

Caring

Headlines

July 22, 2010

Leading the way in nursing research



*The
Clinical
Nurse
Researcher
Forum at the
Charlestown
Navy Yard
June 4, 2010*



Doctorally prepared nurses from throughout the region come together for special forum to discuss issues affecting the future of nursing research. See story on page 4.

Delivering high-quality care in the most cost-effective way possible

*It's not about cutting services;
it's about improving care while reducing waste
and unnecessary expenses*

In our efforts
to manage costs
and improve
care, we must
be creative and
resourceful. We
must observe our
surroundings, think,
question, suggest,
and act.

Economics is a complex science. It deals with the production, distribution, and consumption of goods and services in broad systems (governments and corporations) and small ones (homes and individuals). It's fair to say that when a national economy is in flux, it affects all the people and businesses participating in that economic system. And that includes every one of us.

Despite what's happening with the economy, we have a responsibility to provide the highest quality care in the safest possible environment. Our challenge is to identify ways to reduce waste and unnecessary spending without eliminating crucial services or negatively impacting our patients or our workforce.

In anticipation of ongoing unrest in the national economy, taking into account the added costs of running an academic medical center, and gearing up to open the Building for the Third Century, we are diligently working to position MGH for continued success. We've been asked to reduce hospital expenses by 3% going into fiscal year, 2011. In order to do that and maintain the highest standards of care, we're asking



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

the MGH community, especially clinicians at the bedside and support staff, for ideas on how to make care-delivery more efficient. No idea is too far-fetched. In our efforts to manage costs and improve care, we must be creative and resourceful. We must observe our surroundings, think, question, suggest, and act.

This was the topic of discussion at a recent meeting of the Staff Nurse Advisory Council, and I got some wonderful feedback. One nurse suggested letting clinicians know the cost of frequently used items. Her thinking was that if clinicians knew the cost of supplies they might be more likely to use them only as needed. As it happens, Clinical Support Services in conjunction with Materials Management recently conducted a

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pilot study (on Ellison 12, Blake 7, and Bigelow 13) to look at supply cost awareness. Many clinicians were surprised to learn the cost of some frequently-used items. (Did you know that Foley catheter trays cost \$6.00 apiece? A pulse oximeter sensor is \$8.00–\$11.00 dollars depending on size.) This cost awareness campaign will be rolled out hospital-wide in the coming months.

Someone suggested switching to motion-detectors in rooms that aren't frequently used to save electricity. Or just making sure lights are off when rooms are empty. We do it at home; why not here?

Another nurse suggested taking the stairs instead of elevators. If all (able-bodied) employees switched to stair-climbing, we could reduce our electric bill, lower health-insurance costs, and have a healthier workforce. Talk about a win-win situation.

We talked about reducing unnecessary testing, moving supplies closer to the bedside, expanding the use of bar-code technology, limiting shuttle runs during off-peak hours, and looking at the costs associated with sending patients home with supplies when discharged. I heard many wonderful ideas, and this was just one meeting.

I want to stress that we're looking for ideas that enhance practice and improve care while reducing costs.

Standardizing our care-delivery model with electronic systems would have a positive impact on care. Strategies to reduce falls and pressure ulcers would help reduce length of stay, which in turn would allow us to accept more patients.

As we go about our daily work, we need to be mindful of opportunities to improve systems, eliminate barriers to good care, and identify lapses in efficiency. These are unpredictable economic times. We're all affected by global, national, and local economics. We must make it our business to spend wisely, use resources judiciously, and eliminate expenses that no longer add value to our work.

I look forward to hearing your ideas. Please forward suggestions to Jen Daniel, staff specialist, at 6-6152.

Update

I'm pleased to announce that Catherine (Cathy) O'Malley, RN, has accepted the position of quality assurance staff specialist in the Perioperative Services. She will be responsible for following through on all quality review cases related to clinical care and serve as liaison to other hospital quality and safety programs.

