Caring Headlines
March 4, 2010

MGH in Haiti...

Obstetrics staff nurse, Mimi Pomerleau, RN (left), and her daughter, nursing student, Kimberly Pomerleau (center), present new mom with baby supplies on the Labor & Delivery Unit at Hopitale Sacre Coeur in Haiti.

...days before the earthquake

(See story on page 4)

The newsletter for **Patient Care Services**
Massachusetts General Hospital

Jeanette Ives Erickson

Raising the bar on patient safety

Raising the bar can also mean advancing a philosophy—a way of thinking—that promotes safety, embraces perpetual improvement, and keeps the patient at the center of our decision-making every moment of every day.

In health care, 'raising the bar' can mean anything from discovering a cure for a disease, to introducing new technology, to sharing a best practice. Raising the bar can also mean advancing a philosophy—a way of thinking—that promotes safety, embraces perpetual improvement, and keeps the patient at the center of our decision-making every moment of every day. It's in this spirit that we created collaborative governance, established our Office of Quality & Safety, and implemented our comprehensive Safety Reporting System. It's in this spirit that we committed ourselves to a culture of Excellence Every Day.

At the heart of this way of thinking is an intrinsic desire to help others. Every time we enter a patient's room, we do so with the intent to help. Sadly, not all patients can be saved. Most veteran clinicians know the pain of losing a patient. Every loss is a tragic reminder of our limitations and a reason to re-commit ourselves to the important work we do. Raising the bar means always looking for ways to improve systems, improve technology, and improve care.

This is the mind-set that underlies all our safety-improvement initiatives. We know that vigilant attention to quality and safety is linked to positive clinical outcomes. Some of our current safety-improvement initiatives include:

- improving responsiveness
- improving practices related to electronic physiological monitoring
- safe patient transport

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

- eliminating patient falls
- eliminating hospital-acquired pressure ulcers
- enhancing utilization of evidence-based practice to promote safety

Hourly rounding, which has already been adopted on some units, is one strategy we're employing to improve responsiveness. Hourly rounding helps build rapport between patients and caregivers, has a reassuring effect on patients, and enhances patient safety. We're looking at ways to roll this approach out to the wider hospital community.

We're re-visiting our practices related to physiological monitoring (see Fielding the Issues II on page 13 for more details about this initiative). Physiological monitoring is an essential tool in the care of some patients. We're assessing current technology, evaluating policies and practices associated with monitor use, and re-evaluating the criteria for patients to be placed on electronic physiological monitoring. One undesirable feature of the monitor is that the audible alarm can be

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turned off (versus re-set when a clinician responds to the alarm). Working with our colleagues in Biomedical Engineering, we have disabled this feature so that electronic physiological monitors can no longer be turned off. And we've adjusted the volume on monitors to ensure they can be heard within a reasonable distance without disturbing patients in surrounding rooms.

Any conversation about raising the bar on safety must include a system for reporting adverse events, near-misses, and any other concerns that might arise in daily practice. I can't overstate the importance of a robust Safety Reporting System. If, as Richard Bluni of the Studor Group reminded us, quality and safety *is* the patient experience, I would suggest that it is also the foundation on which evidence-based practice is built.

Every safety report submitted to the MGH Center for Quality & Safety is evidence. Each report is a valuable lead in our on-going search for ways to improve care. When a near-miss is reported, we have an opportunity to prevent an adverse event from occurring in the future. Our ability to effectively respond to systems failures, to correct potential safety hazards, depends on the willingness of every employee to speak up when he or she identifies a need to improve a particular practice, policy, pathway, or device.

If we want employees to be forthcoming when issues arise, we need to provide an environment where that behavior is supported, where employees feel safe sharing this vital information.

In the past, in health care and other industries, fear of incrimination prevented employees from reporting adverse events. More and more, in a trend I whole-heartedly support, healthcare organizations are moving away from that kind of punitive culture toward an environment where medical errors and near-misses are openly identified, analyzed, and corrected. Current literature refers to this trend as a shift toward 'a just culture.' It pre-supposes that healthcare providers are acting in the best interest of their patients. When adverse events occur, they are most likely the result of systems issues as opposed to the reckless or negligent behavior of an individual. In a fair, just, and transparent setting, errors and near-misses are more apt to be reported. And when incidents are reported, systems can be improved.

