

Caring

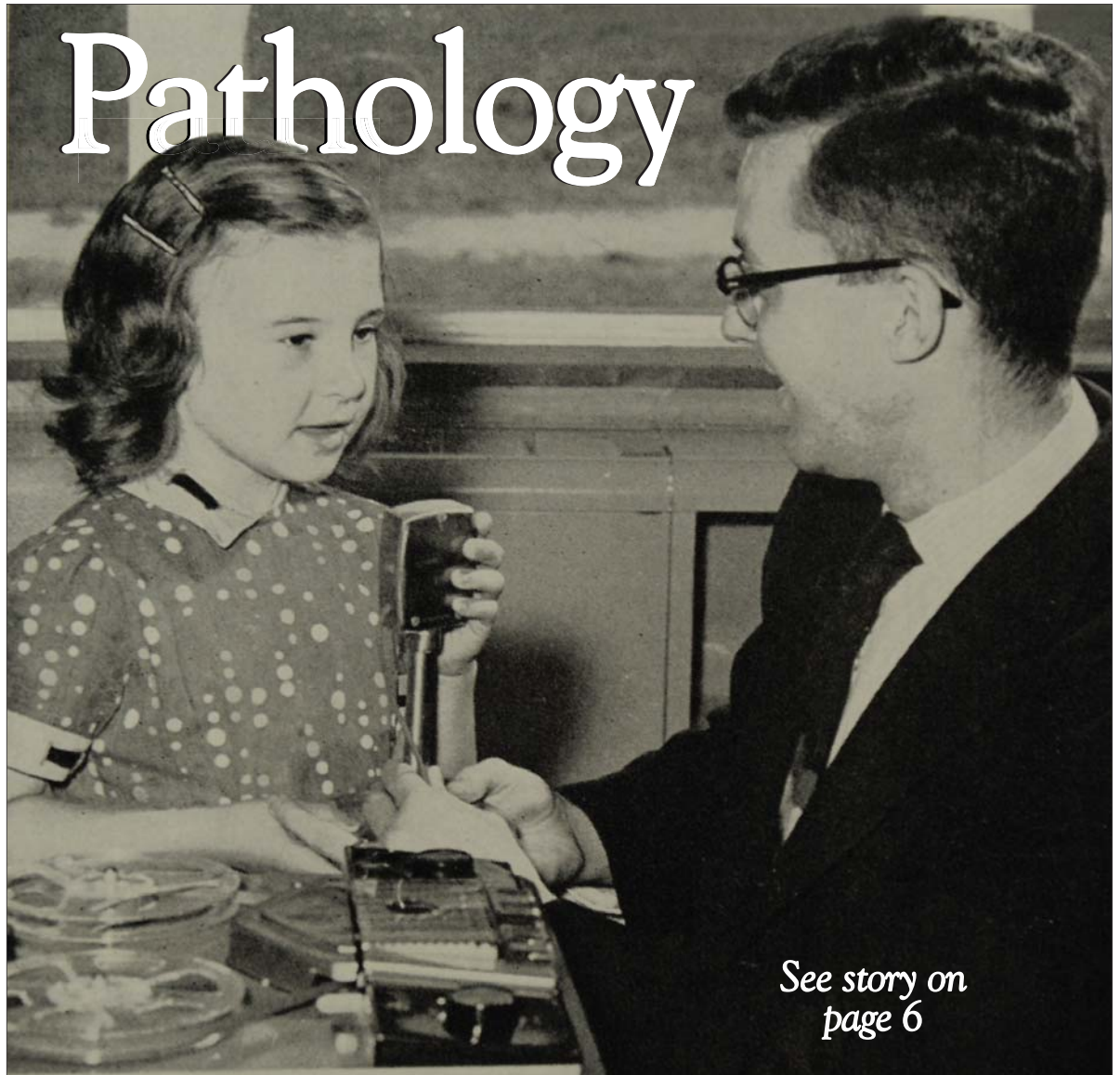
Headlines

May 5, 2011

Speech-Language

Pathology

People have studied speech problems for more than 2,000 years, but most historians trace the origins of speech pathology to the early 20th century when scientific, academic, and practical applications began to emerge.



See story on
page 6

Circa 1957, children evaluated the improvement in their speech by listening to tape recordings of their own voices. This photo appeared in the booklet, *Speech Correctionists: the Competencies They Need for the Work They Do*, published by the US Department of Health, Education & Welfare.

2011 National Patient Safety Goals

Safety goes hand-in-hand with Excellence Every Day

This year, the National Patient Safety Goals are taking a less prescriptive approach... This encourages organizations to make choices based on current evidence.

In 2002, the Joint Commission established a series of National Patient Safety Goals (over and above the list of standards required for Joint Commission accreditation) to help call attention to areas of heightened concern related to patient safety. Each year, these National Patient Safety Goals are updated by a panel of experts who work closely with the Joint Commission. This update occurs as a result of a comprehensive review of the literature and a thorough examination of healthcare databases to identify the most prevalent patient-safety issues. After reviewing these findings with clinicians, healthcare organizations, consumer groups, payers, and others, the panel makes recommendations to the Joint Commission as to what changes should be made to the National Patient Safety Goals.