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MGH hosts Clinical Nurse Researcher Forum

—by Diane L. Carroll, RN, and Dorothy A. Jones, RN

Nurse researchers (l-r): Dorothy Jones, RN, director; Yvonne L. Munn Center for Nursing Research; Wendy Budin, RN, director of Nursing Research at New York University Medical Center and clinical professor at New York University; Nancy Redeker, RN, professor and associate dean of Scholarly Affairs, Yale University School of Nursing and president of the Eastern Nursing Research Society; and Gaurdia Banister, RN, executive director of The Institute for Patient Care

On June 4, 2010, the Yvonne L. Munn Center for Nursing Research, one of the four centers within The Institute for Patient Care, sponsored a forum for doctorally prepared nurse researchers working in clinical settings. The forum, held at the Charlestown Navy Yard, drew scores of participants from hospitals and medical centers throughout the northeast (Massachusetts, Connecticut, New Hampshire, New York, and Pennsylvania). The forum was planned by a team of MGH nurse researchers to begin a dialogue among clinical nurse researchers and nurse scientists. Nancy Redeker, RN, as-

sociate dean for Scholarly Affairs at Yale University School of Nursing and president of the Eastern Nursing Research Society, was invited to participate and offer remarks.

Gaurdia Banister, RN, executive director of The Institute for Patient Care, and Dorothy Jones, RN, director of the Munn Center, shared their vision for nursing research at MGH. Sara Dolan-Looby, RN, MGH nurse researcher, shared the results of an on-line survey describing participant demographics including areas of research. Research interests included risk-modeling, symptom-management, and complementary healing therapies for all patients from infants to geriatric populations. Discussion centered around strategies and barriers that affect the nurse researcher role, issues such as achieving Magnet certification, identifying content and methodological experts for future collaboration, and accessing potential research sites to enroll subjects. Many participants voiced concern at being 'the only nurse researcher' at their institutions. Participants had an opportunity to network and discuss ways to implement a nurse researcher role at their sites.

Redeker closed with some personal insights and a call to continue the dialogue. She suggested the formation of a Research Interest Group for clinical nurse researchers in the Eastern Nursing Research Society. The Research Interest Group would create an Internet presence to facilitate communication and advance collaboration among nurse researchers in the region. Some participants suggested local group meetings in the Boston area.

The forum was an opportunity to share accomplishments of nurse researchers at MGH and look for new opportunities to advance nursing research across clinical and academic settings.



Welcome receives Ricardo Diaz Memorial Award

—by Susan Doyle, assistant director, Patient Food Services

On Wednesday, June 16, 2010, during the Operations Support Staff Day celebration under the Bulfinch Tent, this year's Ricardo Diaz Memorial Award was presented to nutrition service coordinator, Glendalee Welcome. The award commemorates the life of Ricardo Diaz, a Buildings & Grounds employee who died tragically in 2003 as he was clearing snow from the sidewalks outside MGH. The award recognizes employees who demon-

strate the same qualities that Diaz exemplified—dedication, hard work, and a commitment to support the hospital and his colleagues.

According to the 25 nurses, patient care associates, and operations associates on Ellison 14 who took the time to write a detailed, heart-felt letter of nomination, Glendalee Welcome meets that criteria. Presenting the award, director of Nutrition & Food Services, Susan Barraclough, read excerpts from the nomination letter. "Glendalee is a compassionate, caring, outgoing, dependable worker and our patients need that... She is an excellent person, with a big heart... We love her and our patients love her..."

One excerpt was particularly moving: "Glenda always took the time to go into a particular patient's room and talk with her since the patient didn't have many family members in the area. The patient had stopped eating... Glenda talked to her and comforted her and sure enough, that afternoon, after seven days of not eating anything, the patient started eating..." Clearly, Welcome sees her role as more than passing out trays.

This nomination of a nutrition service coordinator by staff on Ellison 14 speaks to the strong interdisciplinary practice on that unit. It reminds us that every contribution to patient care is an important one. It reminds us that every member of the healthcare team makes a difference in the lives of patients and families. And it reminds us that we're all working toward the same goal: the very best care for our patients.

Ricardo Diaz would be proud that the award created in his honor was presented to Glendalee Welcome, a true ambassador of patient-centered care.

