
 - Enter the date, time, and sign

- Restraint Flowsheet
 - Each shift should include:
 - restraint evaluation every two hours for non-behavioral restraints and every 15 minutes for behavioral restraints
 - release of restraints every two hours at minimum
 - time restraints were discontinued
 - the nurse's signature

We all appreciate the need for care and vigilance when it comes to the use of restraints. A patient's mood, behavior, or medical status can change in an instant. We must always err on the side of safety.

It's good that questions continue to be raised about restraints. When it comes to restraining a patient, we need to listen to our heart, our brain, and our conscience. Decisions about whether, when, and how to restrain a patient should always be made with the patient's best interest in mind and never for the ease or convenience of the caregiver.

For more information, or if you have any questions, call the Office of Quality & Safety at 3-0140.

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The Gil Minor Nursing and Health Professions Scholarship to Advance Diversity

*Five students, five compelling life stories,
one very generous benefactor*

You may recall, in October, 2009, five MGH employees received financial assistance to further their nursing education as recipients of the Gil Minor Nursing and Health Professions Scholarship to Advance Diversity. Gil Minor, former CEO of Owens & Minor and benefactor of the scholarship program, was unable to attend the presentation ceremony at that time, but wanted to meet and congratulate the recipients. On March 24, 2010, Minor did just that. At a special reception on Founders 3, Minor had the opportunity to shake the hands of five very impressive students: Van Abreu, RN, staff nurse in the Post Anesthesia Care Unit; Devona Bailey, patient care associate for the Central Resource Team; Ana Duarte, RN, staff nurse in the Post Anesthesia Care Unit; Franz Edouard, patient care associate in the Blake 12 Neuroscience ICU; and Nida Lam, RN, Ellison 16 Medical Unit.



Each student publicly thanked Minor for his vision and generosity. Each expressed appreciation for the financial support, which in some cases enabled them to give up a second job to devote more time to their studies.

Minor had done his homework, too. He had read each of their portfolios and knew them by name. In his remarks, he commended them for their perseverance and drive. Said Minor, "I've read your narratives. I know what you have overcome to get here. You've all been through pain and joy; as nurses you'll surely experience more pain and more joy. Nursing is a



powerful profession. I know you're going to make a powerful impact on people's lives. I know you are all going to do great things."

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, passed on some sage advice. She urged students to keep a journal so they could look back one day as experienced nurses and see how far they'd come. "Because looking at you now," she said, "I can tell you're going to go very far, indeed."

For more information about the Gil Minor Nursing and Health Professions Scholarship to Advance Diversity, contact Julie Goldman, RN, professional development manager, at 4-2295

April is Occupational Therapy Month

Celebrating Occupational Therapy's unique contribution to the medical team

Occupational therapist, Rachel Ann Augenstein, OTR/L, fabricates elbow splint for patient, Margaret Palazzi, following surgery on her elbow.

Occupational therapists at MGH assist people facing changes in their lives and daily routines due to the loss of physical functioning. Approaching care in a holistic manner, occupational therapists help people find ways to perform activities of daily living to the best of their abilities. Referred to as the P-E-O (Person-Environment-Occupation) model, this approach looks at the

person (physical, mental, and emotional capacities), his or her living environment (physical surroundings), and his or her occupations (life roles, habits, and routines). Evaluating a patient's abilities in the broad context of his or her life is one of Occupational Therapy's unique contributions to the medical team. The input of occupational therapists regarding the appropriateness and readiness of a patient to return home is essential in formulating a safe discharge plan.

Making sure patients are living safely and to their fullest capacity is at the heart of what occupational therapists do.

Not only do occupational therapists take person, environment, and occupation into account when examining a patient, they educate patients to ensure a safer future. Many resources are available at MGH and in the community to assist people in living safe, independent lives.

Some resources available in the community include:

- Meals-on-Wheels
- The RIDE
- Home-delivered medications
- Lifeline, grab bars, shower seats, reaching devices
- Boston Area Agency on Aging, the Alzheimer's Foundation, NAMI, the Brain Injury Association

April is Occupational Therapy Month. At MGH, the department of Occupational Therapy provides care to people of all ages in the inpatient and outpatient settings. (See related stories on next page and on page 10.) For more information about the services provided by Occupational Therapy at MGH, call 6-8537.



Occupational therapy not limited by geography

—by Suzanne Curley, OTR/L, occupational therapist

Ya Quiong and her young son had been living in the Chinese countryside when they were badly burned in a fire last year. They were treated locally but developed severe deformities, so were sent to the Army Hospital in Beijing. Ya's son had been released after treatment, but Ya was still at the hospital in January, which is when I met her. I was in Beijing as part of the HandReach Children's Healing Initiative, an international volunteer program that provides care to children with complex injuries such as burns and amputations. We had come to Beijing to assess the short- and long-term needs of the clinic, provide education and training to the local therapists, and treat as many children as possible.

At 19 years old, Ya was the oldest child we saw — not really a child anymore — as she had a son of her own. Her burns were confined to her face and hands, but they made taking care of a young child difficult. She had typical burn deformities, her knuckles were hyper-extended, her fingertips flexed into a claw, and her thumb tucked into her palm. She was unable to grasp a hairbrush or pick up chopsticks. Her therapist was using a steamer to heat Ya's hands and soften the scarred skin, then he applied a traditional Chinese lotion with massage. Ya's skin was soft despite the heavy scars and grafting. I asked Gao, the therapist, if I could try to duplicate his massage technique and asked for feedback as to whether I was doing it correctly. Making the skin more mobile makes it easier to bend and work the fingers. But when I felt Ya's hand, I could feel the tightness in her joints and tissues. Despite the excellent care of her skin, she needed deeper treatment to get her hands moving. I asked if I could try a few things.