You may recall that in 2009 the Joint Commission embarked on an extensive review process that led to a decrease in the number of National Patient Safety Goals. Believing that sufficient improvement had been made in certain areas, the Joint Commission removed some goals from the list of National Patient Safety Goals and moved them to the Manual of Standards for Accreditation. That doesn't mean the issues are no longer important—it's just an indication that these safety standards are being met so they no longer need to be highlighted as National Patient Safety Goals. Fall-reduction, for example, is an aspect of care that has moved from a National Patient Safety Goal to a regular Joint Commission standard for accreditation.



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

This year, the National Patient Safety Goals are taking a less prescriptive approach. Where last year, the National Patient Safety Goal related to central-line infections stated that a “chlorhexadine-based” antiseptic should be used prior to insertion, this year it states that an antiseptic should be used that is, “cited in the scientific literature or endorsed by professional organizations.” This encourages organizations to make choices based on current evidence.

One significant change in 2011 has to do with medication-reconciliation. In 2009, The Joint Commission stopped factoring medication-reconciliation into the accreditation process because of feedback that the requirements were too intricate and difficult to implement. After much deliberation and field testing, changes were made. Effective July 1, 2011, medication-reconciliation requirements will be streamlined, focusing more on the critical-risk aspect of the reconciliation process, and this will be reinstated as Goal #3. The Joint Commission is once again factoring medication-reconciliation into the accreditation process.

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We're committed to delivering safe, efficient, effective, timely, equitable, patient-centered care to every patient every moment of every day. To do that, we must employ best practices, stay abreast of current research, and adhere to the standards and requirements put forth by the Joint Commission and other regulatory agencies.

We are committed to Excellence Every Day. We're committed to delivering safe, efficient, effective, timely, equitable, patient-centered care to every patient every moment of every day. To do that, we must employ best practices, stay abreast of current research, and adhere to the standards and requirements put forth by the Joint Commission and other regulatory agencies.

2011 National Patient Safety Goals

(Numbers are not consecutive because some goals do not apply to hospitals)

Goal 1: Improve the accuracy of patient identification

- Use at least two patient identifiers when providing care, treatment, and services
- Eliminate transfusion errors related to patient mis-identification

Goal 2: Improve the effectiveness of communication among caregivers

- Report critical results of tests and diagnostic procedures on a timely basis

Goal 3: Improve the safety of using medications

- Label all medications, medication containers, or other solutions on and off the sterile field, in peri-operative and other procedural settings
- Reduce the likelihood of patient harm associated with use of anticoagulant therapy
- Maintain and communicate accurate patient medication information (effective 7/1/11)

Goal 7: Reduce the risk of healthcare-associated infections.

- Implement evidence-based practices to prevent healthcare-associated infections due to multiple drug-resistant organisms in acute-care hospitals
- Implement best practices or evidence-based guidelines to prevent central-line-associated bloodstream infections
- Implement best practices for preventing surgical site infections

Universal Protocol:

- Conduct a pre-procedure verification process
- Mark the procedure site
- Perform a time-out before procedures

In the coming weeks, the PCS Office of Quality & Safety will distribute a pocket-sized Resource Guide with information relevant to upcoming regulatory surveys, including the 2013 Magnet site visit. Staff from the Office of Quality & Safety will conduct quarterly tracers to help units prepare, and they're available to answer any questions about patient-safety, standards of care, and National Patient Safety Goals.

For more information, call the PCS Office of Quality & Safety at 3-0140, or visit the Joint Commission website at: www.jointcommission.org.

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The Allan Moore, MD, Memorial Medical Services Blood Drive

Medical nurse, Suzanne Lynch, RN, kicks off the Allan Moore, MD, Memorial Medical Services Blood Drive as nursing director, Susan Morash, RN, provides moral support. Martin White, RN, of the Blood Donor Center performs the blood collection.

Those who knew resident, Allan Moore, MD, remember his passion and commitment to patient care. Nowhere was that passion more obvious than in his crusade to encourage healthcare providers to make blood donation a regular part of their practice at MGH. Moore believed healthcare workers had an obligation to donate blood, so every year throughout his residency, he coordinated an employee blood drive. Sadly, Moore was killed in a motor-vehicle accident in 2008, but the blood drive he established continues in

his name. Nursing director, Susan Morash, RN, partnered with Moore in his efforts to establish this blood drive, and she continues to play a key role in championing the cause. This year, the Allan Moore, MD, Memorial Medical Services Blood Drive will be held May 2–31, and all MGH employees are invited, or as Moore would have said, ‘encouraged,’ to participate.

To take part in the challenge, go to the MGH Blood Donor Center in the Gray Lobby. You’ll be asked which Medical Services team you’d like to support (nursing, house staff, fellows, attending physicians, or practice-based teams). The winning team will receive a party for 30 at the Limelight Stage Karaoke studio or \$500 toward a party (or other prize) for their team. Raffles will be held throughout the month with prizes such as Red Sox tickets or a stay at the Liberty Hotel.

Two double-point days are incentives for teams to plan ahead and donate on a specified day. During the first two weeks and again in the last two weeks, the days with the most total donations will be deemed double-point days, significantly boosting a team’s chances to win.

Much of the blood donated at MGH is utilized on medical units. What a fitting tribute if the 2011 Allan Moore, MD, Memorial Medical Services Blood Drive broke all records for blood donations in a single month. If you’re not eligible to donate, feel free to recruit a friend or colleague to donate in your place. Or cover for a colleague so he or she can donate.

Giving blood is a simple, meaningful way to help our patients and honor a cherished colleague. For more information, contact your blood drive captain or call the Blood Donor Center at 6-8165.