I want to thank you for supporting our own just culture by keeping a vigilant eye and reporting events and near-misses as you observe them. It is only through the active participation of our workforce that we're able to identify systems failures, implement improvements, and keep raising the bar on safety. It is your commitment, your advocacy, and your practice that has made Excellence Every Day a tangible reality at MGH.

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In this Issue

(Cover photo provided by staff)

MGH in Haiti days before the earthquake

—by staff nurses, Carine Luxama, RN, and Mimi Pomerleau, RN

In January, we had the opportunity to travel to Milot, a small village 75 miles north of Port au Prince, Haiti. A group of nurses from throughout New England went to Hopital Sacre Coeur in Milot as part of the CRUDEM program (http://www.crudem.org) to work with local nurses and share some of our best practices.

Our mission was part humanitarian, part academic, as we recognized the important role nurses can play in effecting change and improving health in the global environment.

Haiti is the most impoverished country in the western hemisphere with a per-capita income of less than $500 per year. Haitian healthcare indicators are also the worst in the western hemisphere. For Carine, a Haitian American, returning to Haiti was a dream come true. She left Haiti as a young child. At first, she wanted to return to visit family and friends. But as she became aware of the issues facing the country, she knew she wanted to give something back to the country she calls home. She became a nurse to help underserved communities. She wanted to use her skills to provide care, educate, and empower others to make a difference for the people of Haiti.

Below: visiting US nurses arrive at Hopitale Sacre Coeur for their first day on the job.

As nurses, we respect the dignity and worth of individuals without regard to social or economic issues. The need for health care transcends all boundaries. The American Nurses Association recommends international exchange programs to advance the education of nurses and improve health, research, and services to under-served populations. When nurses from medically advanced nations bring support and education to less developed countries, we go a long way toward achieving that goal.

Our MGH colleagues helped us prepare for our mission by donating supplies, advocating for donations, and providing equipment to be used at the hospital in Haiti. Everyone was so eager to help. It made us proud to be part of such a caring community.

In Haiti, we spent mornings working in the hospital and visiting clinics. We wanted to gain insight into the healthcare challenges Haitian nurses face and see how they dealt with those challenges. Hopital Sacre Coeur is considered one of the best hospitals in the region, but the lack of resources was shocking. Despite the obvious challenges, Haitian nurses were eager to learn anything we could teach.

We offered seminars every afternoon for nurses working the day shift, and every evening for nurses working the night shift. We focused on nursing assess-

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ment, including basic head-to-toe assessment; newborn assessment; pediatric, respiratory, and gastrointestinal assessment; and pre-natal assessment for infections and infection control. We initiated an instructor training program for basic life support in which four Haitian nurses became BLS instructors. More than 50 nurses attended the daily seminars. They were eager to participate and asked many questions.

This experience gave us a greater appreciation of the amenities we have in our own communities, homes, and hospitals. Haitian people accept the lack of resources. Pain and suffering are accepted, often expected. Patients are thankful for what little they get—we never heard a complaint. Though our cultures are different, our healthcare needs are the same.

We learned to appreciate Haitian practices even though they were very different from ours. We were forced to look beyond what we knew to be standard practice and remember the principles behind the practice. Providing education and recognizing the incredible efforts of our Haitian colleagues helped them feel appreciated, proud.

We returned from Haiti two days before the earthquake devastated this already impoverished country. The news was staggering. It was incomprehensible to imagine the challenges the Haitian people now had to endure. At the same time, we were overwhelmed by the outpouring of support from our friends and colleagues at MGH.

Co-workers called us at home to make sure we had returned safely from our trip. Our e-mail and Facebook accounts were flooded with well-wishes. The response of MGH and Partners HealthCare in the immediate aftermath of the earthquake was truly humbling.

We hope that the time we spent and the support we provided to the nurses in Milot helped as their 70-bed hospital took in more than 200 critically injured victims of the earthquake. We're honored to have been part of nursing education at Hopital Sacre Coeur. We know that despite their limited resources and in the face of this great disaster, our Haitian colleagues are doing the very best they can.

Top: staff nurse, Carine Luxama, RN, in the Neonatal Intensive Care Unit at Hopitale Sacre Coeur in Haiti. **Below left:** staff nurse, Sherline Chery-Morisset, RN (left) and Kim Pomerleau bring supplies to the Maternity Unit. **Below right:** US nurses with Hopitale Sacre Coeur nurses after a "Newborn Assessment" presentation.