After examining her hands a bit more, I demonstrated some soft-tissue mobilization and range-of-motion exercises. The other therapists circled around and asked questions. They wanted to feel what I was feeling. We practiced on one another and on Ya, who

was very patient throughout the session. I had brought some beads with me to give to the children as gifts. I brought them out and asked Ya if she could pick them up. With great difficulty, she tried and finally managed to pick up a single bead... then another. The therapists were very excited and wanted to know more. I explained how our goal is to help patients resume activities that are important to them. Being able to successfully perform an important activity is a great incentive for continuing to participate in treatment. Ya spent every day patiently trying to pick up anything she could get her hands on. Her goal was to be able to take care of her baby again, and I hoped I was helping her achieve that goal.

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Occupational therapist, Suzanne Curley, OTR/L (top left), works with children in Beijing as part of the HandReach Children's Healing Initiative, an international volunteer program that provides care to children with complex injuries such as burns and amputations.

Occupational Therapy (continued)

In contrast to Ya's steady, patient demeanor, Jia was one of the few children I saw cry. At 4 years old, she was a little shy, but her bright, bedazzled boots and colorful hair ribbons told me she had spunk. In 2007, Jia had been shopping with her mother when curiosity drew her too close to a restaurant stove. She fell into a large wok of soup and was badly burned. Her mother donated her own skin for Jia's skin grafts. As with many of the children, Jia's mother stayed with her day and night, brought her food, and washed their clothes in the communal bathroom. Jia's hands were like Ya's in the typical burn deformity, which made it difficult to grasp objects such as toys and utensils. She had significant atrophy in both upper extremities. I wasn't sure what musculature remained under her tight, grafted skin, but I wanted to make the most of it so she'd be able to play, reach up over her head, and extend her arms for a hug (maybe even for me!) The Chinese therapists did a wonderful job preparing Jia's thick, tight skin for movement using heat, but Jia cried during treatment. I tried to cheer her up with puzzles and balloons, subtly trying to get her to reach for objects, but she wasn't buying it. I tried more lotion, and surprisingly, she let me touch her without protest, though she did turn away and frown. As I rubbed the lotion into her skin I talked—just chatted away. Neither she nor her mother understood me, but I smiled and told the kind of stories I'd tell my own niece back home. Soon, I felt her relax. She began to watch me. I playfully held out the tube of lotion then pulled it back. Jia smiled for the first time as she reached out to grab it from me. I pulled it away again and she laughed out loud. We played this game for 15 minutes with Jia smiling and squealing. It gave me a chance to assess her muscles and estimate her strength. I showed the therapists some exercises and activities that would help maximize her strength.

Unlike Jia, it took no effort at all to make Tiacheng smile, which was amazing considering how badly he'd been burned just a year before. Tiacheng was so badly injured he was unable to ambulate or sit up. His wrists were fixed in hyper-exten-

sion and his fingers webbed together so that they looked like a fist. He did have good range of motion in his shoulders. I wanted to see what he could do, so I brought some toys to our session. I hoped he'd be able to learn to pick up a block or two. Tiacheng figured out the game immediately and began stacking blocks using the heels of his hands. He kept at it even when the small pegs took him many tries. Tiacheng's parents were devoted to him—his father had saved him in the fire. They were with him constantly, carrying him around, playing with him, adoring him. As I watched this family together, I felt their joy; any sorrow I may have felt for them disappeared.

Tiacheng had to be fed as he was unable to hold utensils due to his fisted hands. I thought a modified universal cuff might help. A universal cuff is a strap that has a 'pocket' where utensils, toothbrush, etc., can be placed so the patient can function despite not being able to hold them himself. An MGH colleague had helped me modify some universal cuffs for children before leaving Boston, so I tried one on Tiacheng. As usual, he was up for anything and quickly grasped the concept. He eagerly picked up bits of food using the fork in the cuff. He was so proud, and his parent's were tickled to see him able to do things for himself.

After observing the children for a couple of days, I concluded that, despite their various abilities and disabilities, they had similar needs: to be able to move their stiff joints; strengthen their weakened muscles; increase their activity tolerance; and have more fun. I thought a group activity might be a good idea. I remembered an exercise we did in OT school using a parachute. It would fit our needs perfectly. I got a sheet and a couple of beach balls and arranged the children around the outside holding the sheet down on the floor. The goal was to raise the sheet up and down making the balls bounce but not letting them fall off the sheet. A colleague held Tiacheng on her lap, wrapped the sheet around his hands, and encouraged him to lift. I helped Jia. And Ya held a child on her lap despite not being able to hold the sheet herself. Some children were able to do it themselves, others needed assistance, but everyone laughed and played, fully engaged in the game. As I looked around at the beautiful, happy faces of the children, the families, and the therapists, just like Tiacheng and his parents, I felt that joy of being part of something wonderful.

See related story on page 5 and clinical narrative on page 10



The parachute game

65Plus and Council on Disabilities Awareness partner to improve care for older adults

by Deborah D'Avolio, RN, 65Plus, and Carmen Vega-Barachowitz, CCC-SLP,
Council on Disabilities Awareness, Disabilities Access Initiative

It has been shown that providing geriatric assessment and early recognition of geriatric problems can prevent complications and reduce lengths of stay for hospitalized older adults. Older adults comprise the majority of hospitalized patients—they account for 43% of the inpatient population at MGH, and they represent 30% of all visually impaired individuals. Hearing impairment is the third leading chronic condition affecting older adults. Sensory impairment can impact cognitive function, mood, safety, and quality of life, and sensory impairment increases with age.