Sixth Annual Cardiac Nursing Visiting Scholar Program

—by Diane L. Carroll, RN, Yvonne L. Munn nurse researcher

On April 7 and 8, 2011, in recognition of the unique contributions of cardiac nurses, the MGH Heart Center welcomed Marjorie Funk, RN, a professor at Yale University School of Nursing and principal investigator for the National Institute for Nursing Research's, "Implementation of Practice Standards for Electrocardiogram (ECG) Monitoring." She is the sixth Cardiac Nursing visiting scholar to come to MGH. During her two-day visit, Funk took part in a number of activities, including presentations, a panel discussion, poster displays, and unit rounds.

Funk's program of research focuses on cardiac critical care nursing, specifically the safe and appropriate use of technology, the equitable distribution of technology, and the human-machine interface. She has studied bio-impedance monitoring, utilization of monitor-watchers, the impact of arrhythmias following cardiac surgery, and ECG standards.

Funk gave two presentations during her visit, one research-oriented, the other clinical. Her research presentation, "As Healthcare Technology Advances: Benefits and Risks," addressed a variety of human-technology issues and revealed the preliminary results of the PULSE Trial, a randomized clinical trial of ECG learning modules designed to improve nurses' knowledge and skill and measure the modules' impact on skill-enhancement and patient outcomes. Her clinical presentation, "Optimizing ECG Monitoring," focused on knowledge- and skill-development and the barriers to optimizing ECG monitoring.

In a panel discussion, four staff nurses, from novice to expert, read their clinical narratives: Jessica Hancock, RN, Cardiac Intensive Care Unit; Christine Suchecki, RN, Cardiac Step-Down Unit; Junjira Saengvanich, RN, Cardiac Surgical Step-Down Unit; and Cindy Finn, RN, Cardiac Surgical Intensive Care Unit. Each narrative focused on the unique needs of a cardiac patient and the contributions the nurses made to meet those needs (at their respective levels of practice) and Funk offered her expertise.

Posters were displayed outside O'Keeffe Auditorium highlighting the innovative clinical practice in the Knight Center for Interventional Cardiovascular Therapy, the Electrophysiology Laboratory, all the inpatient cardiac care units, and the Chaplaincy. Members of the Cardiac Practice Committee, chaired by Leann Otis, RN, had an opportunity to speak with Funk about ECG education and other issues related to cardiac nursing practice.

Funk accompanied staff on unit-based rounds where discussion centered on research in the Electrophysiology Laboratory and the safe and judicious use of ECG monitoring.

Cardiac Nursing
visiting scholar,
Marjorie Funk, RN,
professor at Yale
University School of
Nursing, presents,
"As Healthcare
Technology Advances:
Benefits and Risks."



The evolution of speech-language pathology: a transformative journey

Children with 'speech handicaps' were given a thorough oral examination before embarking on a plan of speech correction.

Most historians agree that the discipline of Speech-Language Pathology has its roots in the 19th-century teachings of Ebenezer Porter, an instructor of Elocution and Rhetoric at the Andover Theological Seminary, and Andrew Comstock, a physician and fellow elocutionist. Most elocutionists of the time focused on public speaking as part of school cur-

riculums, but Porter and Comstock saw communication disorders as within their scope of practice and offered treatment for stammerers in the form of sound drills based on the phonetic alphabet and the recitation of memorized passages aloud.

In the late 19th and early 20th century, as classifications of speech disorders emerged, the scope of treatment grew to include stuttering, lisping, articulation, cluttering (rapid, indistinct speech) aphasia, and other serious communication disorders. Two important and enduring texts came out of this period, Samuel Orton's, *Reading, Writing and Speech Problems in Children* (1937), and Charles Van Riper's *Speech Correction: Principles and Methods* (1939).

The American Speech-Language and Hearing Association was formed in 1925 when a small group of practitioners who had been doing research and teaching in the field of speech-correction decided to establish a new and independent profession.

At about the same time, an informal language clinic was established at MGH under the direction of Edwin Cole, MD, as part of the outpatient Neurology Department. Initially, the clinic provided evaluation services to a small number of patients with language disorders. During World War II, the clinic became the primary training ground and treatment center in the eastern United States for patients with aphasia.

Because of this success, the Language Clinic became a formal entity at MGH with permanent staff and dedicated space at the hospital. The end of the war saw a decrease in services for veterans but increased demand for evaluation and treatment for children with impairments in speech, language, and reading.

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(Photos from the US Department of Health, Education & Welfare)

Speech Language Pathology (continued)

During the 1970s the Language Clinic underwent major expansion formally becoming the Speech-Language Pathology Department under the direction of Julie Atwood, and in 1976 it began offering services at the Bunker Hill Health Center (now the Charlestown HealthCare Center). In 1996, soon after Atwood retired, Carmen Vega-Barachowitz, SLP-CCC became director, and she continues to lead the department today.

Throughout its history, the department of Speech-Language Pathology re-located several times, spending almost three decades on the third floor of the Clinics Building. In 1976, it moved to Vincent-Burnham 7, and in 1981, to the Wang Ambulatory Care Center where it remained until 2007. Today, the department of Speech, Language & Swallowing Disorders and Reading Disabilities (as it is currently known) has a presence on the MGH main campus (in the Profes-

Speech correction teachers used picture books to assess speech defects and make speech stimulation more fun for children.



sional Office Building on Cambridge Street) and at the healthcare centers in Chelsea and Revere.