(Photos provided by staff)

"Mesi, MGH"

("Thank-you, MGH")

In her opening remarks, Evette Sewell, coordinator in the Emergency Department, explained, " 'Mesi' means thank-you in Creole."

This year's annual African American Pinning Ceremony took on a decidedly international flavor as the PCS Diversity Program joined forces with a motivated group of Haitian employees who wished to give thanks to the MGH community for its support in the aftermath of the devastating Haiti earthquake. On February 12, 2010, in O'Keeffe Auditorium, an inter-disciplinary group of Haitian employees expressed their appreciation through song, dance, photographs, and stories.

In her opening remarks, Evette Sewell, coordinator in the Emergency Department, explained, " 'Mesi' means thank-you in Creole. That's what the Haitian community would like to say to Massachusetts General Hospital.

"The outpouring of support has been overwhelming. Times like these allow us to show our humanity and selflessness on a global scale. Haiti is experiencing a disaster beyond what any of us can comprehend. Mass General has made the healing and recovery process a priority. Fellow Haitians and colleagues feel proud to be part of this hospital that has reached out to a country experiencing so much devastation. We are very grateful. Mesi, Mesi, Mesi, MGH."

ED treatment area coordinator, Franchette Rock, provided a history of Haiti's turbulent political past. Lisa Moise, of the MGH Registration and Referral Center, sang the Haitian national anthem and an original piece she wrote as a tribute to her homeland. Attendees were treated to a lesson in Haitian Creole by Louis Gerard of Materials Management. And ED

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Evette Sewell

Lisa Moise

Harold Roy

support associate, Evadne Seale, modeled traditional African dress as she danced along with other attendees to traditional Haitian music.

Keynote speaker, Harold Roy, of Police & Security, gave a first-hand account of his experiences in Haiti as he caught the last flight off the island just moments after the earthquake. In a talk that was alternately funny and poignant, Roy spoke of the powerful impact his first visit to his ancestral country had on him. He spoke of the heartbreak of poverty, the pride of Haitian families, and the desire that was re-kindled in him to become more involved with Haiti.

Following the Haitian portion of the program, director of PCS Diversity, Deborah Washington, RN, took the podium signalling the beginning of the pinning ceremony. Of this year's two recipients, only one, patient care associate Solomon Mugati, was present.

Introducing Mugati, staff nurse, Devora Baronofsky, RN, said, "Solomon has worked at MGH since 2005. He is an outstanding PCA, he's clinically competent, and he respects the needs of individual patients. Solomon is a nursing student at the University of Massachusetts, Boston. And he is a volunteer medical officer with United for African Growth. In 2008, he participated in a three-week medical mission to Kenya. Solomon's White 7 colleagues are proud to see him receive the 2010 African American Pin."

> Adversity is like a strong wind. It tears away from us all but the things that cannot be torn, so that we see ourselves as we really are.
>
> —Arthur Golden, author

The other recipient, staff nurse, Marie Guerrier, RN, was unable to attend; her nursing director, Ann Kennedy, RN, accepted on her behalf. A Haitian-born nurse, Guerrier wrote in her letter of introduction: "I have been a staff nurse on Ellison 12 for eight years. I couldn't imagine leaving Mass General to work anywhere else. Being a Haitian nurse has helped many of my Haitian patients, especially those who don't speak English. When a Haitian patient hears their native language, they're comforted. I'm so honored to have been nominated to be part of the African American Pinning Ceremony."

Tokens of appreciation were presented to members of the MGH leadership and executive teams for the part they played in responding to the disaster in Haiti.

Members of the African American Pinning Ceremony/Haitian Appreciation Planning Committe were: Jean Alexis; Victoria Benalfew; Kendrick Durrette; Louis Gerard; Erika Goler; Bernice Mcfield-Avilla; Lisa Moise; Franchette Rock; Harold Roy; Evadne Seale; and Evette Sewell.

See "Fielding the Issues I" on page 12 for information about the MGH Haitian Relief Fund.

A proud Haiti supporter

Devora Baronofsky, RN; pinnee, Solomon Mugati (center); and Louis Gerard

New nurse learns life lessons caring for dying patient

Laura Maguire, RN, neuroscience staff nurse

My name is Laura Maguire, and I am a relatively new nurse on the Ellison 12 Neuroscience Unit. About three months ago, I approached the nurses' station to begin my second of three consecutive night shifts. I was happy to see that a few of my patients from the night before had been assigned to me again. One patient, 'Mary,' was CMO (comfort measures only). I was honestly surprised she had made it through the day and hoped she would make it through my shift, as well.