In April, 2008, Deborah D'Avolio, RN, geriatric specialist, 65Plus, began implementing bedside geriatric teaching rounds. This is an evidence-based program that provides unit-based geriatric education. The goal is to disseminate best practices in the care of older adults through demonstration and modeling of geriatric assessment and intervention. During geriatric teaching rounds, a significant number of older adults was found to have impairment in vision and/or hearing. This finding highlights the fact that older adults aren't functioning at their maximum capacity due to limited sensory status. In response to the evidence, 65Plus began piloting assistive vision and hearing devices. Devices were given to patients who exhibited sensory impairment during geriatric rounds. Feedback from families and patients who used the devices was overwhelmingly positive.



Based on the success of the pilot program, it was clear that assistive devices were an important intervention and in line with our strategic goal to enhance evidence-based practice to promote safety and improve the patient experience. 65Plus, the Council on Disabilities Awareness, and Materials Management, came together to discuss logistics. The Council on Disabilities Awareness, established in 2003 to advise, challenge, and engage the MGH community to create a welcoming and accessible environment for all, views the intervention as a critical step in ensuring optimal care for individuals with hearing and visual disabilities. In 2009, MGH joined with BWH and the Boston Center for Independent Living to launch a major initiative to improve access and care for people with disabilities. The effort fo-

focuses on employee awareness and education; the physical environment; patient services; and equipment. The joint effort of the Council on Disabilities Awareness and 65Plus to acquire assistive devices for inpatient units is an example of the kind of collaboration we need to provide optimal care to all patients.

For more information about 65Plus or if you would like to participate in unit-based geriatric rounds, contact Deborah D'Avolio, 65Plus, at 3-4873.



To order a hearing enhancer or handheld magnifier, call Materials Management Customer Service at 6-9114. Inpatient areas, please provide the name of the patient (for tracking purposes). Ambulatory Areas may request up to 10 of each item.

5th annual Medical Nursing Visiting Scholar Program

“Using your nursing intuition”

—by Monica Staples, RN, staff nurse

In recognition of the specialized practice of general medical nursing, the 5th annual Visiting Scholar Program, held March 23, 2010, was entitled, “Making Use of Your Nursing Intuition.” Sponsored by Medical Nursing and The Norman Knight Nursing Center for Clinical & Professional Development, the event featured visiting scholar, Terry Foster, RN, critical care clinical specialist from Saint Elizabeth’s Medical Center in Kentucky. Foster talked about nursing intuition in presentations and interactive discussions throughout the day.

In his morning presentation, “I’ve got a bad feeling about this patient,” Foster described clinical nursing intuition and explored

its uses, risks, and benefits in direct patient care. Said Foster, “Every nurse can identify with that feeling that something isn’t quite right. We’re happy to be proved wrong, but more often than not, our feelings are right on target.”

Narratives presented by medical staff nurses, Naomi Martel, RN, and Megan Brown, RN, emphasized how nursing intuition factored into clinical emergencies with positive patient outcomes.

In his next presentation, “Preventing a code... before they code,” Foster discussed rapid response teams. Citing research that suggests, “almost all cardiac-arrest events are preceded by warning signs an average of 6.5 hours in length,” Foster presented data showing a decrease in ‘failure to rescue’ outcomes and statistics of the types of calls made to rapid response teams. He reviewed learning opportunities and areas for improvement. The presentation was followed by a roundtable discussion with medical nurses facilitated by nursing directors, Maria Winne, RN, and Kathryn Hall, RN. The group was joined by nursing director Colleen Snyder, RN, and Maureen Schneider, RN, who fielded questions about the Rapid Response Team at MGH.

Associate chief nurse, Theresa Gallivan, RN, and clinical nurse specialist, Theresa Evans, RN, introduced the afternoon session, entitled, “How can you laugh at that—a closer look at the use of humor in nursing.” This light, entertaining talk focused on the ‘unorthodox’ sense of humor shared by nurses who often use humor as a coping mechanism. Foster discussed the appropriate use of humor and recalled some wonderful, comical episodes from his 30-year nursing career. Foster’s unique style, wit, and comedic timing had audience members ‘laughing til they cried.’

Throughout the day, posters highlighting medical nursing practice were on display in the Main Corridor, and special carts visited medical units disseminating information. For more information on medical nursing at MGH, call Sara Macchiano, RN, at 6-6384.



Visiting scholar, Terry Foster, RN, critical care clinical specialist from Saint Elizabeth’s Medical Center in Kentucky

Occupational therapist helps amputee re-learn essential skills

My name is Leslie McLaughlin, and I am an inpatient occupational therapist on the Burn and Plastic Surgery Unit. In the three years I've been an occupational therapist at MGH, I've had the opportunity to work on several rotations, including General Medicine, Neurology, and Orthopedics. My training and experience on those rotations taught me the importance of evaluating and treating each patient as an individual and a whole person.

On the Burn Unit, I've treated many patients with severe upper extremity injuries and amputations, so when I met Ms. S, a 79-year-old woman whose right arm had been amputated, her diagnosis was not new to me. I've seen how devastating it can be for someone to lose an extremity, especially when it's the dominant arm or hand. As an OT, one of my goals is to help patients re-learn how to function as independently as possible and participate in their daily activities, roles, and routines. Often this means incorporating a combination of compensatory strategies while working to remediate the impairment.

I met Ms. S one week after she had been admitted emergently. She had developed sudden-onset shoulder pain that had progressed to right-arm weakness. She had activated her Lifeline alert, and by the time paramedics arrived, she was weak and confused. In the emergency room, she showed symptoms consistent with necrotizing fasciitis, a serious infection of her soft tissues, which had already progressed up her right arm to her shoulder. She was taken to the operating room, where she underwent a forequarter amputation. It was necessary to remove her right arm and all surrounding bones and tissues to prevent the infection from spreading and to save her life. A VAC dressing was placed over the area to help facilitate healing, and she was taken to a surgical unit. One week later, she underwent skin grafting to permanently cover the area around her shoulder. It was after this skin grafting that I met Ms. S.



