Caring Headlines

August 5, 2010

# CRNAs

## Certified registered nurse anesthetists


Nurse anesthetist, Celeste Day, CRNA, prepares to administer anesthetic agent to patient during procedure in the Electrophysiology Lab. See senior vice president for Patient Care, Jeanette Ives Erickson's column on page 2.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

# Certified registered nurse anesthetists

## *opportunities abound for nurses practicing in this critical, expanded role*

A certified registered nurse anesthetist is an advanced practice nurse with a minimum of one year experience in a critical-care setting, has attended an accredited nurse anesthesia education program, and passed the national certifying exam.

You almost never hear a patient request an anesthesiologist or nurse anesthetist by name. You never hear a patient say, "My nurse anesthetist was great, I'm going to refer her to a friend." This highly specialized discipline that involves pharmacologically inducing a state of unconsciousness or lack of sensation may not be a high-profile health profession. But the ability to allow patients to undergo surgery without feeling pain is one of the most crucial services provided in operating rooms.

According to the American Association of Nurse Anesthetists, nurse-delivered anesthesia was the first clinical nursing specialty back in the late 1800s. And nurse anesthetists have been involved in the full range of surgical procedures ever since, including contributing to the development and refinement of anesthesia practice and equipment.

Today, a certified registered nurse anesthetist (CRNA) is an advanced practice nurse with a minimum of one year experience in a critical-care setting, has attended an accredited nurse anesthesia education program, and passed the national certifying exam. Different from an anesthesiologist both by education and training, nurse anesthetists perform in much the same capacity, meeting patients' anesthesia needs before, during, and after surgical or obstetrical procedures.

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

Nurse anesthetists:

- perform physical assessments
- provide pre-operative teaching
- prepare for the anesthetic management of each patient
- administer anesthesia to keep patients free of pain
- maintain anesthesia throughout the surgical procedure
- oversee recovery from anesthesia
- follow patients' post-operative course through recovery to the patient care unit

Regulations guiding the practice of nurse anesthetists vary from state to state and hospital to hospital. In more than 2/3 of rural hospitals in the United States, nurse anesthetists are the sole providers of anesthesia care. At MGH, nurse anesthetists practice under the supervision of an anesthesiologist, meaning an anesthesiologist must be present when the patient is ini-

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"CRNAs are an integral part of our department. We want to make sure we provide them with the education and opportunities they need to succeed and become leaders in their field."

—Wilton Levine, MD, clinical director, Anesthesia, Critial Care and Pain Medicine

tially induced and when the patient wakes up from anesthesia. One anesthesiologist can supervise as many as four nurse anesthetists, making the employment of nurse anesthetists a cost-effective strategy in meeting the growing need for anesthesia care.

Nurse anesthetist, Celeste Day, CRNA, still remembers the day she made that career choice. "On my first day of nursing school at Boston College, a nurse anesthetist spoke to our class. I'd never heard of a nurse anesthetist before, but it sounded like a great job. After I graduated from nursing school, I went back to school to become a nurse anesthetist as soon as I could."

Celeste never regretted that decision. "The exciting thing about anesthesia," she says, "is that you learn about chemistry, physics, pharmacology, patho-physiology—then, when you administer medication, you see it all come together right before your eyes. And I love the human side. Some patients come to us on the worst day of their lives. It's rewarding to be able to show them compassion, kindness, and maybe a little humor. I try to help every patient think of something relaxing and peaceful before they go to sleep. The more comfortable they are when the go to sleep, the more comfortable they are when they wake up."

Nurse anesthetist, Bhavika Patel, CRNA, worked in the Surgical-Trauma ICU at Tulane Hospital in New Orleans before coming to MGH two years ago. For her, being a nurse anesthetist is 'the whole package.' As a nurse anesthetist, she says, "We work collaboratively with the anesthesia team taking into consideration any and all concerns of other members of the care team. We're autonomous, we have a strong skill set, and we make critical decisions all the time. It's hands-on, fast-paced, and high-risk. It's everything I love."

Says Wilton Levine, MD, clinical director, Anesthesia, Critial Care and Pain Medicine, "CRNAs are an integral part of our department. We want to make sure we provide them with the education and opportunities they need to succeed and become leaders in their field."

Shortly before press time, we learned that a bill had been approved by the Massachusetts House and Senate (awaiting the signature of Governor Patrick) giving certified registered nurse anesthetists the authority to write prescriptions and order tests under the supervision of a physician as it affects the immediate perioperative care of patients. Nursing and medical boards will co-regulate this new practice.

For more information about the role of certified registered nurse anesthetists, call 6-3030.

### Updates

I'm pleased to announce that Christine Gryglik, RN, will assume the position of clinical nurse specialist for the Cardiac Surgical Intensive Care Unit, effective August 9, 2010.

Vivian Donahue RN, has accepted the position of nursing director for the Cardiac Surgical Intensive Care Unit on Blake 8.