Nutrition service coordinator, Glendalee Welcome (center), with (l-r): Jeanette Ives Erickson, RN, senior vice president for Patient Care; Susan Barraclough, director, Nutrition & Food Services; MGH president, Peter Slavin, MD; and Jean Elrick, MD, senior vice president, Administration



TEAM USA building skills and camaraderie

—by Christine Marmen, educational development and project specialist

On Thursday, June 3, 2010, The Norman Knight Nursing Center for Clinical & Professional Development and Clinical Support Services hosted a TEAM USA 'spring cleaning' event for unit service associates. TEAM USA

(Training, Education, Awareness, Making a difference for USAs) is an on-going collaboration that provides tools and support for specific cleaning and service initiatives. It has come to be known not only as an educational gathering, but a place to connect with co-workers and review skills in a relaxed atmosphere.

Founders 325, the newly remodeled classroom, was the setting for the interactive session. Participants were greeted by staff of The Knight Center and guided through a series of demonstrations on Exergen thermometers, microfiber cloths, dusting high places, and rest-

room cleanliness. Support was available for anyone needing assistance with HealthStream coursework.

Stephanie Cooper, senior operations manager, and Dave Cohen, senior project specialist, worked with Tom Drake and Christine Marmen to plan the session, relying on USA competency information to design the content.

Said Cohen, "We recently observed unit service associates cleaning patient rooms to verify their competencies. We observed and verified the competencies of 95 percent of our USA staff."

With competency results in mind, the training strategy was to demonstrate proper technique as a way of reinforcing what many already knew, and add to USAs' understanding about the importance of 100% compliance to these standards. Participants had opportunities to ask questions, make suggestions, and share feedback. Tips were offered related to ergonomic issues.

Ellison 10 unit service associate, Cristina Charles, arrived at the session after having won Red Sox tickets at the My Giving Helps employee campaign celebration. Though high dusting may have been less exciting than winning free tickets, she gave her full attention to the demonstrations as did all who attended.

Said Charles, "I try to attend all the TEAM USA events. It's a great idea because if there's something you don't know, you can pick it up there. I've been here for thirteen years. This is my second home. It's nice when you come to your job and feel supported."

For more information about TEAM USA educational sessions, call Christine Marmen, educational development and project specialist, at 4-3085.

Senior operations manager, Stephanie Cooper, (right) demonstrates use of new ergonomic cleaning tool at recent TEAM USA educational session.



(Photo provided by staff)

Nursing Research Journal Club looks at workplace bullying

—submitted by the Nursing Research Journal Club

Workplace Bullying Experienced by Nurses Newly Licensed in Massachusetts and the Relationship to Intention to Leave the Organization was the topic at the May 14, 2010, Nursing Research Journal Club, presented by Shellie Simons, RN.

Research shows that bullying negatively affects job satisfaction, retention, and the physical health of the person being bullied. While nurses may recognize that bullying exists, it's rarely spoken about. Simons' study examined bullying experienced by nurses and its relationship to a nurse's intention to leave the organization. Much of the present research was conducted in Western Europe, Australia, and New Zealand, however few of those studies included nurses and none was conducted in the United States. Literature shows that bullying is categorized as a distinct phenomenon separate from harassment, which can be

either sexual or racial. At a mid-sized hospital, the cost associated with bullying can be as high as \$5.2 million per year (replacement costs). And absenteeism can cost anywhere from \$30,000 to \$100,000 per year.

Simons' research question evolved when she was an intern at the Board of Registration in Nursing. In a survey of 2,200 new-graduate nurses, the leading concern was that co-workers would be nice to them. This ranked higher than concerns about income.

Bullying was defined as verbal abuse, exclusion or isolation, psychological harassment, intimidation, assigning meaningless or impossible tasks, and/or withholding information vital to performance. Bullying had to occur repeatedly to be included in the study.

Simons used a questionnaire based on a five-stage protocol. Bullying behavior was measured with the Negative Acts Questionnaire-revised (NAQ-R) which measures perceived exposure to bullying. Intent to leave was measured by a sub-scale of the Michigan Organizational Assessment Questionnaire. Simons' questionnaire was mailed to 1,000 newly licensed nurses in Massachusetts. The response rate was an impressive 54.4%.