Leslie McLaughlin, OTR/L, occupational therapist

I reviewed her history and anticipated some of the impairments she might have, especially considering it was her dominant arm that had been amputated. She would have to re-learn basic tasks such as feeding herself, brushing her teeth, dressing, and toileting. I knew this kind of amputation would significantly affect her balance and mobility.

Losing a limb can be emotionally traumatic. I had to get a sense of Ms. S's understanding of her diagnosis and how she was coping with this devastating loss. I had to be sure she was physically and emotionally ready to accept treatment. When I entered her room, Ms. S was sitting in bed, her son was in a chair beside her. She still had a dressing on her scalp where they had harvested skin for her grafts. She looked small and frail. I introduced myself and explained the role of occupational therapy in her recovery.

"It's Miss S," she said. "Don't call me Mrs. I haven't been married for a long time. I'm Miss now."

I promptly obliged, correcting myself, and quickly realized there was more to Miss S than met the eye.

I gathered information from Miss S and her son about her

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After working with Miss S for two weeks, she was discharged to an inpatient rehabilitation facility where she was able to continue to build on the skills and foundation we had laid together... She went from being a person living a very isolated life to someone, at the age of 79, learning how to live again.

activities of daily living, routines, and hobbies. Miss S had been independent in activities of daily living but described herself as a shut-in—she hadn't left her apartment in more than a year. She was fearful of getting in and out of the bathtub and became easily fatigued walking around her apartment. She spent most of her day watching TV.

After talking with Miss S and her son, I realized they hadn't fully processed how Miss S's amputation was going to impact her function.

I asked Miss S how she was managing with basic tasks such as feeding herself. She admitted it was a challenge.

I gave Miss S a scoop dish—a combination bowl and plate with a non-slip bottom. I showed her how to use the spoon or fork to push the food against the rounded edge so she could easily scoop it up without spilling. I put a container of applesauce on a skid-proof mat and showed her how it prevented the container from sliding around. Miss S was overjoyed. I encouraged her to try the dish at dinner that night, and I educated her nurse on how to use the tools, as well.

The next morning, Miss S reported that she'd been able to eat her entire meal without any assistance. She was thrilled. But when I sat down to talk further about her goals and what activities were important to her, she became overwhelmed and tearful when talking about the many things she now needed help with.

I knew that in order to help her feel that she was making progress, I'd have to tailor her treatment to include tasks that would challenge her while also allowing her to succeed. In each session, I tried to incorporate compensatory strategies with remediation techniques. During one session, I showed her how to open various sized containers using one hand. I had her engage in fine motor and coordination exercises with her left hand to help increase her dexterity and re-train her brain to be left-handed.

In another session, Miss S expressed an interest in trying to write with her left hand. I was pleased she was thinking of new things and actively participating in her recovery. It was a sign she was able to start thinking about the future and starting to accept that her life was going to be different. I encouraged her to continue to try to do more for herself by incorporating the strategies I was teaching her. Slowly, she gained more confidence, and her caregivers reported that she was doing more and more of her daily activities on her own.

Throughout her hospitalization, pain was an issue for Miss S. In addition to the pain associated with her

skin grafts, she suffered from phantom-limb pain. I knew phantom-limb pain was common for amputation patients.

"I keep forgetting it isn't there," she said.

I educated her that all the sensations and pain she was experiencing were normal. I think she was relieved to know this was an expected part of her recovery. Her doctors worked to manage her pain with medication, and we identified strategies to help minimize some of her phantom-limb pain, including relaxation, visualization, and deep-breathing exercises. Despite her pain, Miss S was always motivated to participate in her sessions.

After working with Miss S for two weeks, she was discharged to an inpatient rehabilitation facility where she was able to continue to build on the skills and foundation we had laid together. With the help of her entire care team, Miss S had begun to re-gain her sense of self and build a new identity following her amputation. She went from being a person living a very isolated life to someone, at the age of 79, learning how to live again. And interestingly, she became a very social person in the process.

As I reflect on my time with Miss S, I feel I played an integral role in her recovery by helping her begin to re-gain her independence and sense of self. I realized that to truly take a patient-centered approach, I had to slow down at times and find a way to proceed in a manner that best suited Miss S' learning style and emotional needs. By being in tune with her goals, we were able to collaborate to identify what was most important to her in the time she was here. I know Miss S still had many things she needed to learn, but I feel a sense of accomplishment that I was able to help start her off in the right direction.

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

With the loss of her arm, Ms. S could very easily have retreated into an isolated world. But Leslie helped her on many levels to re-define her sense of self and start to re-gain her independence. Taking into consideration Miss S' physical needs and learning style, Leslie crafted a treatment plan that both challenged her and rewarded her progress. Under Leslie's gentle guidance, Miss. S began to re-gain her confidence and ability to do for herself. Of all the tools and strategies Leslie employed to help Miss S, perhaps giving her a sense of hope was the most important.

Thank-you, Leslie.

March NRC Journal Club: “Falls in the General Hospital”

—submitted by the Nursing Research Committee Journal Club

The average cost of falls in hospitals per year can reach as high as \$17.5 million... a meta-analysis over 40 years showed no sustained effect of fall-reduction efforts.