One patient, 'Mary,' was CMO (comfort measures only). I was honestly surprised she had made it through the day and hoped she would make it through my shift, as well.

I began my rounds, checking on my patients. I walked down the hall to Mary's room. She was alone, no roommate. We often try to give grieving family members privacy during such difficult times. Mary's room, however, was different—there were no grieving family members, no pictures of grandchildren, no flowers. Mary was alone, quietly breathing in soft, regular huffs, a slight gurgling sound in the back of her throat. I checked the setting on her PCA (patient-controlled analgesia) and her temperature and heart rate for signs of pain. She appeared comfortable.

I had only cared for a handful of CMO patients before, and I was still somewhat uncomfortable with the whole process. I hated seeing patients straining for their final breaths, appearing so frail in their hospital gowns. Looking at this woman so helpless and alone, I wished I could let her know what I was thinking. I wished I could let her know that I appreciated her for the person she was and for the many things she had accomplished in her life. But as we do, I continued on my rounds. I administered 8:00pm meds and checked new orders, every so often assessing Mary for pain and changing her position to keep her comfortable. As the night wore on, Mary's breaths became more frequent and her heart rate increased slightly.

I had conferred with Mary's doctor about her pain-management. He ordered Dilaudid for her with instructions that the dosage could be increased or decreased (within a certain range) depending on Mary's level of discomfort.

As a new nurse, I was hesitant to increase Mary's Dilaudid drip knowing that every increase would bring her closer to her last breath. I asked one of our senior nurses to look at Mary before I increased the rate. I wanted to be sure my judgment was correct. The nurse agreed with my assessment and supported my decision to increase the drip. As I did so, I talked to the nurse about Mary's situation. Mary was 91 years old and had

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a subdural hematoma. Her healthcare proxy was a woman who had been her roommate at the nursing home. She had no family and only a few elderly friends at the nursing home. Mary was alone in her room and would remain alone until she passed.

My seasoned colleague took Mary's hand and said, "Mary, it's okay to go. It's okay, Mary, we're right here with you."

I was blown away. It was exactly what I had wanted to say all night but didn't know how. I had never been in a situation like this before. I'd never been alone with a dying patient, her only source of comfort and human contact. Prior to hearing my colleague's words, I had been hesitant to talk to Mary or give her the true comfort and reassurance she needed. I had wanted to tell her she wasn't alone and that it was okay to let go, but I was hesitant. I had quietly gone about my work, speaking to her only when it was necessary with statements about her care and what I was doing. I had continued to care for my other patients, discussing their treatment plans and talking about sports as if everything were fine. But the thought of Mary alone in her room was heavy on my mind.

I returned to Mary's room. Her respiratory rate and heart rate had increased, and her secretions were thick. I held her hand and following the example of my colleague whispered, "Mary, it's okay to go to God, I'm here with you. You're not alone." I increased the Dilaudid a second time. I spoke to her softly as I applied cream to her back and legs. I no longer viewed Mary as a body I was frightened to disturb, but as a woman in her final moments of life who needed the comfort and support of another soul.

As I watched Mary struggle for each breath, I said, "Please, God, be with her and end her suffering."

I truly felt a connection with Mary and hope she felt it, too. I left Mary's room for a few minutes to assist with another patient. When I returned, Mary had passed. Though I was sad, I was relieved that she was finally at peace and free from suffering.

This experience taught me never to lose sight of the person I'm caring for. It's not that I had felt uncomfortable with patients before caring for Mary. I could always come up with something to make an awkward situation seem normal or provide encouraging words to a grieving family. But the thought of Mary alone in her final hours was disturbing. I realized the best thing I could do for her was to be there. My experienced colleague had shown me how to be fully present, providing emotional support even during the most difficult moments.

But the thought of Mary alone in her final hours was disturbing. I realized the best thing I could do for her was to be there. My experienced colleague had shown me how to be fully present, providing emotional support even during the most difficult moments.

As I look back on this situation, I hope Mary felt my presence in the moments prior to her death. I appreciated her for the person she was and the life she led. As nurses, we often take on the emotional 'burdens' of our patients. Sometimes, we defend against this by losing sight of the person behind the patient. I truly saw the person in Mary. I hope she was comforted by my presence and knew the sincerity of my words.