Results indicated that 31% (n=158) of respondents were bullied at work; i.e., they experienced at least two negative behaviors by another nurse on a weekly or daily basis over a space of six months. A significant correlation was found between bullying and intent to leave.

According to Simons, the issue of bullying needs to be brought into the open so that all concerned realize this behavior will not be tolerated. Limitations cited by Simons include difficulty separating aspects of bullying unique to nursing from those generally experienced by females; sampling only Massachusetts nurses; and not knowing what other factors might be related to intent to leave.

The next NRC Journal Club presentation will be held Wednesday, September 8, from 4:00–5:00pm, in Bullfinch 222. Janice Goodman, RN, will present, "Detection, Treatment, and Referral of Perinatal Depression and Anxiety by Obstetrical Providers. For more information, call Martha Root at 4-9110.



Shellie Simons, RN, presents at recent meeting of the Nursing Research Journal Club

(Photo by Paul Batista)

Meshing patient's expectations into best possible treatment plan

After my fourth visit with Mrs. S, I received an e-mail from her. She said she felt that when I was with her, all I saw was a frail, old woman. I felt as if I'd been kicked in the stomach. I read the e-mail three more times to make sure I had read it correctly.

My name is Eric Smith, and I have been a physical therapist for five months. A few months ago, I evaluated Mrs. S, a pleasant woman who presented with right-sided, intermittent, upper-extremity numbness and tingling. During my initial evaluation, I determined that she was experiencing symptoms of thoracic outlet syndrome with a mild component of carpal tunnel syndrome. I was able to identify thoracic outlet syndrome, but it wasn't completely clear to me what was compressing the neurovascular bundle. After the second visit, I determined that the point of compression was under the clavicle. I sat down with Mrs. S, and we discussed what thoracic outlet syndrome is, what causes it, and what her treatment plan would be going forward. We talked about her goals, which were to learn exercises to help get rid of the numbness that occurred predominantly when she read.

My next treatment session with Mrs. S consisted of light exercises for the upper trapezius, postural education, and education about positions to help unload the neurovascular bundle. I educated Mrs. S on improved sitting posture when she read at home since that was when her symptoms were most noticeable.



Eric Smith, PT, physical therapist

The next three treatment sessions consisted of minor stretching, continued postural education, and light upper-trapezius muscle-strengthening. With this treatment plan Mrs. S's symptoms had become less frequent and were easily modifiable. I felt Mrs. S's symptoms were being well managed.

After my fourth visit with Mrs. S, I received an e-mail from her. That wasn't surprising; I often receive e-mails from patients with questions or scheduling issues. I opened the e-mail and was stunned by what I read. Mrs. S said she felt that when I was with her during our treatment sessions, all I saw was a frail, old woman. She said she might be old, but she was anything but frail. I felt as if I'd been kicked in the stomach. I read the e-mail three more times to make sure I had read it correctly.

For the rest of the day as I treated other patients, I tried to force the e-mail out of my mind. Every time I

continued on next page

From this interaction I learned how important it is to understand the patient's expectations of physical therapy and be able to merge that expectation with my own goals based on my evaluation. Once I was able to move beyond my feelings of shock and disappointment, I gained a better understanding of the patient's perspective.

had a break I found myself reading it again. I was angry at myself. I felt terrible. After all my time here at MGH and other clinics, I prided myself on my ability to build trusting relationships with patients. I feel strongly that trust is the foundation of every clinical relationship and the basis for positive therapeutic outcomes. I couldn't believe I had failed so miserably.

Once those feelings moved through me, I asked myself how this could have happened. What had I not understood about Mrs. S that could have led to this outcome? I shared the e-mail with my colleagues, Marie and Ann, to get their advice and help with the situation. They agreed it was a very angry e-mail. They felt I needed to draft a response that would diffuse the situation, demonstrate that I understood Mrs. S's feelings, and explain the reasoning for my treatment plan to date.