Over the years, the department has seen great advances in the care and treatment of individuals with speech, language, and swallowing disorders. In the early 1990s the addition of video-fluoroscopic technology (modified barium swallow tests) gave speech pathologists greater ability to recommend appropriate foods and swallowing positions for patients with swallowing difficulties.

In 1999, speech pathologists began performing fiberoptic endoscopic evaluations of swallowing disorders (FEES), using an endoscope at the bedside.

Comprised of a speech pathologist, physical therapist, and occupational therapist, the Pediatric Therapy Team was formed in 2002 to conduct multi-disciplinary pediatric evaluations.

MGH speech-language pathologists specialize in diagnosing and treating communication and swallowing disorders. The mission of the department is: "Guided by the needs of our diverse patients, families and communities, we strive to provide the highest quality care for individuals with communication and swallowing disorders in a thoughtful and compassionate manner; to share best practices and mentor current and future generations of speech-language pathologists; and to advance practice through clinical research and innovation." Speech-language pathologists offer comprehensive diagnostic evaluation and treatment for all communication and swallowing disorders in acute and outpatient populations, from newborns to adult.

The goal is to maximize an individual's communication and swallowing abilities to enable them to function at an optimal level. Services range from prevention to identification, diagnosis, consultation, treatment, and referrals.

Today, the department is comprised of 35 speech-language pathologists providing services at three MGH sites. Speech-language pathologists are integral members of the healthcare team who are increasingly more involved in the care of acutely ill patients.

For more information about the history or services provided by Speech, Language & Swallowing Disorders and Reading Disabilities, call 6-2763.

Patient Memorial Service for Staff

We will never forget...

—by Todd Rinehart, LICSW, palliative care social worker

I will never forget Lisa, a 40-year-old homeless woman with AIDS who, before she died, told me, "If I had any money I would leave it to you."

I'll never forget Bob, a 23-year-old man with testicular cancer, who when facing the end of his life asked, "Where do you think your soul goes when you die?"

I'll never forget Bernice, a 68-year-old woman with breast cancer, who in the final hours of life, smiled as I entered her room, turned to her daughter and said, "Be sure to send Todd a thank-you card."

These are only some of the patients who have left indelible impressions in our hearts. These memories are gifts that remind us of the importance of the often brief relationships we form with patients and families.

In 2010, to honor those relationships, Katrina Scott, staff chaplain, and Todd Rinehart, LICSW, palliative care social worker, created the first Patient Memorial Service for Staff to give caregivers an opportunity to come together, reflect, and honor patients through poetry, music, meditation, and humor.

The idea for a service began in 2009 when Rinehart attended the final course of The ACE Project: Advocating for Clinical Excellence, Trans-Disciplinary Palliative Care Education, in Pasadena, California, funded by the National Cancer Institute. The goal of this project was to improve the delivery of care provided by palliative-care social workers, spiritual care providers, and psychologists through intensive advocacy and leadership.

As part of that project, participants were asked to focus on an area of palliative care for deeper reflection. Rinehart chose bereavement services. The idea of a memorial service for hospital staff evolved during a small group session. When he returned to MGH, he shared his idea with Scott, who had attended the course in 2008. She agreed to partner with Rinehart in creating an MGH Patient Memorial Service for Staff. Michael McElhinney, director of Chaplaincy, and Vicki Jackson, MD, chief of Palliative Care Services, both enthusiastically supported the idea.

The service will be held in the MGH Chapel, Wednesday, May 25, 2011, at 1:00pm. All are welcome to attend to reflect on the patients who've touched our lives and share stories with friends and colleagues.

Says Rinehart, "We hope the service will be an uplifting occasion as we take this opportunity to honor the many patients we've cared for."

Lorie Kubicek and Kimberly Khare will perform songs of remembrance. Readings, poetry, and reflections will be offered by Rinehart; Scott; unit service associate, Aneita Gayle; Richard Penson, MD; medical assistant, Melissa Calverley; clinical nurse specialist, Elizabeth Johnson, RN; and physical therapist, Meaghan Costello, PT. A slide show has been created for the service by chaplain, Daphne Noyes. There will be light refreshments following the service.

For more information, call Todd Rinehart, at 4-4525.

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Diabetes-education in the Hispanic population

—submitted by the Nursing Research Journal Club

Of approximately 35 million people of Hispanic ethnicity in the US, nearly 2 million have been diagnosed with diabetes; that's 1.7 times the likelihood of Caucasians being diagnosed with the same illness. Until recently, the research tool, Diabetes Self-Management Assessment Report Tool (D-SMART), was only available in English. James A. Fain, RN, recognized the need to translate this tool into Spanish based on his work at the Worcester Family Health Center.

Fain presented his research, "Psychometric properties of the Spanish version of the Diabetes Self-Management Assessment Report Tool (D-SMART)," at the March meeting of the Research & Evidence-Based Practice Committee

Journal Club. The National Diabetes Education Outcomes System recognizes that D-SMART is useful in measuring health-related

changes in behavior such as exercise, eating habits, medication adherence, blood-glucose monitoring, management of hypo- and hyper-glycemia, and overcoming barriers to successfully managing diabetes.