And Zary Amirhousseini is the new disabilities program manager within the MGH Office of Patient Advocacy.

## In this Issue

# Hospital clowning

## *Never underestimate the healing power of 'clowning around'*

—by Shelly Bazes, RN, nurse practitioner and quality improvement nurse specialist

The cry came from a room at the other end of the corridor at Safra Children's Hospital in the Tel Hashomer Medical Center in Tel Aviv. It was a signal for me to go to work. I slid closer to the open door and looked inside. Huddled between the crib, the IV pole, and assorted stuffed animals was a sweat-soaked woman holding a crying baby. There was steam wafting around the baby's head from a displaced nebulizer mask. When the woman looked in my direction, I gestured for permission to enter the room. Smiling, she nodded.

I disinfected my hands and tip-toed toward them accompanied only by the faint tinkling of bells on my ankles. I cranked out *Somewhere Over the Rainbow* on my tiny music box as I inched closer. The crying subsided. The baby opened her eyes and stared. Her breath settled as she started to relax. She broke into a big smile as the last tear fell from her cheek. When our eyes met, I twinkled my nose, raised my eyebrows, and smiled back. I cooed with her as she stared at my small, red, star-shaped nose. Just then, a nurse hurried in, paused, then grinned when she caught on to what was happening in the room. It was one of those magical moments —one I had come 6,000 miles in search of.


(L-r): Shelly Bazes, RN, with members of the Dream Doctors Project of Israel, Talia Safra and Anat Zonenfeld

My name is Shelly Bazes, (aka: Tweedles, the clown). I have been a hospital clown for the past eight years. I've worked as a quality improvement nurse specialist with the Performance Improvement and Analysis Group for the past year. And I oversee the MGH Relaxation and Humor Channels (45/46).

During my two-week holiday in Israel, I had an opportunity to clown, listen, play, make music, and share stories, experiences, and ideas with an amazing team of hospital clowns. The 53-member Dream Doctors Project of

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Israel integrates professional medical clowning with the therapeutic teams in pediatric wards and clinics at 17 Israeli hospitals. Their work overlaps the work of child life specialists but with a unique twist—non-scary clowning with a psychological and therapeutic focus.

Hearing about this project motivated me to explore the possibility of an exchange program between the Israeli Dream Doctors Project and the hospital clown troupe I'm a member of here in Boston, the Hearts and Noses Hospital Clown Troupe. The Dream Doctors Project seeks to transform clown therapy into an officially recognized health profession with specialized academic training. In collaboration with Haifa University, they've developed a special BA curriculum that incorporates theatre arts, psychology, biblio-therapy, and nursing theory.

The day I clowned with the Dream Doctors at Safra, they were being filmed for a news program that became the basis for a video about their efforts to create an 'Island of Sanity' for patients (check YouTube for Dream Doctors Project + Island of Sanity). I returned to the United States a changed clown. I hope to explore how the Dream Doctors' methods support the work of the clinical team without being an intrusion—in fact, by being a therapeutic asset.

My time with the Dream Doctors Project raised so many questions: How do you create a fantasy moment for a child within the context of critical care? What does it mean to 'clown to the healthy side of a child?' And does it make a difference?

The Boston-based Hearts and Noses Hospital Clown Troupe has decided to invite members of the Dream Doctors Project to continue this remarkable cultural exchange program here in Boston.

For more information about hospital clowning, contact Shelly Bazes at: sbazes@partners.org.

For information about the Dream Doctors Project of Israel, go to: http://www.le-haim.org.il/site/index.asp.

**At right:** Bazes with clown colleagues at Safra Children's Hospital in Israel. **Below left:** Bazes with Cheryl Lekousi (TicToc) and Brian at Franciscan Hospital for Children in Boston. **Below right:** Bazes with Nimrod Eisenberg (Max) and Tamar at Hadassah Hospital in Jerusalem.