With Ann's help, I reflected on my interactions with Mrs. S and began to understand why she may have felt the way she did. While her goal was to get rid of her symptoms, I hadn't realized that she felt she needed to achieve this through rigorous exercise. She had told me many times how active and independent she was. At the time, I agreed that she *was* active and independent, and that it was a good thing. What I didn't realize was that in her mind, my treatment plan didn't reflect this.

My treatment had been more passive than she wanted, relying on light exercise. Mrs. S was trying to tell me that my plan wasn't in line with her expectation of physical therapy. Looking at her e-mail again, I noticed that Mrs. S was a coordinator of an exercise program for the elderly. While I knew what she did for a living, I hadn't fully comprehended what she did and what her position meant to her. Mrs. S didn't see herself as old; she saw her role in life as someone who helped elderly people. I realized I hadn't made a connection between my plan of care and her expectation of physical therapy.

With Ann's help, I drafted a response to Mrs. S. I acknowledged her concerns, discussed the rationale behind the treatment plan I had implemented, and based on my new understanding of Mrs. S's expectations, I described what our future treatment plan would be. I sent the e-mail and waited for Mrs. S to respond. Her response didn't come by e-mail, rather it came in person at our next treatment session.

Leading up to Mrs. S's next visit, I was nervous, unsure of exactly what would happen. Mrs. S was very pleasant. We had a discussion about the treatment plan, and she told me what she felt she needed from physical therapy. From this discussion, we formulated a more exercise-based treatment program, and she was very appreciative for this shift in our approach. She was leaving for vacation at the end of the week so we decided to follow up when she returned in a few weeks time.

From this interaction I learned how important it is to understand the patient's expectations of physical therapy and be able to merge that expectation with my own goals based on my evaluation. Once I was able to move beyond my feelings of shock and disappointment, I gained a better understanding of the patient's perspective. While this case had a positive outcome, I still feel if I had listened to the subtle signals Mrs. S was trying to send, the whole issue could have been avoided. The therapeutic relationship was maintained, but I would like to have picked up on those signals sooner.

I learned from Mrs. S that my role as a therapist is different from what I had perceived it to be. I'm a guide to a patient's healthcare decisions, and I'm responsible for meshing their expectations into the best possible treatment plan for that person. A great therapist doesn't try to convince the patient that his plan of care is correct; rather, the therapist listens and guides the patient into the best treatment plan based on their mutual goals and expectations. I learned this to be a key component of patient-centered care.

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

Who was it who said we learn more from our mistakes than our successes? It's hard for any clinician to hear that we're not meeting our patient's expectations. But if that mistake leads to learning, especially learning that benefits the patient, it's a success in my book. With the help of his more experienced colleagues, Eric reflected on his interaction with Mrs. S and did, indeed, learn from it. This is a testament to his maturity as a person and his professionalism as a clinician. I think this level of insight after five months of practice bodes well for Eric's future patients.

Thank-you, Eric.

Tailor your teaching to the individual needs of each patient

—submitted by the Patient Education Committee

When teaching about medications, the focus should be 'need to know' rather than 'nice to know.' Don't try to communicate more than four main points, and always use plain language.

Discussing health issues is a very personal matter. Patient education, whether presented verbally, by demonstration, via written materials, or a combination of all three, should be relevant to the patient. Sensitivity to cultural issues such as ethnicity, age, and gender should be reflected in all patient-education exchanges making information easier to understand and follow. All patients should be assessed for health literacy, and written materials should be tailored accordingly. Generally, materials should be written at a sixth-grade reading level, and healthcare providers need to *listen* to what the patient is saying. A non-judgmental, blame-free environment allows patients to feel safe and ask questions.

When teaching about medications, the focus should be 'need to know' rather than 'nice to know.' Don't try to communicate more than four main points, and always use plain language. Explain the purpose, common side-effects, and how to safely take medication in words and phrases familiar to the patient. Keep sentences short, and be specific with instructions. Use multi-media techniques such as printed materials, charts, videos, and verbal instructions to convey information.