On March 10, 2010, in an event co-sponsored by the Nursing Research Committee Journal Club and the PCS Quality Committee, Barbara Lakatos, RN; Monique Mitchell, RN; and Leslie Delisle, RN, presented their research study, “Falls in the General Hospital: Association with Delirium, Advanced Age, and Specific Surgical Procedures,” which had been conducted in 2003 with funds from an Yvonne L. Munn Nursing Research Award. Co-authors, Virginia Capasso, RN, and Connie Cruz, RN, were also in attendance. The article was published in the 2009 journal, *Psychosomatics*.

The average cost of falls in hospitals per year can reach as high as \$17.5 million. Short-term interventions can be successful in reducing falls, but a meta-analysis over 40 years showed no sustained effect of fall-reduction efforts.

The study is significant for showing how recognizing delirium is important in preventing falls. According to a literature review, 70% of doctors and nurses nation-wide fail to recognize delirium. Lack of evidenced-based education and a failure to consider the diagnosis have been associated with this inability to recognize delirium. The fluctuating nature of delirium contributes to the lack of recognition. The Parable of the Six Blind Men was a useful analogy—while every clinician sees the same patient, that patient may present differently over the course of a day. Nurses are in the best position to see the big picture.

A descriptive, retrospective, electronic, record review was used for this study. A single, quarterly batch of incident reports was examined by nine raters trained to identify delirium with criteria from the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Falls were classified as minor, moderate, or major. Data were collected from two days before the fall, the day of the fall, and the day of admission, then an analysis of symptoms such as change in cognition, encephalopathy, acute confusion syndrome, etc., was conducted.



Barbara Lakatos, RN, presents at recent meeting of the NRC Journal Club

Characteristics considered included age, number of falls, gender, type of injury, and clinical service (medical or surgical). Male and female subjects were evenly divided. Most falls occurred in those aged 70 or older. More surgical patients fell than medical. The length of stay was three times greater for patients who fell. In the final analysis, taking into account the DSM criteria and other symptoms, 96% of patients who fell showed evidence of delirium.

The study showed that patients who fall are often delirious but are not diagnosed as such. The cognitive impairment associated with delirium needs to be addressed in interventions to prevent falls. Quality and safety can be enhanced and hospital costs reduced when fall-prevention programs assess the evidence-based risk factors of delirium. More research is needed to validate the expanded indicators for delirium and their relation to falls.

The next Journal Club presentation, “Workplace Bullying Experienced by Massachusetts Registered Nurses and the Relationship to Intention to Leave the Organization,” will be held May 12, 2010, in Bullfinch 222. For more information, call Martha Root at 4-9110.

New model for PCS awards and recognition programs

—by Julie Goldman, RN, professional development manager

For the first time this year, PCS is piloting a recognition process whereby nominations for all departmental awards will take place once a year, and one ceremony will be held to honor all recipients at the same time.

Numerous award and recognition ceremonies pepper the Patient Care Services annual calendar. Many awards, scholarships, and fellowships have been established to recognize excellence and achievement among clinical and support staff throughout Patient Care Services.

In an attempt to make the nomination process for these awards more manageable and to allow more people to attend recognition ceremonies, a new model for PCS awards is being considered. For the first time this year, PCS is piloting a recognition process whereby nominations for all departmental awards will take place once a year, and one ceremony will be held to honor all recipients at the same time.

This new process will affect the Norman Knight Preceptor of Distinction Award; the Brian M. McEachern Extraordinary Care Award; the Stephanie Macaluso, RN, Excellence in Clinical Practice Award; the Marie C. Petrilli Oncology Nursing Award; the Norman Knight Clinical Support Award; and the Anthony Kirvilaitis, Jr., Partnership in Caring Award.

An ad-hoc committee comprised of associate chief nurses, nursing directors, clinical nurse specialists, past award recipients, and others welcomed the opportunity to re-evaluate the current process, examine barriers, and look at alternative ways to recognize PCS staff.

Said one committee member, “The award and recognition programs are an important part of our values. It has become part of our culture to celebrate clinical and support staff and their commitment to serving patients and families at MGH.”

According to committee recommendations, this year Patient Care Services will hold one award ceremony for the departmental awards listed earlier; all scholarships will be presented in June; and unit-based awards and fellowships will remain the same.

The committee feels the new model will provide greater recognition for nominees and recipients, give leadership more time to review award categories and criteria and nominate staff as appropriate, and give everyone adequate time to plan ahead to attend the award ceremony.

The nomination process began in March. One nomination form was created so clinicians, patients, and family members can nominate employees for any award using a single form. All nominations must be received by May 6, 2010. Once candidates have been nominated, selection committees will be formed to review portfolios and select the recipients. The ceremony celebrating all recipients will be held in the fall and will be widely publicized to give people ample time to plan accordingly.

For more information on the new PCS recognition model, contact Julie Goldman, RN, professional development manager at 4-2295.

Knight Center collaborates to create dynamic PCA workshop

—by Sheila Golden-Baker, RN and Cynthia LaSala, RN

A feeling of trust quickly developed that allowed participants to share their ideas and experiences openly. Many expressed pride in the special role they play in caring for and meeting the needs of patients on their units.

The Norman Knight Nursing Center for Clinical & Professional Development and nursing leadership of Phillips House 20 and 21 worked together recently to create an educational program for patient care associates. Unit leadership had identified some learning needs, which led to the development of this full-day workshop. The program was offered twice to allow flexibility of participation and to allow patient care associates from both units to attend.

Sheila Golden-Baker, RN, professional development specialist, and Cindy LaSala, RN, clinical nurse specialist, worked together to develop the course content and recruit guest lecturers. Topics included: teamwork and communication; caring for patients with changes in mental status; infection-control practices; nutritional needs of patients; body mechanics; patient care associates' role in caring for acutely ill adult patients; fall-prevention; oxygen-delivery systems; and documentation. Many of the topics dovetail with the National Patient Safety Goals and support our Excellence Every Day initiative.