New nurses can get caught up in the tasks and time-management aspects of care-giving. Over the last few months, I've grown more comfortable and confident in my nursing skills and knowledge. I find myself more able to care for the person rather than just the patient. I feel lucky that my first nursing experience is on Ellison 12 where senior staff provide unbelievable support and guidance to new nurses. I have a close bond with many of the veteran nurses and have benefited greatly from seeing how they forge relationships with patients and families.

I'm grateful to the staff on Ellison 12 and especially to the many new graduate nurses I'm privileged to work with. I couldn't ask for better teammates. I've had an amazing year learning and experiencing more than I ever thought possible. Just as I did my best to give Mary the support and compassion she needed, I'll do my best to support my patients, families, and co-workers as I continue to learn on Ellison 12.

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

Laura was fortunate to have an experienced colleague model compassionate, end-of-life care for her. Laura knew instinctively there was more to be done than appropriate pain-management and sedation. So when her veteran colleague led by example, it gave Laura the confidence she needed to follow her own instincts. This is a powerful narrative—not only for its wonderful example of mentoring and support between nurses, but for the act of being present to a patient at one of life's most intimate moments. I'm sure Mary felt Laura's gentle presence in those moments prior to her death.

Thank-you, Laura

National Patient Safety Week

An interview with Ellen Kinnealey, RN, advanced infusion systems specialist and MGH drug library manager

Question: How did you get started in this position?

Kinnealey: The MGH bedside technology specialist position was created in 1990. It called for an experienced nurse to act as liaison between Nursing and Biomedical Engineering for issues related to equipment such as vital-sign monitors and infusion pumps.

At the same time, Dr. Nat Sims, cardiac anesthesiologist, had resolved to improve IV medication safety after observing a serious error in dosing calculations. Dr. Sims and collaborators developed the technology for Smart Infusion Pumps, which puts a customized electronic database of safe IV drug practices 'inside' every pump. For the first time, the most-up-to-date IV-medication dosing guidelines were at clinicians' fingertips as they programmed pumps.

In 1994, when Smart Pumps were introduced into clinical practice, the need arose for a drug library manager. I expanded the role of bedside technology specialist to include drug library manager and have continued in that role for fifteen years.

Question: What kind of calls do you get from clinicians?

Kinnealey: The most valuable calls are the ones that report a problem before it happens. These calls often provide insight into what we can do to prevent adverse events. We like to hear about near-misses because we can follow up with a team approach to keep the problem from happening again. When there is a problem, it's important for clinicians to 'sequester' or remove the pump from service so I can figure out what happened. Incident reports allow us to craft new policies and procedures, update our drug library entries and dosing guidelines, and provide the impetus for educational programs and posters. We're all part of the patient safety team.

Question: What's next in your work?

Kinnealey: Our dream of the seamless digital pathway between Provider Order Entry and the patient will be complete when the order for a patient's medication and the pump are in sync. The final frontier will involve networking all pumps so they can 'talk' to Clinical Information Systems. When this happens, we'll have increased patient safety and can use informatics tools to track our progress. A key step will be implementing wireless technology to allow the process of updating pump libraries to be easier, more frequent, and simultaneous. The advent of EMAR/EMAPPS was a big step in that direction. We can now build on the EMAR platform to have electronic assurance that caregivers are selecting the correct drug, concentration, dose rate unit, and dose rate, both on the pump and in EMAR. Closing this gap is very important.

Question: What happens when a clinician requests a new medication be added to an infusion pump's drug library?

Kinnealey: First, I work with the requesting clinicians, domain experts, and Pharmacy to understand the clinical context and exactly how MGH uses the drug to care for patients. Then I convert this knowledge into a proposed new drug library entry. A number of committees review the entry and final approval is given by the MGH Medication Education Safety Approval Committee (MESAC). Only then do I load the new medication into the library with assurance that the new guidance has been cross-checked thoroughly. This process could not be accomplished without the expertise of Deana Alioto and Paul Arpino from Pharmacy, as well as many others.

For more information about what I do and how I work with Pharmacy and others to ensure safe drug administration, call me at 6-8824.

The MGH Chaplaincy and Ash Wednesday

—by Michael McElhinny, MDiv, director, Chaplaincy

I have witnessed 11 Ash Wednesdays at MGH, and I still find it difficult to describe the experience. Father Tom Mahoney, staff chaplain, reminds us, "Ash Wednesday is the first day of Lent, a penitential season observed by many Christians, a time of self-examination and spiritual reflection." Receiving ashes on the forehead is an expression of sorrow for one's sins.