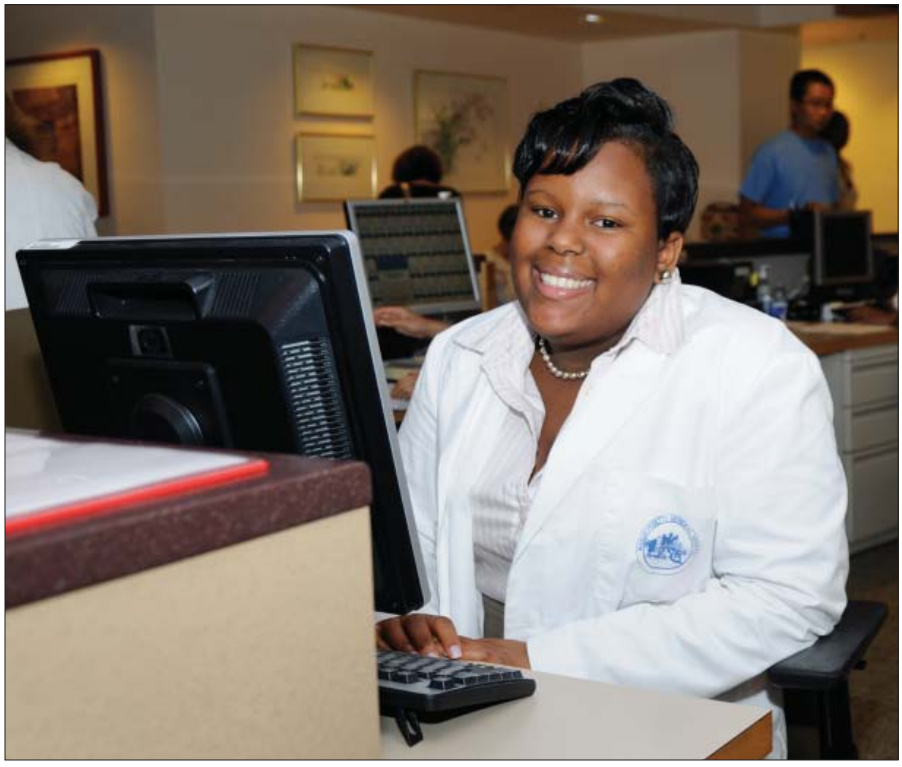
(Photos provided by Bazes

# Youth programs provide inspiration and opportunities to high-school students

—by Julie Goldman, RN, professional development manager; and Tywanda Coston, ProTech student

Youth programs offered by the MGH Center for Community Health Improvement provide students with academic, life, and career skills that help expand their educational and career opportunities. Programs provide students with hands-on experience, career-exploration opportunities, and mentoring relationships that can be invaluable to their science, technology, engineering, and math education. In grades 11 and 12, students are eligible to participate in paid after-school and summer internships.

ProTech student, Tywanda Coston, a graduate of the Edward M. Kennedy Academy for Health Careers, at her internship position on the Blake 4 Endoscopy Unit. Coston is mentored by operations associate, Yvette Chappell.



ProTech, one MGH youth program, is an internship for high school juniors and seniors interested in pursuing health and/or science careers. The ProTech program combines work-site rotations, professional-development forums, and college-planning assistance with an 18-month paid internship to introduce students to the broad range of careers in health care and the sciences.

Each year at the Youth Programs Volunteer Appreciation Celebration, sponsored by the MGH Center for Community Health Improvement, students have an opportunity to share their experiences. On June 29, 2010, Tywanda Coston, ProTech senior, spoke about her experience. Following, is the text of her remarks.

My name is Tywanda Coston, and I'm happy to be here this afternoon to share my experience with you. Let me to tell you a little about myself. I'm 18 years old and just graduated from the Edward M. Kennedy Academy for Health Careers. This fall, I'll be attending Virginia State University. This is a proud moment for me. I have four brothers and two sisters, and I am the first one in my family to go to college. I'm very excited. Since I was a little girl, I knew I wanted to

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do something related to health care. I plan to major in Psychology and Criminal Justice.

I'm currently an intern on the Endoscopy Unit where Yvette Chappell is my mentor. I support the operations associates and operations managers in their work. It is a challenging environment where I get to see employees in action, observe procedures, and meet patients. I learn something new every day. I'm amazed by staff I work with—their compassion, their work ethic, and what they do for patients.

Before coming to the Endoscopy Unit, I interned in The Institute for Patient Care, where I worked with executive director, Gaurdia Banister, RN, and her assistant, Robyn Stroud. It was a busy office where I learned the importance of time-management, accuracy, and prioritizing. I was introduced to clinical educators and a whole other side of health care I didn't know existed.

How did I get here? These amazing opportunities were provided to me through the ProTech program.

ProTech students, Jennifer Pierre (center), soon to be a junior at East Boston High School, and Ivana Maya (right), a graduate of the Edward M. Kennedy Academy for Health Careers, work with their mentor, Kelly-Ann Brathwaite in the White 13 General Clinical Research Center.

Since my introduction to MGH in my freshman year, I've had nothing but positive experiences with MGH staff—shadowing a nurse on the OB/GYN Unit, participating in professional-development forums, listening to MGH speakers.

Last year, Peter Slavin, MD, president of MGH, offered the opportunity of a life time to me and three other students—a tour of Historical Black Colleges. It was a trip like no other. It inspired me to dream big. Because of that trip, I chose to attend Virginia State University. As if that weren't enough, I was the recipient of two MGH scholarships that will help pay for my college tuition, fees, and books.

I've met some extraordinary people at this hospital. My supervisors and co-workers are more than just supervisors and co-workers. They have been supportive in so many ways. They inspire me to be successful and follow my dreams. They advised me on college and career planning, gave me the flexibility I needed when I was struggling in school, taught me important skills like prioritizing, balancing school and work, and what it means to be a good employee. They guided me when I had questions about college and even some personal matters. They stressed the importance of education, working hard, and staying focused.