Classes were highly interactive. Patient care associates were engaged, responsive, and honest. A feeling of trust quickly developed that allowed participants to share their ideas and experiences openly. Many expressed pride in the special role they play in caring for, and meeting the needs of, patients on their units.

Patient care associates expressed appreciation at having a program devoted entirely to their role group,

saying it demonstrated leadership's recognition of the important part they play in supporting positive patient outcomes.

Feedback from participants included:

"It was a great review which made me re-assess how I can do my job better."

"The information I learned will help me become a better team member."

"I'll be better able to provide safer care to my patients regardless of their illness."

Many successful outcomes were achieved. Patient care associates had an opportunity to demonstrate the knowledge and skill they bring to their role, validate their perceptions and intuition regarding patient needs, and take pride in the special role they play in meeting those needs. The workshop also gave them an opportunity to network with other patient care associates and became better acquainted with those who work different shifts. The course laid a good foundation for future team-building.

On the other side of the equation, leadership was able to more fully appreciate the valuable contributions of patient care associates and identify learning opportunities for future education and training programs.

This is an excellent use of resources offered by the Knight Center. Feel free to call the Center to inquire about how we can help with any learning needs you might have on your unit. For more information, call 6-3111.

The Orren Carrere Fox Award for NICU Caregivers

—by Mary Ellin Smith, RN, professional development manager

On Friday, March 26, 2010, the Orren Carrere Fox Award for NICU Caregivers was presented to respiratory therapist, Patricia Harron, RRT. The award, endowed by the Fox family, was created to honor and recognize the compassionate, holistic, family-centered care they received when their son, Orren, was a patient in the NICU 13 years ago.

Family and friends of the Fox and Harron families joined the staff of the NICU to celebrate Harron and the exquisite care she provides to patients and families. Every year, this event is an opportunity to celebrate and take pride in the smart, caring, talented young man Orren Fox has become since his stay in the NICU.



Below: Fox award recipient, Patricia Harron, RRT (left), with director of Respiratory Care, Robert Kacmarek, RRT (second from left), and Fox family. **At right:** Harron with members of her family.



(Photos by Joe Ferraro)

Nursing director, Peggy Settle, RN, welcomed guests and expressed staff's gratitude to the Fox family for the continuing gift of funding this award.

Robert Kacmarek, RRT, director of Respiratory Care, introduced Harron and presented the award. He described Harron as a talented and versatile clinician whom all members of the team respect and admire. Not only is she highly skilled to handle the most technical equipment and procedures, she has a natural ability to partner with families during the most difficult moments of their lives—the illness of their child.

Accepting the award, Harron thanked the Fox family, her own family, and the “awesome team” she is “lucky enough to work with.”

Orren thanked staff for the care he received, which his ophthalmologist told him contributed to his excellent eye sight. The Foxes expressed their gratitude to the friends and family who saw them through Orren's illness, and to the NICU staff, saying, “We think of you and are grateful to you every day.”

What are pressure ulcers and how do you prevent them?

Question: What is a pressure ulcer?

Jeanette: A pressure ulcer is a localized injury to the skin or underlying tissue as a result of pressure, or pressure in combination with shearing or friction. Pressure ulcers can develop quickly when circulation is compromised, and they're often difficult to heal. When they do occur, they put patients at risk for infection and prolonged hospitalization as well as adding to their emotional and financial burden.

The National Pressure Ulcer Advisory Panel has defined stages of pressure ulcers based on amount of tissue that's affected. These guidelines are available at: <http://www.npuap.org/pr2.htm>, and will soon be added to patients' green books.

Question: Why is identifying pressure ulcers important?

Jeanette: Pressure ulcers are preventable, adverse outcomes, and we should do just that—prevent them from occurring.

In October, 2009, the Centers for Medicare and Medicaid Services implemented regulations that identify hospital-acquired pressure ulcers as one of eight 'never events' that will no longer be covered by Medicare. Pressure ulcers present on admission are excluded, but a head-to-toe skin assessment and accurate staging must be documented by an admitting physician, nurse practitioner, or physician assistant, and a registered nurse. Clinical practice guidelines should include early identification of patients at risk for pressure ulcers and early interventions to prevent them.

Pressure ulcers put patients at risk for other adverse events such as infection, prolonged admission, and emotional and financial burden.

Question: Where should the skin assessment or pressure ulcer be documented?

Jeanette: On admission, a thorough skin assessment should be documented on the Nursing Dataset. If pressure ulcers are present, complete the Pressure Ulcer Staging Section (Section 6) of the Dataset.

The Nursing Progress Note should describe the wound(s), including length, width, depth, tissue type, a description of the wound bed, wound exudate, peri-wound area, and dressing or treatment plan.

The Skin Integrity Problem Lists on the MGH Intranet can be used in creating a Plan of Care.

The wound should be re-assessed and documented in the Post Hospital Discharge Plan within 24 hours of discharge.

Question: How is risk for pressure ulcers determined?

Jeanette: At MGH, the Braden Scale is used to identify patients at risk for developing pressure ulcers. The Braden Scale is a reliable tool for predicting patients at risk for pressure ulcers.

The scale is composed of six sub-scales that reflect sensory perception, skin moisture, activity, mobility, friction and shear, and nutritional status. Completing the Braden Scale is the first step of a two-part pressure-ulcer prevention and treatment program.

The second step is customizing a plan of care based on the Braden sub-scales, which can be found in the Skin Integrity Problem Lists.

Question: What resources are available to guide early intervention and preventative measures?

Jeanette: Increasing knowledge around pressure-ulcer prevention is key. The MGH intranet houses Skin Integrity Problem Lists with suggestions for interventions that correspond to the overall Braden score and specific interventions for sub-scale scores.