Chaplaincy office manager and volunteer Eucharistic minister, Gina Murray, gives ashes to one of hundreds of visitors who stopped by the MGH Chapel, Ash Wednesday, February 17, 2010.

On Ash Wednesday, thousands of people obtain ashes on the main campus of MGH and at several of our satellite locations.

The Chaplaincy starts planning well in advance of Ash Wednesday to ensure we can respond to the spiritual needs of the MGH community. Receiving ashes is very important to patients and family members who can't get to their local churches due to illness or scheduling issues. Chaplains and volunteer Eucharistic minister offer ashes to patients, families, and staff on inpatient units and in outpatient areas. Even for those who don't receive ashes, the offer is appreciated. Ashes are given out in the Chapel and at two Catholic masses and an ecumenical service. We're grateful to our colleagues at the information desks who direct people to the Chapel when they're asked about ashes.

Ash Wednesday is one of the busiest days of the year for our department. Chaplains, administrative staff, and volunteers work together to honor the request for ashes. Even our rabbi who doesn't distribute ashes generously offers to make spiritual visits to free up other chaplains so they can bring ashes.

I am humbled as I place ashes on another person. I am reminded of my own imperfections and my desire to improve. I'm struck by our common humanity as we live each day as a precious gift. I believe Ash Wednesday is a sign of hope, and we in the Chaplaincy are privileged to be part of it.

More on our Haitian relief efforts

Since my column in the February 4, 2010, Caring Headlines *describing our efforts to help with the crisis in Haiti, I've heard from many of you with questions and concerns. Below are some of the questions I've received.*

To date, the MGH community has donated more than $137,000 via cash, check, credit card, and payroll deductions. For more information about the MGH Haiti Relief Fund, contact your human resources generalist.

Question: I understand MGH is helping with legal services for individuals affected by the earthquake in Haiti. Is that true?

Jeanette: MGH has been working with Catholic Charities of Boston and the Political Asylum/Immigration Representation Project. Catholic Charities provided free legal assistance to Haitian immigrants seeking temporary protected status during the month of February. We expect that more workshops will be added in March. If so, they will be listed on the Catholic Charities website: http://www.ccab.org/help-haiti.html.

MGH Human Resources arranged a free legal services information session on the main campus with the Political Asylum/Immigration Representation Project, on February 4, 2010. The session gave MGH employees an opportunity to talk about immigration, adoption, travel, and other issues with lawyers who specialize in these areas.

Question: Will there be other sessions for employees who weren't able to attend the February 4th session?

Jeanette: Yes. Response to the session was very positive with more than 100 employees attending. Another session will be scheduled in March. Watch all-user e-mails for more details.

Question: What is the MGH Haitian Relief Fund?

Jeanette: As many of you know, the MGH Development Office established the MGH Haitian Relief Fund. To date, the MGH community has donated more than $137,000 via cash, check, credit card, and payroll deductions. For more information about the MGH Haiti Relief Fund, visit: http://intranetstage.massgeneral.org/intranet/HaitiPayrollDeduction-PledgeCard.pdf.

Question: What about the MGH Haiti Grant Program?

Jeanette: A portion of the contributions made to the MGH Haitian Relief Fund go directly to MGH employees affected by the earthquake by way of the MGH Haiti Grant Program. I encourage employees impacted by the Haitian disaster to apply for this funding. Applicants must work at least 20 hours per week and have been employed at MGH for at least six months. The maximum grant is $300 (after taxes). Grants can be used for travel, re-location costs, food and shelter for those still in Haiti, and funeral expenses.

Question: How can I apply for this funding?

Jeanette: Applications are available in Human Resources offices and at the Employee Access Center on Bulfinch 1. Applications can be downloaded from the intranet at http://intranet.massgeneral.org/intranet/HaitiGrantProgramApplication.pdf, or contact your human resources generalist.

Educational plan for change in practice related to physiological monitoring

We are currently reviewing our standards related to the use of physiological monitors—the criteria for placing patients on monitors and discontinuing their use. And we're developing an educational plan to help staff review the knowledge and skills necessary to effectively use physiological monitors.

Question: I heard at a staff meeting that there's a safety-improvement initiative underway to improve practices related to physiological monitoring. What is that about?