Teaching Tips:

- Assess the patient's readiness to learn. Make sure the patient understands and believes her diagnosis. Patients are more likely to follow a medication regimen if they understand the rationale behind it

- Assess health status, including factors that may affect the patient's ability to learn. If a patient is anxious, tired, or in pain, it might not be the best time for patient education. Assess the patient and family's knowledge level. What do they know; what do they want to know; what do they *need* to know?
- Assess the patient's health literacy. Patients may try to hide the fact that they can't read. Review written materials with patients. Read aloud and allow them to ask questions. Show videos when appropriate
- Always look for teaching moments. Patients who are ready to learn ask questions about their illness and medications
- Include family and caregivers in patient education so they can provide additional support and reminders
- Don't wait until discharge to start teaching about complex drug regimens

Many resources are available to help inform patients about medications. Most medication handouts are available in different languages. KnowledgeLink provides easy access to information whether in CAS, LMR, or eMAR. Select the KnowledgeLink tab or icon then follow the prompts to access desired information.

To access information in other languages, once in KnowledgeLink, select Lexi/Comp patient leaflets on the left of screen. Under medication lookup, click on the drop down menu and select the desired language.

For more information about evaluating health literacy or accessing patient-education materials, call Judy Gullage at 6-1409, or any member of the Patient Education Committee.

Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy

—by Julie Goldman, RN, professional development manager

On June 11, 2010, in a small ceremony on Phillips 21, the 2010 Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy was presented to operations associate Heather Bolivar. The award was established by the Raphael and Cronin families in 1999 to recognize the contributions of a clinical or support-staff person on Phillips House 21 who consistently demonstrates excellence in identifying and addressing the individual needs of patients and families through advocacy and empowerment.

Award recipient, Heather Bolivar (right) with senior vice president for Patient Care, Jeanette Ives Erickson, RN (left) and associate chief nurse, Jackie Somerville, RN.



Bolivar was nominated by many of her colleagues. In her letter of recommendation, staff nurse, Ashleigh Smith, RN, wrote, “Heather shares her joyous spirit with patients on this unit every day. She’s always ready to help in any way she can. One example stands out: a teenage girl with terminal cancer was with us for several weeks before she passed away on our unit. During her stay, the girl started a charity to support the cancer program at MassGeneral Hospital for Children. After she passed, Heather spear-headed an initiative to raise money for the charity in her honor. Heather sent the money to the girl’s parents with a note describing our fond memories of their daughter. Her advocacy on behalf of patients and families is consistently thoughtful.”

Bolivar is currently in a program at Bunker Hill Community College to become a medical imaging technician. She will graduate in 2011. When asked what she likes best about her role as operations associate, Bolivar responded, “I enjoy getting to know patients and assisting them. I take pride in supporting staff in whatever way I can.”

Said associate chief nurse, Jackie Somerville, RN, “Today is a day of remembrance and celebration. Many fond memories and events make up the legacy of Paul Cronin and Ellen Raphael. Perhaps one of the most enduring is this award. This year we honor Heather Bolivar for her outstanding efforts in advocating for patients and families. I’d like to take this opportunity to acknowledge the efforts of all support staff on Phillips 21 for their continued dedication to patient-centered care.”

For more information about the Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy, contact Julie Goldman, RN, professional development manager at 4-2295.

Lipkis-Orlando, new director, Office of Patient Advocacy

“I’ve worked closely with Robin over the years... With her knowledge, temperament, and familiarity with the MGH culture, she’ll be right at home as director of the Office of Patient Advocacy.”
— Keith Perleberg, RN, director, PCS Office of Quality & Safety

Effective July 12, 2010, Robin Lipkis-Orlando, RN, formerly the nursing director for Inpatient Psychiatry and the Psychiatric Consultation Nursing Service, became the new director of the MGH Office of Patient Advocacy. Always an advocate for patient- and family-centered care and a highly respected leader in psychiatric services, Lipkis-Orlando’s appointment seems like a perfect fit. Her clinical knowledge and experience coupled with her ability to collaborate across disciplines and role groups will be invaluable in her new position. As a member of the Patient Care Services Executive Team, she will continue to bring the voice of patients and families to executive decision-making and strategic planning.