I admire my supervisors and co-workers; they show me that great things are possible regardless of where you come from. They taught me what it means to be respectful, committed, and compassionate. They demonstrate this in the work they do every day to deliver the best possible patient care. I am so fortunate to have these wonderful individuals in my life as role models and mentors.

I would like to thank MGH for all they do for patients, families and employees. Thank-you to my supervisors and mentors, Robyn, Guardia, Yvette, Mary Ellin Smith, Sabrina Ciulla, and others who guided and supported me during my time here. Thank-you to MGH Youth Programs for providing these opportunities to young people. Don't ever stop doing what you're doing.

# New nurse sees first-hand how trust impacts patient care

Amber Lessard, RN, staff nurse
Bigelow 13 Burn Unit

Four years ago, I packed my knapsack and walked into Bunker Hill Community College to start my journey toward a new career... I knew the arm bone was connected to the hand bone, and I knew a fever was bad, but that was about it.

My name is Amber Lessard. Five years ago, I was a waitress doing volunteer work at Children's Hospital a few hours a week. I played with children as they waited for their appointments. I remember looking at the nurses with envy, wanting to be one of them. Four years ago, I packed my knapsack and walked into Bunker Hill Community College to start my journey toward a new career. My first class was Anatomy & Physiology, an unfitting choice for an English major, I thought. I knew the arm bone was connected to the hand bone, and I knew a fever was bad, but that was about it.

Three years ago, I started nursing school at Simmons College. Finally, I was going to learn to be a nurse. Over the summer, I had learned the basic skills that would allow me to start my first clinical experience with some basic knowledge.

It seems like just yesterday that I took my Synthesis class. It was then that, (for a lack of a better word) things really started to 'synthesize' in my head. I started to put the pieces together, knew some of the questions I should be asking my patients, and while the thought of hanging an IV was daunting, I approached the task as if I knew what I was doing. My heart felt as if there was a hummingbird in my throat, but I don't think my patients ever noticed my fingers shaking.

I became a nurse on February 25, 2008.

Since then, I've become more comfortable in my role as a nurse. Looking back to my first year, it was 12 months of simply becoming comfortable with the basic aspects of the role—completing the necessary tasks during my shift. I was just that: task-oriented. I wanted to be able to draw blood on the first stick, control a patient's pain, do all my documentation perfectly so senior nurses would think highly of me at shift change. I was focused on mastering the kinds of things you can teach anyone. It doesn't take years of practice to master simple nursing tasks.

This year was a year of tremendous growth for me. I've been less focused on tasks and more focused on embracing the true art of nursing. I hate to bring nursing theory into this narrative, but I hark back to my

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studies of Hildegard Peplau, whose research focused on the nurse-patient relationship as the foundation of nursing practice. This year, I came to understand firsthand the need for a true partnership between nurse and patient. While it's easy to see why that relationship is beneficial to the patient in the sense that we develop trust, honesty, and open communication; little do patients realize how beneficial that relationship is to me as a nurse.

One patient in particular will always stand out in my memory. 'Tom' was a young man who had a past I could only imagine— addiction, personal tragedy, and an attempt to take his own life. Thankfully, he failed, allowing me to get to know and care for him. He has done more for me than he will ever understand.

Tom was trached and couldn't speak. One night, early in his admission, he was agitated and tried to get out of bed. I went into his room to help another nurse settle him down, and he wrote on his note pad, "I just don't want to die."

I was puzzled, bothered, and saddened by his comment. It stayed in my thoughts for days. A few weeks later, I started caring for Tom. The first few days were difficult; he was a medically and psychologically complex patient. I sensed a lack of trust between us, which was understandable. He had at various times been sedated or restrained. I probably wouldn't have trusted anyone in scrubs, either.

Over the next few days, we somehow broke the silence as I administered medications, cleaned suture lines, and packed wounds. Slowly, we started to become friends. He talked about *Judge Judy* and how excited he was about the upcoming *Law and Order* marathon. I'll never forget the first time he was able to walk around the unit. He touched everything, took a drink from the water fountain every time he passed it. It was as if he were a child seeing things for the first time.

Watching him and the progress he was making made me feel hopeful inside. I knew for sure he, "didn't want to die."

Finally, near the end of his stay, it was a beautiful, crisp, fall Saturday. The sky was that perfect blue-bird color you only see a few times a year. I longed to be outside. I asked Tom how long it had been since he'd been outside. It had been almost three months.

I told him we would go outside together. I bundled him up in a wheelchair. We stopped at Coffee Central for a mocha, then we went outside for a walk around the Bulfinch lawn. To this day, the look in Tom's eyes still moves me.

My time spent caring for Tom made me realize the importance of the nurse-patient relationship. I looked beyond his history. He trusted me. I truly think our friendship was more beneficial to him than the antibiotics and the medications he was receiving. I still think of Tom every once in a while and hope he's okay.