Completion of the four on-line National Database of Quality Nursing Indicators (NDNQI) Pressure Ulcer Training modules is highly recommended to improve skill and accuracy in recognizing, staging, and treating pressure ulcers. Completion of Module One is required for all MGH nurses.

The CNS Wound Care Task Force offers one- and two-day wound care classes throughout the year. This year's classes are:

- One-Day Wound Care Class
April 16, September 9, and November 9
- Two-Day Wound Care Class
July 28 and 29

For more information or to register for a class, contact The Knight Nursing Center at 6-3111.

Healthcare community mourns passing of visionary leader

“She was truly
a forerunner of
Excellence Every
Day, and the legacy
of her influence
is felt in our
department
to this day.”
—Michael Sullivan,
director of Physical
& Occupational
Therapy

On March 25, 2010, Marjorie Katherine Ionta, a pioneer and influential leader in the world of Physical Therapy, passed away peacefully at her home in Duxbury at the age of 97. Ionta was the director of Physical Therapy at MGH from 1958–1981. Still remembered fondly and with great respect by therapists who knew and studied with her, Ionta began her career in 1945 when she was awarded the first scholarship in Physical Therapy by the National Foundation for Infantile Paralysis. She was a founding member of the American Physical Therapy Association, a prolific lecturer, and co-author of *Proprioceptive Neuromuscular Facilitation*, an enduring reference for physical therapists, now in its 10th edition.

With Stanley Paris, Ionta founded the North American Academy of Manipulative Therapy, a forerunner of the Orthopaedic Section of the American Physical Therapy Association; she served on the National Education Committee and as chapter president in 1971. Throughout her tenure as chief physical therapist at MGH, Ionta was an active clinician and teacher and was committed to the advancement of the MGH Institute of Health Professions. Ionta was the first person to be named professor emerita at the Institute where each year, The Marjorie K. Ionta Award for Clinical Excellence is presented to a student who demonstrates advanced skills, empathy, ‘simple elegance,’ and outstanding humanistic qualities.



Marjorie K. Ionta
supervisor of Physical Therapy 1958-1981

Said Michael Sullivan, PT, director of Physical & Occupational Therapy, “Ms. Ionta is remembered not only for the high standards of clinical care and professionalism she established, but for the values and beliefs she instilled in her students regarding ethics, respect, and human dignity. She was truly a forerunner of Excellence Every Day, and the legacy of her influence is felt in our department to this day.”

The Marjorie K. Ionta Fund was established to promote excellence in physical therapy by supporting the involvement of physical therapists and physical therapy students in special projects and professional endeavors. For more information, contact the Office of Institutional Advancement at the MGH Institute of Health Professions, at 6-8009.

Announcements

Be Fit Lunchtime Seminars

Join advanced personal trainer, Mike Bento of The Clubs at Charles River Park, for a one-hour, lunchtime Be Fit seminar. Topics vary

Next session:
April 15, 2010
12:00–1:00pm
Bigelow 4 Amphitheater

For more information, call 6-2900.

MGH College Fair

Employees are invited to the 2010 MGH College Fair

April 28, 2010
12:00pm – 3:00pm
under the Bulfinch Tent

Explore careers in health care, healthcare administration, healthcare policy, and business management. The fair is an opportunity to compare undergraduate, graduate, and certificate programs.

Some of the colleges and universities scheduled to attend include:

Boston University
Bunker Hill Community College
Cambridge College
Curry College
Harvard Extension School
Mass Bay Community College
Massasoit Community
Mass College of Pharmacy
MGH Institute of Health Professions
Northeastern University
North Shore Community College
Regis College
Roxbury Community College
Suffolk University
UMass, Lowell
University of Phoenix

No registration required. Sponsored by Training and Workforce Development.

For more information, call John Coco at 4-3368.

Linda Kelly Visiting Scholar in Women's Health

Inaugural Program

April 29, 2010
1:30–2:30pm
O'Keeffe Auditorium

presented by
Nancy Fugate Woods, RN, professor; Family and Child Nursing and dean emeritus
University of Washington School of Nursing

Linda Kelly Nursing Lecture
"To HRT or Not to HRT: is this the Right Question?
Providing Decision Support for Mid-life Women"

Reception to follow

For more information, call Donna Perry, RN, at 4-0340

Clinical pastoral education fellowships for healthcare providers

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

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

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

Deadline for application is May 1, 2010

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

Eldercare monthly discussion group

Join facilitators, Janet T. Loughlin, LICSW, Partners EAP, and Barbara Moscovitz, LICSW, geriatric social worker for the Eldercare monthly discussion group, sponsored by the Employee Assistance Program. Come and discuss subjects relevant to eldercare.

Next session:
May 4, 2010
12:00–1:00pm
Doerr Conference Room
Yawkey 10-650

Old friends and new members are welcome

Feel free to bring your lunch
For more information, call 6-6976 or visit www.eap.partners.org.

Ethics Forum: a discussion series for the MGH community

Friday, April 30, 2010
12:00–1:00pm
Yawkey 2-210
Brown Bag Lunch

Ethical and Tactical Planning for Pandemic and Disaster Preparedness:
Reflections on H1N1 and the Earthquake in Haiti

Panelists: Paul Biddinger, MD Emergency Services; Maryfran Hughes, RN, Emergency Services; Taylor Thompson, MD, Medical Intensive Care Unit; and Ed Bajwa, MD, Medical Intensive Care Unit

Moderators: Dr. Alex Cist, Optimal Care Committee and Susan Warchal, RN, Emergency Services

Sponsored by the MGH Ethics Taskforce. For more information e-mail Jennifer Hood

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For more information, call: 617-724-1746

Next Publication
May 6, 2010

Patient education should be a shame-free experience

—by Shellie Léger, LICSW; Angelica Tringale, RN; and Maika Escandón, RD

Teach-back and show-me techniques are tools used by clinicians to verify patients' understanding of information and instructions. Asking a patient to draw insulin after he's been shown how; asking how she'll tell her family about her condition; or asking him to explain certain information or written materials are examples of techniques used to validate patients' understanding.