The Office of Patient Advocacy serves as liaison between patients and the hospital ensuring that patients’ concerns are addressed and standards of care upheld. Under Lipkis-Orlando’s leadership, the Office of Patient Advocacy will continue to respond to patient inquiries, reports, and accolades; help patients navigate the system, provide information, and liaise between patients, families and the clinical team. New to the role of director of Patient Advocacy, Lipkis-Orlando will also oversee the MGH Disabilities Program as well as a new initiative being implemented to welcome and assist patients, families and visitors as they arrive at the hospital.

Says Keith Perleberg, RN, director of the PCS Office of Quality & Safety and chair of the OPA director screening committee, “We’re thrilled that Robin sought and accepted this position. I’ve worked closely with Robin over the years, and I know her to be a thoughtful, caring, experienced clinician and an effec-



Robin Lipkis-Orlando, RN, director
Office of Patient Advocacy

ive, fair-minded manager. With her knowledge, temperament, and familiarity with the MGH culture, she’ll be right at home as director of the Office of Patient Advocacy.”

Said senior vice president for Patient Care, Jeanette Ives Erickson, RN, “I’m delighted to welcome Robin to her new role. She has been a passionate nursing director, and I know she’ll bring that passion with her as she embarks on the next chapter of her career. I’d like to thank Sally Millar for her leadership of the Office of Patient Advocacy for the past twelve years. Through her vision and hard work the department has grown and evolved, truly embracing a culture of advocacy and Excellence Every Day. We’re grateful for her leadership.”

Says Lipkis-Orlando, “I’m thrilled to have this opportunity. I look forward to working with my colleagues throughout Patient Care Services and the organization to improve the healthcare experience of our patients and families.”

MGH mourns the loss of Janice 'Jay' Ciano

The department of Radiation Oncology and the entire MGH community were shocked and saddened to learn of the passing of administrative assistant, Janice Ciano, on June 13, 2010. Ciano was killed in an automobile accident. She was 54 years old.

Ciano, known by her friends as 'Jay,' was born in Chelsea and lived in Malden for the past 30 years. She began her career at the MGH in 1991 as an office assistant in the department of Gynecology before transferring to the MGH Cancer Center in 1998 as a patient service coordinator. She began working in Radiation Oncology as a staff assistant in 2007.

Andrea Paciello, executive director of Radiation Oncology, describes Ciano as well-liked and friendly. "We were deeply saddened by the news of Jay's death. She was a vibrant, spirited, committed contributor and a good friend to her administrative co-workers. She is missed. Our thoughts continue to be with Jay's husband and family."

Not only was Ciano a beloved colleague to those in her department. She was part of an informal group that became close friends over the years while commuting on the Partners shuttle. Many of her commuter friends have fond memories of Ciano from their travels together. Said 'shuttle buddies,' Sandy Brown, Maria Sanchez, and Susan Prince, "We miss her funny stories, her engaging laugh, and her great enthusiasm for life. Our daily commute just isn't the same without her. Our memories of Jay and the conversations and fun we had

will keep her memory alive. We send our deepest sympathy to Jay's wonderful family: Vinnie, Gina, and Michael. Words cannot express our sadness at the loss of our dear friend."

A memorial service will be held in the MGH Chapel on Thursday July 22, 2010, at 12:30pm. All are welcome. For information, call 6-9056.



(Photo provided by staff)

"We miss her funny stories, her engaging laugh, and her great enthusiasm for life. Our daily commute just isn't the same without her."
— Ciano's 'shuttle buddies'

Infection control: a key component of patient safety

It takes a village. Everyone needs to be comfortable speaking up to remind our colleagues to follow these basic infection-control practices. We're all responsible for keeping patients safe.

Question: Surveyors from the Centers for Medicare and Medicaid (CMS) recently visited MGH for a second time. What was the purpose of the second visit?

Jeanette: Six CMS surveyors returned to MGH in May for a follow-up visit. Surveyors were here to review specific policies, practices, or procedures put in place following their original survey. At that time, discussion centered around restraints; patient privacy; pressure ulcers; blood transfusion; and infection control.