As I reflect on my journey, I know I've made great strides. As I grow older, I no longer differentiate between the person I am and the person I've become. I've discovered I have a deep concern for the human condition; it's apparent in every interaction I have with my patients. I care about their well-being. By finding compassion in my experiences as a nurse, I have developed greater compassion for others.

Nursing can be dirty, gritty, messy, and heart-breaking. Every day, I'm inspired, challenged, enriched. Every day, I encounter something fun, comforting, and exhilarating. I've met the most incredible individuals whose stories sometimes bring tears to my eyes.

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I think back to when I was a waitress, envious of that nurse at Children's Hospital, and I'm thankful I accomplished my goal. I love being a nurse.

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

Patients are our greatest teachers. This narrative is a testament to the clinical and life lessons we take from our interactions with patients. Every intervention is an opportunity to grow and develop our human, clinical, and communication skills. Amber's presence and enthusiasm triggered something in Tom. He trusted her. And as Amber rightly observed, a trusting nurse-patient relationship can be stronger than the strongest medicine. I'm sure Tom is thankful Amber achieved her goal of becoming a nurse, too.

Thank-you, Amber.

# CNS sees opportunities for complementary therapies in clinical practice

—by Marion Phipps, RN, clinical nurse specialist

Several years ago, a former colleague asked if I would participate in a Reiki class she was teaching. I was unsure at first, but after giving it some thought, I decided it would be a nice way to spend time with an old friend. The class was an entire day of learning Reiki and practicing with the other folks in the class. Despite my initial hesitation, I found the class enjoyable and informative.

Though I never formally practiced the techniques I learned in the Reiki class, I do incorporate some principles of Reiki and yoga into my practice—guided imagery, breathing techniques, and meditation. I can recall a number of patients in the past year whom I believe were helped by these interventions. Perhaps hearing these stories will inspire staff to use these techniques in their own practice.

Though I never formally practiced the techniques I learned in the Reiki class, I do incorporate some principles of Reiki and yoga into my practice—guided imagery, breathing techniques, and meditation.

Mrs. M was re-admitted to the Neuro Unit for treatment of leiomyosarcoma, a disease few of us had heard of. During her first admission, she had been very anxious and afraid. She knew she had a terminal disease. Her 8-year-old son had recently died of a brain tumor. She and her son had gone through radiation and chemotherapy treatment at the same time. During her first admission, she had cried often and was fearful of all interventions. She was a beautiful woman in her late 40s.

By the time of her second admission, Mrs. M's appearance had changed dramatically. She had lost her hair, and her face had become puffy from the steroids. She had been admitted for surgery on her skull, where the disease had now spread. Mrs. M needed to sleep in a special bed to prevent pressure on her head. The tube-shaped bed requires patients to 'sink' into sea of silicone beads. When she saw it, she was terrified and became hysterical. She said it looked like a casket. She thought she'd be suffocated by the beads.

Marion Phipps, RN,
neuroscience clinical nurse specialist

I sat with her and told her I understood her fear. I offered to get into the bed and show her how it worked. As I got in the bed, I assured her she wouldn't sink or get smothered. She was still frightened, but said she'd give it a try. I asked if she'd like me to employ the relaxing techniques of Reiki to help her feel less frightened. With the support of her nurse and me, Mrs. M got into the bed and began to cry uncontrollably.

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I calmly instructed her to listen to my voice as I put my hands on her shoulders the way I had learned in class. With my voice and my touch, I helped her slow her breathing and imagine a place that brought her comfort. After a few moments Mrs. M stopped crying and began to breathe more slowly. I stayed with her for about ten minutes, repeating these guided-imagery techniques until she fell asleep. She slept for about an hour before requesting to get out of bed. We practiced these techniques again later in the day, and by afternoon, she was confident she'd be able to sleep in the bed that night. Mrs. M and I chatted over the next few days of her admission. She was a remarkable woman. She talked about her impending death, about her two remaining children, her husband, parents, and her life. I'm most grateful for the connection we made. In late January, Mrs. M's obituary appeared in *The Boston Globe*. It reflected a woman who, despite great tragedy, had led a full, rich life.

I met Ms. C in the ED. I'd been asked to perform a swallow exam as she had presented with signs of a stroke. I found a very distressed woman lying on a stretcher, her upper body in only a bra as she'd removed her hospital gown. She said she desperately needed the swallow exam because she had Parkinson's disease and couldn't be without her medications. The whole time I was with her, she was talking on her cell phone. A young woman with her identified herself as Ms. C's daughter. She wanted me to know that her mother was very intelligent and would make her own decisions about her care.

As I observed Ms. C, I noticed she had a marked dysarthria making it difficult to speak. I performed the swallow exam and found she had a yeast infection in her mouth. With the head of her bed at 30 degrees, she coughed when she tried to drink water. I raised the bed and she was able to swallow better. Although she had somewhat passed the swallow exam, I still wanted to consult a speech-language pathologist because I was worried about her dysarthria.

As we waited for a consult, Ms. C and her daughter became irate that she wasn't able to take her medications. I worried that delaying them might contribute to the dysarthria. I asked the nurse to crush her pills and give them to her in a little applesauce.