Jeanette: Patient safety is our top priority. We constantly assess systems, processes, and procedures related to various components of practice to ensure optimal patient care throughout the hospital. Sophisticated technology is an integral part of practice today. Physiological monitors are one example of technology in use at MGH. We are currently reviewing our standards related to the use of physiological monitors—the criteria for placing patients on monitors and discontinuing their use. And we're developing an educational plan to help staff review the knowledge and skills necessary to effectively use physiological monitors.

Question: What's the focus of the educational plan?

Jeanette: The educational plan for physiological monitoring provides a comprehensive review of the functionality of the monitors. The plan is comprised of three components:

1) An overview of the principles and responsibilities associated with physiological monitoring via a self-study course in HealthStream entitled, "MGH Patient Safety Initiative Physiologic Monitor Alarms"
2) A skills check-list designed to reinforce optimal use of monitors in the care of specific patient problems. Staff will have an opportunity to reinforce and demonstrate their competency in using the monitors as outlined on the skills check-list.
3) Measurement of compliance in completing the first two steps. We have set a target of 95% by March 15, 2010, for nurses, and March 30th for physical therapists, respiratory therapists, and speech-language pathologists. We specified 95% instead of 100% because some staff are away from the hospital on extended leave and aren't scheduled to return until after the target dates.

Question: Types of monitors vary across units. How will the educational program account for this variation?

Jeanette: The Knight Nursing Center for Clinical & Professional Development has partnered with clinical specialists to customize the training and check-lists for the type of monitors in use on particular units.

Question: Who can I contact if I have questions about the training program?

Jeanette: Check with your director or clinical specialist first. You can also visit the Biomedical Engineering website and watch for notices from the Knight Nursing Center. In the coming weeks the Knight Nursing Center will offer training opportunities in the Founders 3 Skills Lab. They will also be visiting units with a training monitor (on weekend shifts, as well).

For more information, call The Knight Nursing Center at 6-3111.

Announcements

Ethics Forum

"Seeing the Unseen: Spirituality as a Frequently Overlooked Element in Clinical Ethics Decision-Making"

Panelists: Wendy Cadge, Angelika Zollfrank, MDiv, and Betsy Catlin, MD

Moderator: Dr. Alex Cist, of the Optimal Care Committee

Friday, March 12
12:00–1:00pm
Sweet Conference Room
Bigelow 432
Brown Bag Lunch

For more information, call 6-4954.

Eldercare
monthly discussion group

Join facilitators, Janet T. Loughlin, LICSW, Partners EAP, and Barbara Moscowitz, 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:
March 9, 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.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday, 7:30am – 5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday, Thursday, 7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

Career Information Day

Do you have an interest in allied health professions?
Come to Career Information Day

March 25, 2010
Haber Conference Room

Attend any of the sessions between 10:30am and 4:25pm:

Nursing 10:30–11:10am
Medical Imaging 11:15–11:55am
Medical Technology/Pathology 12:00–12:40pm
Surgical Technology 12:45–1:25pm
Professional Billing Office and Medical Coding 1:30–2:10pm
Electrodiagnostic (Sleep) Technologists 2:15–2:55pm
Radiation Therapy 3:00–3:40pm
Respiratory Therapy 3:45–4:25pm

Employees applying for the Support Service Employee Grant are encouraged to attend.

Sponsored by Training & Workforce Development in Human Resources

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

Taking the First Step

MGH Training and Workforce Development is hosting Taking the First Step: Strategies to get on a Successful Career Path

March 18, 2010
12:00–1:00pm
Satter Conference Room
Yawkey 2-210

This seminar will help employees identify barriers that may be preventing them from returning to school and provide information on how to get on a successful career path. Topics such as: goal-setting, managing priorities, and staying motivated will be addressed.

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

Patient Safety Awareness Week
March 8–13, 2010

Monday–Friday
Patient safety posters will be on display throughout the MGH community.

Tuesday and Wednesday
Booths promoting patient safety will be set up in the White, Yawkey, and WACC lobbies. Visitors can enter a raffle for a chance to win a copy of, *You, the Smart Patient*, by Michael Rozien, MD and Mehmet Oz, MD. Staff who filed a safety report in 2009 will be eligible to win prizes in a random drawing.

Thursday
"The History of Safety at MGH; a Lot has Happened Since Ether!" presented by Jeff Cooper, director of the MGH Center for Simulation and a panel of experts in patient safety
O'Keeffe Auditorium
3:00–5:00pm

All are welcome

For more information, call the Center for Quality & Safety at 6-9282.