Question: What recommendations did they offer regarding infection control?

Jeanette: CMS surveyors offered recommendations based on observations they made as they toured the hospital. Four specific areas of improvement were identified:

- Keep cleaning chemicals, such as Virex, secure and safely out of reach of visitors, children, and patients. These chemicals can be harmful if not used properly, if they come into contact with skin or eyes, or if swallowed
- Review the importance of *properly* donning precaution gowns. Both ties on the back of the gown must be tied to ensure clothing does not come into contact with the patient. The goal is to keep patients safe by avoiding contact with contaminated clothing

- Instruct staff to disinfect hands with Cal Stat before and after patient contact. Remind staff that hands must be disinfected prior to donning gloves and entering a patient's room. Gloves are not a perfect barrier and are not a substitute for proper hand hygiene. Cal Stat is always necessary even before donning gloves
- Remind staff that once linen is brought into a patient's room, it must be used for that patient and not stored on a counter or window sill for use later on. Only bring to the bedside what your patient will use; keep all other linen properly stored and covered until it is needed

Question: How are we implementing or reinforcing these practices?

Jeanette: The first step is getting the word out. This information has been shared with staff. To keep patients safe we must be vigilant in identifying when and where safe practices break down.

Unit leadership and specialists from Infection Control will review these recommendations with clinicians and assist in identifying and eliminating obstacles to safe infection-control practices.

It takes a village. Everyone needs to feel comfortable speaking up to remind our colleagues to follow these basic infection-control practices. We're *all* responsible for keeping patients safe.

For more information on the results of the CMS revisit, or specific infection-control practices, call the PCS Office of Quality & Safety at 3-0140.

Announcements

Pathways of Healing

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

September 24, 2010
8:30am-4:00pm
O'Keefe 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

Research Nurse Roundtable

Tuesday, July 27, 2010
12:15-1:15pm
Garrod/Mendel Conference Room
Simches Research Building

The Research Nurse Roundtable
provides a forum for nurses who
work in clinical research to discuss
issues common to their practice.

The purpose of this month's
meeting is to plan for the
upcoming year.

Feel free to bring a lunch.

Registration is required.
Please register at:
<http://hub.partners.org/catalog>

For more information about
the Research Nurse Roundtable,
contact Linda Pitler, RN, at 3-0686.

Sponsored by the MGH Clinical
Research Program.

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.

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) medication guidelines formerly
located in the MGH IV Medica-
tion 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.

Lunchtime Seminars

presented by The Clubs at
Charles River Park

Join advanced personal trainer,
Mike Bento for a 30-minute
lunchtime seminar:
"Back Pain: Common Causes,
Straightforward Solutions"
July 22, 2010
12:00-1:00pm
Bigelow 4 Amphitheater
For information, call 6-2900.

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.

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'Keefe Auditorium

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

Published by

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

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Submissions

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

Next Publication
August 5, 2010

A fitness program for golfers of all levels



Mobility and flexibility are key components of a good golf swing. In his June 14, 2010, lunchtime seminar, advanced personal trainer, Mike Bento, shared a sample fitness program geared at increasing flexibility and mobility to reduce the potential for repetitive stress injury that can sometimes accompany 'the perfect swing.' Bento's program combines soft-tissue massage (performed on a foam roller); a series of stretching, rotation, and core stabilization exercises, and four warm-up exercises to be done prior to hitting balls at the driving range or golf course.

Says Bento, "When executing a full golf swing, the hips and shoulders rotate at different angles. Tight hips and upper-back muscles limit rotation and put increased stress on the lower back. It's important to increase core stability to minimize the risk of injury."

Always consult a physician before embarking on any exercise program. For more information about improving your golf swing or future lunchtime seminars, e-mail Bento at mbento@partners.org.

Advanced personal trainer, Mike Bento, of The Clubs at Charles River Park, gives some fitness pointers to attendees of recent lunchtime fitness seminar focused on improving your golf swing.

Caring
Headlines
July 22, 2010

Returns only to:
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