Later, I learned Ms. C. had been admitted to White 12. She was out of control, insisting she be allowed to wear her own clothes and sit on the edge of her bed. Traci, her nurse, was very patient and kind. At one point Ms. C insisted on transferring to a chair. Traci and I attempted to help her, but she screamed for us not to touch her. She almost fell, but we held her at the waist and assisted her to the chair. Misunderstanding our intentions, she thought we were trying to hurt her. Traci explained we were just trying to keep her from falling, but Ms. C insisted she wasn't at risk for falling.

Wanting to help her relax, I asked if she might want to do some breathing exercises. She said she'd "chase me with a frying pan." Her way of relaxing was through work, work, work.

The next afternoon Ms. C's stroke extended. She needed an emergent MRI and CT scan. I accompanied her to the MRI. Ms. C became hysterical in the imaging machine. I tried to explain that she had the power to gain control of herself by regulating her breathing. Together, we practiced some breathing techniques. After the MRI, she became hysterical again. Soothing touch and controlled breathing again helped ease her anxiety. The CT was quickly completed, and we returned to the unit.

The next day, Ms. C asked if we could do the breathing exercises again. I reminded her that she had control; she could concentrate on her breathe and control her anxiety any time she wanted. We practiced for a while. I don't know if it had any impact, but for a few minutes she was able to draw on her personal resources and bring herself out of her fear and frustration.

These stories suggest that the use of complementary techniques such as Reiki, therapeutic touch, and controlled breathing exercises might have broader application in our practice. I hope to explore ways to incorporate these therapeutic techniques into care on our unit.

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# The Carol A. Ghiloni Oncology Nursing Fellowship

—by Mandi Coakley, RN, staff specialist

Now in its tenth year, the Carol A. Ghiloni Oncology Nursing Fellowship provides two student nurses an opportunity to learn about oncology nursing as a specialty at MGH. Since June 1, 2010, nursing students, Alison Nazarro and Gabrielle Stevens, have been observing the varied roles that nurses play in oncology care and learning about the many career opportunities available upon graduation. The fellowship was developed in 2001 to provide a learning experience with the hope that students would accept an oncology nursing position upon graduation. To date, 18 fellows have completed the program, ten have accepted positions at MGH upon graduation.

For the first four weeks of the ten-week program, Nazarro, a student at UMass, Amherst, spent time with preceptor, Sarah Brown, RN, on Phillips House 21. Stevens, a student at Clayton State University in Georgia, worked with preceptor, Peg Baldwin, RN, on Bigelow 7. Then they switched units to give them both experience on a medical oncology and surgical oncology unit.

Nazarro and Stevens had a chance to observe nursing practice in Radiation Oncology, Interventional Radiology, the Infusion Unit, and the outpatient disease centers in the Yawkey Building. They attended Schwartz Center Rounds, spent time in the Blood Transfusion Center, and took advantage of other learning opportunities within the Cancer Center, such as the HOPES program and the Cancer Resource Room.

The Carol A. Ghiloni Oncology Nursing Fellowship received partial funding from the Hahnemann Hospital Foundation. For more information, Call Mandi Coakley, RN, at 6-5334.

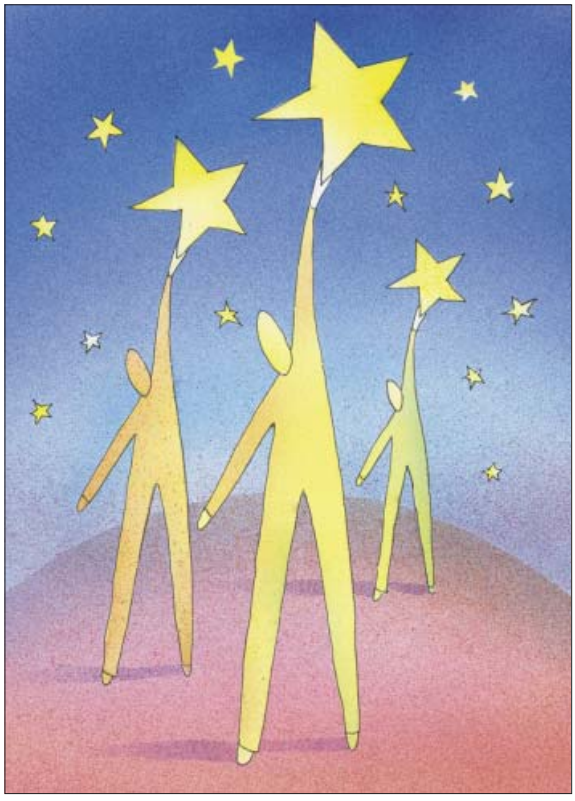
**Below left:** Liz Johnson, RN; precepts nursing students, Alison Nazzaro (center), and Gabrielle Stevens.
**Below right** (l-r): Johnson; Carol Ghiloni, RN; Jackie Somerville, RN; Mandi Coakley, RN; and Peg Baldwin, RN. Seated: Stevens and Nazzaro

# Clinical Recognition Program survey results

—by Mary Ellin Smith, RN, professional development manager

Implemented in 2002, the Clinical Recognition Program (CRP) was designed to formally recognize professional clinical staff within Patient Care Services for their expertise. Over the past eight years, all clinicians have been recognized at the entry and clinician levels of practice, and close to 400 clinicians have been recognized as advanced clinicians and/or clinical scholars. The CRP Review Board and Steering Committee wanted to get a sense from PCS clinicians and leadership as to their understanding and perceptions of the program and the impact it's had on their units, practice, and the MGH community.