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For more information, call: 617-724-1746

Next Publication
March 18, 2010

Educational Offerings – 2010

March 10

Nursing Research Committee's Journal Club

Bulfinch 222
4:00–5:00pm
Contact hours: 1

March 10

A Nursing Director's Guide to Evidence-Based Practice

Founders 311
10:00–11:00am and
11:00am–12:00pm
Contact hours: TBA

March 12

Pediatric Simulation Program

Founders 325
12:30–2:30pm
Contact hours: 2

March 15 & 22

ACLS Provider Course

Day 1: 8:00am–4:00pm
O'Keeffe Auditorium
Day 2: 8:00am–3:00pm
Thier Conference Room
No contact hours

March 17

PALS Re-Certification

Simches Conference Room 3-110
7:45am–4:00pm
No contact hours

March 17

BLS/CPR Re-Certification for Healthcare Providers

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

March 17

Starting a Journal Club to Promote Evidence-Based Nursing Practice

Founders 311
11:00am–12:00pm
Contact hours: 1

March 18

BLS/CPR Certification for Healthcare Providers

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

March 18

CVVH Review and Troubleshooting for the Experienced CVVH Provider

Founders 311
8:00am–4:00pm
No contact hours

March 22 & 23

Advanced Trauma Care for Nurses

Founders 3
Day 1: 7:00am–5:00pm
Day 2: 9:00am–7:00pm
Contact hours: TBA

March 24

Preceptor Development: Learning to Teach, Teaching to Learn

Charles River Plaza
8:00am–4:30pm
Contact hours: 6.5

March 25

BLS/CPR Re-Certification for Healthcare Providers

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

March 26

PCA Educational Series: "Understanding your Patient's Diet and Nutritional Needs"

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

March 31

BLS Instructor Program

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

April 1 & 2

Oncology Nursing Society Chemotherapy Biotherapy Course

Yawkey 2-220
8:00am–4:30pm
Contact hours: TBA

April 5

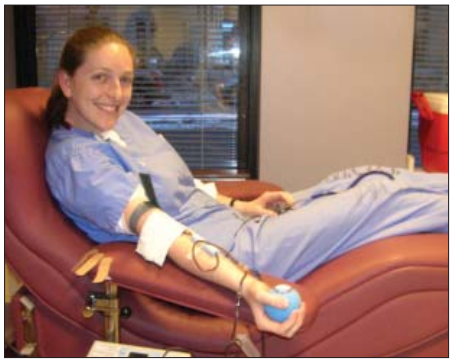
BLS/CPR Re-Certification for Healthcare Providers

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

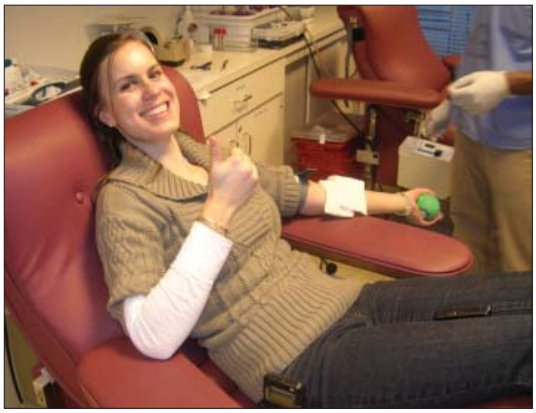
Beginning April 1, 2010, educational offerings will be found on the Knight Nursing Center website (http://www2.massgeneral.org/PCS/ccpd/cpd_sum.asp) and in the e-newsletter distributed weekly by the Center. For more information, call 6-3111.

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

Raising awareness about heart health



Joining together to raise awareness about heart health, members of Physical and Occupational Therapy and the MGH Heart Center held several events last month to help educate staff and visitors. (Clockwise starting at the top right): Dottie Sullivan, RN, from Heart Failure Disease Management, spins the Risk Factor Wheel to test knowledge and increase awareness of heart-failure risk factors; physical therapists, Kristin Morris, PT (left), and Abby Folger, PT, staff an informational heart-health booth in the Main Corridor; physical therapists Sarah Moran, PT (lower left), and Lisa Duncombe, PT, donate blood as part of a PT-OT-sponsored blood drive. The two departments donated more than 50 units of blood in the month of February in observance of National Heart Health Month.



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