Fain's research was conducted in two phases using a multi-method design. The first phase, a qualitative study, used focus groups to see how culture influences behavior. Bilingual groups discussed the readability, interpretability, and relevance of information measured by the D-SMART. One area where differences arose was diet and meal-planning. Many vegetables common to Hispanic culture are not available in American stores. Other areas were religious beliefs and outlook on illness which could potentially present barriers to disease-management.

Fain's presentation focused on the second phase of his research, evaluating whether the Spanish version of the tool was reliable and valid. Would the items in the scales render similar answers repeatedly? Were they culturally and linguistically relevant? Would results stand the test of time? Fain recruited 174 adults of Hispanic ethnicity with Type 2 diabetes who met eligibility criteria. Both surveys were completed by 95 participants. Results confirmed the validity and reliability of the Spanish version, which makes it a key tool in efforts to collect and analyze data about high-risk populations across the country.

The next meeting of the Journal Club will be held May 11, 2011, at 4:00pm in Founders 311. Diane Carroll, RN, nurse researcher, will present, "Fall-Prevention in Acute Care Hospitals: a Randomized Trial." For more information, call Martha Root, RN, at 4-9110.



James A. Fain, RN, presents, "Psychometric Properties of the Spanish Version of the Diabetes Self-Management Assessment Report Tool (D-SMART)," at the March meeting of the Research & Evidence-Based Practice Committee Journal Club.



(Photos by Paul Batista)

New nurse gains insight into delicate ‘art’ of nursing

While on the medical unit, Mary experienced a sudden change in her mental status prompting her to be transferred to our unit for neurological services.

My name is Kristin Cina, and I am a new graduate nurse. Over the past year working on the Ellison 12 Neuroscience Unit, I’ve had many exciting, rewarding, and challenging experiences. Many patients have taught me extremely valuable lessons, but one patient in particular reminded me why I became a nurse in the first place.

‘Mary’ had been transferred to our unit from a medical unit in the afternoon, and I would be caring for her overnight. She had been admitted to the hospital for chronic lower back pain, lower-extremity weakness, nausea, and vomiting that had caused severe weight-loss over the past few months. While on the medical unit, Mary experienced a sudden change in her mental status prompting her to be transferred to our unit for neurological services. Unfortunately, all of Mary’s tests, labs, and imaging studies were inconclusive, leaving her without a clear diagnosis. The team’s plan was to treat Mary’s symptoms until a definitive diagnosis could be obtained. The nurse who



Kristin Cina, RN, staff nurse
Ellison 12 Neurology Unit

admitted her explained in report that Mary’s sister would be very involved in her care, that she planned to stay overnight with Mary, and that she could be ‘demanding.’

As soon as I met Mary and her sister, I could see what she was talking about. As Mary moaned in bed, her sister, ‘Susan,’ spoke for her, saying her sister’s needs were not being met. I assured Mary and Susan that I would do everything in my power to make sure she was comfortable overnight.

Throughout the night, Mary did not sleep at all. Susan called me to the room every 15 or 20 minutes to report a new onset of symptoms. She always spoke for Mary, saying her sister’s pain wasn’t being adequately

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This experience made me realize that it's easy to get caught up in the clinical technicalities of a patient's illness, wanting to ease the physical manifestations of sickness with medications, not stepping back to realize that being hospitalized is emotionally distressing for patients and their families.

controlled, her IV was placed improperly causing her arm to be numb, and Mary had developed a cough which Susan believed was a sign that she had contracted a virus from one of the other patients in the hospital.

I did my best to stay calm every time I was called to her room. Each time, I attempted to treat the symptoms Susan described. I removed Mary's IV, though it didn't appear to be infiltrated. I applied a warm pack, notified the team of each new ailment, obtained cough medicine, and altered her pain-medication regimen.

By 4:00am, neither Mary nor her sister had slept, and I was called to her room once again. Susan demanded to see a doctor because she didn't think the team was doing enough for Mary. She was furious that her sister was unable to sleep and certain her sister's condition would worsen due to her lack of rest. The resident on call had been in to see Mary numerous times throughout the night and was getting frustrated. I tried to stay positive, but I, too, felt as if my efforts were unappreciated. The resident came to her room one last time and explained that we were doing everything possible to treat Mary's symptoms, and we would continue to do so.

When he left, Susan looked at me and said, "Don't they understand my sister is a human being—not some experiment!"

That statement hit me like a ton of bricks.

I suddenly realized I could relate to what she was going through. I explained to Mary and Susan that I also had a sister who was currently in the hospital. I disclosed to them that my sister has cerebral palsy, is non-verbal, and therefore unable to tell us how she feels or what hurts when she's sick. I told Susan I understood how frustrated she must feel, wanting so much to help her sister and not want to see her suffer. I told Mary how lucky she was to have such a caring sister. I reiterated my desire to help them, stressing that I did see Mary as a human being whom I was happy to care for.

I offered to massage Mary's back and apply some lotion, and she eagerly nodded her agreement. After a few minutes rubbing lotion on her back, I made her as comfortable as possible with an extra blanket and heating pack. As I was about to leave, Mary said her first words to me.

"Thank-you for caring," she said.

Susan thanked me, too, and the next time I peeked into the room, they were both sound asleep.

I became a nurse because I wanted to help people. I've always admired the nurses who've cared for my sister over the years, who treated her with compassion and respect. I aspire to do the same for my patients.