In November, 2009, surveys were sent electronically to staff and leadership throughout Patient Care Services. The survey found that staff was very familiar with the Clinical Recognition Program, and that a majority had a favorable opinion of the program. Advanced clinicians and clinical scholars reported that recognition had brought a sense of professional and personal pride, and that since being recognized they had come to serve as resources and role models for others. The survey had a 65% return rate among leadership, and 31% among staff.



Almost 40% of staff who responded said they planned to apply for recognition at the advanced clinician or clinical scholar level in the next two years, though they expressed concern at the amount of time needed to complete the portfolio. Clinicians noted two primary barriers to seeking recognition: the impact of a colleague's refusal to support them and a perception that some of those recognized did not consistently practice at the new level after being recognized.

The results of the leadership survey found that more than 90% had a favorable opinion of the program. They viewed recognized staff as leaders on the unit or within the department. Leadership acknowledged the challenges they face ensuring staff recognized as advanced clinicians and clinical scholars continue to practice at that level after being recognized. They also acknowledged the challenges many staff face in preparing their portfolios for submission.

The CRP Review Board and Steering Committee will work over the next few months to synthesize the survey findings, develop recommendations, and create an action plan. Look for more information about the Clinical Recognition Program in future issues of *Caring Headlines*.

# Maintaining a clean environment: a crucial part of patient care

*Maintaining a clean environment is a crucial part of safe patient care. We're fortunate to have a team of skilled unit service associates who understand the importance of maintaining a clean environment for patients and caregivers. Over the past year, Clinical Support Services embarked on an ambitious campaign to improve the products, processes, and techniques involved in keeping patient care units clean. New products, training, and practices were introduced to enhance the cleaning process and increase satisfaction with the hospital environment. Success will require the support and participation of every MGH employee.*

*Question:* What is the new practice for cleaning patients' rooms?

*Jeanette:* During daily and discharge cleaning, surfaces are disinfected using a micro-fiber cloth dipped in a cleaning/disinfecting solution. Cloths are not re-dipped; they're put in the hamper when no longer sufficiently wet or when they're visibly soiled. The solution is applied wet and must be allowed to air dry for ten minutes.

*Question:* Why do surfaces have to remain wet?

*Jeanette:* We use the most advanced techniques and hospital-grade cleaning products to ensure optimal resistance to germs. In order to be effective, the cleaning solution must go on wet and air dry. We've launched an awareness campaign to highlight this aspect of the new process—we're calling it, 'Wet is the new clean!' One nice side-effect of the cleaning solution is that there's no harsh chemical smell like there is with many other cleaning products.

*Question:* Are we doing anything to increase patient awareness about our new cleaning practices?

*Jeanette:* Earlier this year we piloted a "Patient Perception of Cleaning" initiative, whereby unit service associates introduce themselves to patients, explain their role, and let patients know how to reach them if/when their room needs attention. Unit service associates now leave a signed card in each room verifying that rooms and bathrooms have been cleaned. The initiative was rolled out in inpatient areas July 7, 2010.

*Question:* How often are patients' rooms cleaned?

*Jeanette:* Patients' rooms are cleaned every day, and unit service associates are always available for additional cleaning. Rooms and bathrooms are checked on all unit service associates' shifts and cleaned as needed.

*Question:* How long does it take to clean and disinfect a room?

*Jeanette:* To effectively clean and disinfect a room for discharge takes one person 45 minutes to an hour (less if the room is cleaned by a team).

*Question:* Why are operations managers interviewing patients?

*Jeanette:* We want to know what patients think about their environment and address any concerns they may have. We're learning a lot through these interviews and at the same time reinforcing the message that we're committed to a clean, safe hospital.

*Question:* What can we do to help?

*Jeanette:* Research suggests that satisfaction with cleanliness is influenced by the overall neatness of a patient's room. To help, staff can:

- throw away wrappers from dressings or medications
- discard gloves in trash receptacles
- ask patients if you can throw away old newspapers or anything else that might be contributing to clutter
- keep windowsills and counters free of linen and supplies
- let a unit service associate know if a room needs attention so he/she can address it in a timely manner
- let it be known that we care about the cleanliness of every room

For more information, contact Stephanie Cooper, senior operations manager at 617-724-7841.