These techniques have been shown to be valuable and effective. But there can be underlying factors that, if unrecognized, render even the best patient-teaching ineffective. One such factor is shame.

Anxiety dulls the ability to focus and learn new material. And being asked to teach back or demonstrate understanding can increase anxiety. Patients feel they're being tested, they fear they'll 'get it wrong.' Add to that a sense of shame at being ill or a sense of inadequacy at not being able to understand and you've got a teaching situation that's doomed to fail.

We have strategies to alleviate anxiety but without addressing shame we're not being as effective as we could be. Most (ill) patients experience some level of shame, which makes patient education and teach-backs increasingly challenging. When patients feel shame, they're more likely to hide, deny, try to escape, or externalize blame.

How can we reduce shame, decrease anxiety, and still engage in teach-back and show-me protocols?

Suggestions on how to mitigate shame:

- Understand that shame is often experienced with illness
- Provide a space that allows as much privacy as possible
- Establish a trusting relationship by being empathetic and supportive. Ask open-ended questions that invite dialogue; avoid questions with Yes/No answers. Learning happens best in the context of a relationship
- Keep the patient's needs central. When asking a patient to teach back or show you, emphasize you want to make sure *you* did a good job explaining the material
- Design a user-friendly format for teach-backs. Acknowledge that the patient is the expert on his/her own body; your role is to add to what they already know. Use plain language and terms they can easily understand
- Explain that partnering with you in their care will help lead to better outcomes

When using the teach-back/show-me method, the goal is to be better teachers. Creating a shame-free environment helps patients experience the education we provide as a joint effort in which we're both equally invested.

For more information about shame-free patient education, contact Angelica Tringale at 4-4810, or any member of the Patient Education Committee.

"What do you regard as most humane?

To spare someone shame."

—Friedrich Nietzsche

Educational offerings can now be found on the

Knight Nursing Center for Clinical & Professional Development website

http://www2.massgeneral.org/PCS/ccpd/cpd_sum.asp

For more information, call 6-3111.

Nurse Recognition Week 2010

Sunday, May 2

Staff Nurse Breakfast 7:00–9:00am Trustees Room

Monday, May 3

Nursing Research Scientific Sessions

"Effects of Sensory Interventions on an Inpatient Psychiatric Unit: a Pilot Study,"
presented by Christina Stone, RN

"Evaluation of Basic Arrhythmia Knowledge Retention and Clinical Application by Registered Nurses,"
presented by Laura Sumner, RN, Shelia Burke, RN, Mary McAdams, RN,
and Lin-Ti Chang, R N

10:00–11:30am, O'Keefe Auditorium

"Health Care Reform and Nursing Care of Older Adults: Mission Critical,"
presented by Terry Fulmer, RN, Erlene Perkins McGriff professor,
New York University

1:30–2:30pm, O'Keefe Auditorium

Nursing Research Scientific Session:

"Research Utilization in Nursing Practice at MGH:
a Comparative Study of Barriers and Facilitators"
presented by: Chelby Cierpial, RN

4:00–5:00pm, O'Keefe Auditorium

Tuesday, May 4

"The Proclamation for Change: a Foundation to Promote Nursing Practice"
presented by: Ann Hendrich, RN, vice president, Clinical Excellence Operations,
Ascension Health

10:00–11:00am, O'Keefe Auditorium

"Advancing Practice and Quality through Critical Thinking"
presented by: Ann Hendrich, RN, vice president, Clinical Excellence Operations,
Ascension Health

2:00–3:00pm, O'Keefe Auditorium

Wednesday, May 5

Research Day

Posters on display throughout Nurse Recognition Week
O'Keefe Auditorium Foyer

Wednesday, May 5 (continued)

Nursing Research Scientific Session

"The Effects of a Preparatory Information Session Prior to a Cardiovascular Procedure"
presented by Anne Gavigan, RN, and Carolyn Cain, RN

9:30–10:30am, O'Keefe Auditorium

Interactive Nursing Research Poster Session
10:00am–12:00pm, O'Keefe Auditorium Foyer

Yvonne L. Munn Nursing Research Lecture and Awards
"From the NICU to OB Clinics: a Research Journey"
presented by: Susan Gennaro, RN, dean and professor, Boston College

1:30–3:00pm, O'Keefe Auditorium

Afternoon tea and reception in The Trustees Room following presentation

Thursday, May 6

Staff Nurse Breakfast 7:00–9:00am Trustees Room

Nursing Research Scientific Session

"Patient Experience of Adherence to Endocrine-Based Oral Chemotherapy
'Drug Holidays' in Women with Breast Cancer"
presented by: Jane Flanagan, RN

10:00–11:00am, O'Keefe Auditorium

Chief Nurse Address

presented by Jeanette Ives Erickson, RN, chief nurse

1:30–2:30pm, O'Keefe Auditorium

Reception immediately following

Friday, May 7

"Florence Nightingale: a Medical Revolutionary"

presented by: Kathleen Duckett, RN

10:00–11:00am, O'Keefe Auditorium

Tuesday, May 11

"Pebble in the Water: Why You Make More of a Difference in the
World Than You Might Think"

presented by Bob Welch, author, *American Nightingale* and *Pebble in the Water*

10:00–11:00am, O'Keefe Auditorium

Book-signing immediately following in the MGH Gift Shop

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April 15, 2010

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