This experience made me realize that it's easy to get caught up in the clinical technicalities of a patient's illness, wanting to ease the physical manifestations of sickness with medications, not stepping back to realize that being hospitalized is emotionally distressing for patients and their families. Sometimes, something as simple as a caring touch or a supportive word can mean the world to an ailing patient or family member. I've learned first-hand that healing has a physical component and an emotional component, and I try to incorporate this into my practice every day.

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

The disclosure of personal information by a caregiver is a delicate matter. It's not always appropriate. But when done thoughtfully, compassionately, and with the patient's well-being in mind, it can be a powerful intervention. When Kristin shared her family situation with Mary and Susan, we saw a wonderful example of personal disclosure for all the right reasons. It was only after hearing Kristin's story that Mary and Susan were able to sleep. Kristin learned early in her career the power of empathy, or as she called it, 'a caring touch or a supportive word.'

Thank-you, Kristin.

Ambulatory Practice of the Future optimizes team approach to care

—by Mary Ann Marshall, RN

The Ambulatory Practice of the Future (APF), which opened last summer, operates on a team-care concept in which the patient is the most important member of the team. Within this model, patients work closely with each team member to achieve and maintain good health.

I began working at the APF in August and have seen the positive effects of this fluid, flexible, and empowering approach. At the APF, every member of the team is vitally important to the delivery of customized care. The work environment is open, so by its very nature it promotes comfort, encourages communication, and allows everyone to learn. We take into account patients' demographic information, orientation, and ease of accessibility, and welcome feedback from the team regarding both home- and work-related issues.

Mary Ann Marshall, RN, consults with David Judge, MD, medical director of the Ambulatory Practice of the Future, in the APF's open-concept staff area, which promotes communication among team members.



Days begin and end with a team 'huddle,' which allows us to plan for the day and end with a critique of our process and performance. We use the quality-improvement approach of, Plan-Do-Study-Act, to achieve a seamless, collaborative care-delivery model that is constantly in motion. Respect, honesty, and a sense of humor are core values.

Team members are supported in obtaining higher levels of expertise. Case studies and staff meetings are led by a different team member each week. Workshops, conferences, and care alliance meetings provide opportunities for staff to learn and improve skill sets while providing exceptional care.

With each encounter, we listen to patients' stories, identify concerns, and provide education. We go beyond basic health information to other issues that can impact the management of care. Partnerships are formed around a shared effort to maintain wellness and meet mutually agreed-upon goals.

Patients have 24-hour access to personal records, the ability to update their medication lists, and soon, the ability to schedule their own appointments. And care in the APF extends to urgent-care needs, bridging the gap between emergency and primary care.

We are testing new concepts never before used in the primary-care setting. As the practice evolves, we hope to share our experience, inspire change, and assist others in shifting to a model that caters to the unique needs of each individual (patients and providers alike). We're committed to creating an environment where patients can come, not only when they're sick, but when seeking advice about health and wellness.

This spring, the Ambulatory Practice of the Future is offering MGH employees an opportunity to enroll in the program through a lottery system. Information will be mailed to eligible employees at their homes.

For more information, call 4-1100.

Clinical Recognition Program

excellence is embedded at every level of practice

—by Ann Jampel, PT, and Debra Whitaker, RN, co-chairs of the Clinical Recognition Review Board

The foundation of the PCS Clinical Recognition Program comes from the Dreyfus Model of Skill-Acquisition. In the mid-1960s, the Dreyfus brothers became interested in how certain skills were acquired, defining skill-acquisition as the development of skilled 'know-how.' Patricia Benner, RN, noted author and nursing theorist, applied this model to clinical practice and added to our knowledge of skill-acquisition and practice-development.

Skilled know-how is the result of both theoretical and practical knowledge and therefore requires experience—the refinement of pre-conceived notions, expectations, or theories through encounters in actual clinical situations. It is through experience that clinical knowledge is developed, and from that knowledge comes clinical expertise.

Each stage of skill-acquisition is characterized by quantifiable behaviors. Individuals move from:

- a reliance on rules to reliance on past experience
- detached observer to engaged participant
- perceiving a situation as made of equally relevant parts to perceiving it as a whole in which only certain parts are relevant

Based on a review of more than 100 narratives and interviews with clinicians throughout Patient Care Services, four levels of practice were established that correspond with the Dreyfus Model of Skill-Acquisition. They are: entry-level (advanced beginner), clinician (competent), advanced clinician (proficient), and clinical scholar (expert).

Entry-level practice is characterized by rule-governed behavior and a focus on the present with a great deal of reliance on the experience of others. Recognition at this level occurs at the unit or department level. Clinicians share a written narrative describing their practice, and goals are developed to support their continued development to the clinician level of practice.

The clinician level is characterized by a mastery of skills and organization and the ability to manage competing priorities. Clinicians see the patient and family as unique individuals and advocate for them with members of the healthcare team. They are resources to the team. Recognition at this level occurs at the unit or department level. Clinicians share a written narrative describing their practice, and goals are developed to support their continued development. The clinician level must be achieved within two years of practice at MGH.

The decision to apply for advanced clinician or clinical scholar is voluntary and requires the endorsement of the clinician's director. Advanced clinician is characterized by a willingness to take sound clinical risks, recognition of the most salient aspects of a situation, and the ability to influence practice on the unit. Clinicians must

submit a portfolio and interview with members of the Clinical Recognition Review Board.

Advanced clinician receive a 3% increase in salary.