# Announcements

## Call for Applications

### Jeremy Knowles Nurse Preceptor Fellowship

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

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

Applications are due by September 10, 2010.

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

## Knight Visiting Scholar

Patricia M. Reilly, RN, program manager for Integrative Care at BWH is the 2010 Knight Visiting Scholar. A recognized expert in complementary therapies, Reilly has lectured extensively on stress-reduction, leadership-development, and caregiver fatigue. Her research focuses on the impact of complementary therapies on patients and clinicians.

Reilly will present, "The Shift is *on*! Are you ready to take the Quantum Leap?"

Thursday September 23, 2010
Grand Rounds: 1:30-2:30pm
O'Keeffe Auditorium

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

## The Clubs at Charles River Park

All summer memberships to The Clubs at Charles River Park are now 40% off, and MGH employees can join for less than $11 a week. Membership includes a complementary orientation session with a certified personal trainer!

For more information, call 617-726-2900

## Ramadan at MGH

Join Muslim patients and staff in celebrating the Holy month of Ramadan. An Iftar is the breaking of the fast at sunset during the month of Ramadan.
In the spirit of unity, Patient Care Services, Human Resources and the MGH Muslim community invite you to a community Iftar dinner.
All are welcome.

Thier Conference Room
Tuesday, August 24, 2010
7:00–8:30pm
Iftar (breaking of the fast) will be at 7:32pm

For more information or to RSVP e-mail Firdosh Pathan at fpathan@partners.org.

## Nursing History

### Call for photos and artifacts

In preparation for the MGH bicentennial, the department of Nursing is creating a book commemorating major nursing milestones.

The Nursing History Committee is looking for photographs, articles, artifacts, and information that would help describe the journey of MGH nurses, especially pre-1995.

If you have anything you'd like to suggest or lend to the effort, please contact Georgia Peirce, director, PCS Promotional Communications and Publicity, at 4-9865.

## Pathways of Healing

Mind-Body-Spirit
Continuing Education Program
presented by
the MGH Nurses' Alumnae Association

September 24, 2010
8:30am–4:00pm
O'Keeffe Auditorium

Speakers
Dr. Herbert Benson, director, MGH Mind-Body Institute;
Amanda Coakley, RN, staff specialist

$30.00 for MGHNAA members and MGH employees
$40.00 for all others

Register by September 17, 2010 at: www.mghsonalumnae.org or e-mail mghnursealumnae@partners.org

6 Contact Hours

## Medication policies now in Trove

Effective July 1, 2010, medication-related policies, procedures, and guidelines can now be found in a single Medication Manual in Trove. This includes:

1) general policies and procedures
2) medication-specific policies and procedures, formerly located in the Nursing Procedure Manual
3) the medication guidelines formerly located in the MGH IV Medication Reference and Nursing Procedure Manual:
   - Adult Critical Care
   - Adult General Care
   - Pediatric Critical Care
   - Pediatric General Care

Consolidating these documents in Trove ensures consistency and fosters best practice throughout the hospital.

For more information, contact Sue Tully, RN, at 6-7928; or Joanne Empoliti, RN, at 6-3254.

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# New Medication Manual in Trove

## *standardizing medication-related policies, procedures and guidelines*

The safe, effective administration of medications is a top priority in hospitals everywhere. At MGH, every discipline, department, and service has policies and procedures guiding the use of medications. These policies and procedures had been kept in various locations, in both hard-copy and electronic versions. Periodically, regulatory agencies would change or amend requirements necessitating policies and procedures to be expanded and/or updated.

MESAC (the Medication Education, Safety and Approval Committee) recognized a need to better manage these important documents. So a multi-disciplinary group of nurses, pharmacists, and physicians came together to establish a standardized process to:

- provide a single, easily available, up-to-date, consistent source for all medication-related policies, procedures and guidelines
- support sound medication practices and medication-management processes
- meet regulatory requirements
- integrate multi-disciplinary, medication-related policies, procedures and guidelines

The challenge was to identify existing documents throughout the institution; review and update documents to ensure they reflected current best practice and regulatory requirements; and submit documents to MESAC for review and approval. The final step in the process was completed July 1, 2010, when all approved documents were moved to the new Medication Manual repository in Trove.

The Medication Manual repository consists of six sections:

1) General Policies and Procedures
2) Medication-Specific Policies and Procedures (formerly located in the Nursing Procedure Manual)
3) Adult Critical Care Medication Guidelines
4) Adult General Care Medication Guidelines
5) Pediatric Critical Care Medication Guidelines
6) Pediatric General Care Medication Guidelines

(3–6 were formerly located in the MGH IV Medication Reference and Nursing Procedure Manual)

The new Medication Manual can be found in the Trove library. Since this move represents a change for users, regional pharmacists are available to assist staff in locating documents if necessary. For more information, contact: Chris Coley, MD; Dena Alioto, RPh; Susan Tully, RN; or Joanne Empoliti, RN.

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