At the clinical-scholar level, clinicians intuitively understand the situation and know what actions to take without having to analyze options. They are increasingly comfortable taking

sound clinical risks and their influence is felt on and beyond the unit or department. Clinicians who seek recognition at this level must have the endorsement of their director; submit a portfolio, and interview with members of the Clinical Recognition Review Board. Clinical scholars receive a 6% increase in salary.

Since skilled know-how evolves with clinical experience, it's important to note that excellence exists at every level of practice. Movement from one level to the next is an accomplishment that should be recognized and celebrated.

For more information, visit the CRP website at www.mghpcs.org/IPC/Programs/Recognition/Index.asp, and speak to your director about your level of practice.

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Infection-prevention a top priority for inpatient cleaning program

—by Stephanie Cooper, senior environment of care operations manager

Teamwork: unit service associates, Lourenca Pires (foreground) and Tak Chau, take pride in making sure patient rooms are thoroughly cleaned and disinfected.

Last year, a baseline assessment of room-cleaning practices was conducted, and the results of that assessment were used to design a supplemental training program for unit service associates to ensure patients' rooms were cleaned thoroughly and consistently throughout the hospital. A quality assurance program was implemented to provide feedback to staff, and in subsequent patient-satisfaction surveys, 71.4% of patients reported their rooms and bathrooms were always kept clean. On the heels of that success, PCS Clinical Support Services is ratcheting up its focus on infection-prevention.

Infection-prevention has always been a priority of the inpatient cleaning program. To enhance this objective Clinical Support Services is implementing a new tool that has been shown to help reduce infection rates.

According to the Centers for Disease Control, "Transmission of many healthcare-acquired pathogens is related to contamination of near-patient surfaces and equipment. All hospitals are encouraged to develop programs to optimize the thoroughness of high-touch surface cleaning..."

Toward that end, a new fluorescent marking system has been piloted on a number of inpatient units. High-touch surfaces close to the patient are marked with 'invisible ink' that's only visible in black light. After cleaning, operations managers check the marked surfaces using a beam of black light. With thorough cleaning, the marks are gone, which means germs are gone, too. The process, affectionately called, iGLO (Innovative Germ Locating Opportunity), has been well received and will be rolled out in remaining inpatient areas this month.

Successful infection-prevention requires the involvement and cooperation of all members of the team. Staff can help by ensuring window sills and bedside tables are free of clutter so they can be thoroughly cleaned and disinfected. And educating patients and families about why this is important is key.

In a letter to nursing director, Suzanne Algeri, RN, one patient recently wrote she was, "utterly impressed" with the cleaning team, noting that unit service associates, Tak Chau and Lourenca Pires, "worked as an efficient team, systematically cleaning and disinfecting every surface. As a patient I felt everything possible had been done to protect me from potential infection or sickness."

Says senior operations manager, Stephanie Cooper, "That's exactly the result we're hoping for."

For more information, call 4-7841.



Finding your way in the Lunder Building: a little advance planning

The Patient Navigation Program sponsored by the Volunteer Department and Information Associates offers volunteer- and employee-supported initiatives to help patients and families find their way.

Question: How will patients get to the Lunder Building?

Jeanette: Patients can access the Lunder Building by public transportation:

- From the MBTA Red Line or Charlestown shuttle, patients will enter through the Yawkey Building
- If using a Partners shuttle, patients will enter the Jackson Building and pass through the White Lobby to the Lunder Building

Patient Transport:

- Ambulances will drop patients off in the sheltered emergency drop-off area outside the Lunder Building
- Non-emergency drop-offs will use the Cox entrance
- Chair cars will use the Wang or Yawkey entrances

Patient Valet Drop-Off:

- Yawkey Building
- Wang Building
- White ramp, through the main entrance, or the new Lunder building entrance scheduled to open in May

Question: Once on the main campus, how do I access the Lunder Building?

Jeanette: Two buildings connect directly to the Lunder Building:

- You will be able to walk directly from the White Lobby into the Lunder Building
- The Bander Bridge will take you from Yawkey to the Lunder Building

Question: Will all floors of the Lunder Building be open to the public?

Jeanette: The upper floors, 6-10, are inpatient units, so patients, visitors, and staff will have access. Other floors will house operating rooms, Central Sterile Processing, and Radiation Oncology exam and treatment areas. Access to those areas will be granted accordingly.

Question: Will there be assistance to help patients and families find their way?

Jeanette: The Patient Navigation Program sponsored by the Volunteer Department and Information Associates offers volunteer- and employee-supported initiatives to help patients and families find their way.

- Volunteer greeters and staff assist individuals in need of escort and guidance
- The Appointment Buddy Program assists patients and families coming to the Pediatric Neuromuscular Disorder Clinic
- Appointment Pals are available for patients enrolled in the MassGeneral Care Management Program

Question: Are there plans to expand the Patient Navigation Program?

Jeanette: Additional volunteers will be stationed at the Main, Wang, and Yawkey information desks, and the Greeter Program is expanding to include the Yawkey Lobby.

Once the Lunder Building opens, the Patient Navigation Program will launch a web-based patient-discharge and outpatient escort-request system. This will replace our current telephone request system and will ultimately expand to include the entire main campus.

For more information about the Lunder Building, call 6-2442.

The Mary C. Forshay Scholarship

to advance the care of ALS patients

By Julie Goldman, RN, professional development manager

On April 4, 2011, family and friends of Mary Forshay presented the 2011 Mary C. Forshay Scholarship to Darlene Sawicki, RN, staff nurse in Neurology Clinical Trials and the ALS Clinic. Sawicki was recognized for the compassion and advocacy she shows in the care of ALS patients.

Forshay's husband and family established the scholarship in her memory to recognize compassionate care of ALS patients and promote educational opportunities for staff. Forshay's career spanned more than 30 years. During her illness, Forshay was cared for in the Respiratory Acute Care Unit and ALS Clinic. Her family and friends felt strongly that offering a scholarship to enable caregivers to advance their knowledge and care of patients and families with ALS was a fitting way to honor her life and work.

Sawicki has worked in Neurology Clinical Trials and the ALS Clinic since August of 2005. In her letter of nomination, Merit Cudkowicz, MD, wrote, "Darlene is committed to providing excellent, compassionate care to patients with ALS and their families. She is available, accessible, and dedicated to helping them in every facet of their illness. Recently, Darlene stayed all night in the Emergency Department with a patient who was alone, scared, and unable to speak."

During the celebration, Forshay's husband, Robert, observed, "As a family we were honored to read the wonderful letters of support for each of the nominees. We're thrilled to have so many clinicians committed to the care and advocacy of ALS patients and families. We're happy to provide this scholarship so that each year a clinician can attend the National ALS Conference to learn and come back and share that knowledge with their colleagues, patients, and families."

For more information about this award, call Julie Goldman, RN, at 4-2295.

Below left: Dara Alexander, of the ALS Association with Robert Forshay.
Below right (l-r): award nominees, Julie MacLean, OTR/L; Paige Nalipinski, SLP-CCC; Forshay; award recipient, Darlene Sawicki, RN; and Christopher and Michael Forshay.



(Photos by Bonnie Godas)

The Molly Catherine Tramontana Award for Outstanding Service and Patient Care

— submitted by Kathya Gavazzi, RN, clinical nurse specialist

Established in 2007, the Molly Catherine Tramontana Award for Outstanding Service and Patient Care was created by Mark and Jenn Tramontana and their family and friends in memory of their daughter, Molly Catherine Tramontana. The Fund honors nurses on the Labor & Delivery Unit in recognition of their dedicated care and service to their patients.

Below: Joan Cogliano, RN, this year's recipient of the Molly Catherine Tramontana Award for Outstanding Service and Patient Care (center front; in black pants) with colleagues, friends, and members of the Tramontana family.

On March 4, 2011, nurses from the Labor & Delivery Unit gathered with the Tramontana family to recognize the eight nominees and this year's recipient of the award, Joan Cogliano, RN.

"The Tramontanas are incredible human beings," said nursing director, Susan Caffrey, RN. "Many people

experience a loss and wonder how they'll ever get over it. Mark and Jenn turned their grief into a desire to give back, to create a legacy for their daughter. They say they feel fortunate for how our staff cared for them, but I think we're the fortunate ones."

In one letter of nomination, a grateful patient wrote of Cogliano: "Joan didn't just take me on as a patient; she took my husband and unborn son as well. She understood that we're a family, and it wasn't just about me... She seemed to have an intrinsic understanding of my physical and emotional states and gave me what I needed, sometimes even before I knew I needed it."

This award is an opportunity for the Labor & Delivery team to be recognized and celebrated for their many talents and skills. Labor & delivery nurses help patients through one of the most memorable and intimate

times of their lives often earning an indelible place in the memories of the families they serve. And with 3,500 births at MGH annually, that's a lot of families.

Says clinical nurse specialist, Kathya Gavazzi, RN, "The Molly Catherine Tramontana award ceremony is one of my favorite days of the year."

For more information about this award, call 4-6369.



(Photo provided by staff)

Professional Achievements

McCormick-Gendzel appointed

Mary McCormick-Gendzel, RN, staff nurse, IV Therapy, was appointed, presidential advisor for the New England chapter of the Infusion Nurses Society, March 8, 2011.

Mulligan appointed

Janet Mulligan, RN, nursing director, IV Therapy, was appointed president of the New England chapter of the Infusion Nurses Society, March 8, 2011.

Mawn certified

Amy Mawn, RN, became certified as an adult clinical nurse specialist by the American Nurses Credentialing Center in March, 2011.

Stewart certified

Jean Stewart, RN, became certified as an adult clinical nurse specialist by the American Nurses Credentialing Center in March, 2011.

Baim presents

Margaret Baim, RN, nurse practitioner, MGH-Benson Henry Institute for Mind Body Medicine, presented, "Enhancing Resilience through Meditation," at the First Annual Northeast AHNA Conference, American Holistic Nurse Association, in Manchester, New Hampshire, March 25, 2011.

Ball presents

Stephanie Ball, RN, staff nurse, Emergency Department, presented, "The Lived Experience of a Trauma Nurse in Afghanistan," at the Spring, 2011, Education Program of the Eta Tau chapter of Sigma Theta Tau, in Salem, Massachusetts, April, 7, 2011.

Brown presents

Carol Brown, RN, nurse practitioner, Cardiac Unit, presented, "12-Lead ECG Interpretation: the Basics as Well as STEMI, LVH, Digoxin Effect, Takotsubo Syndrome and Pericarditis," at the Nurse Practitioner Meeting held at Beth Israel Deaconess Medical Center, March 10, 2011.

Olson presents

Gayle Olson, wellness coordinator, presented, "Body Composition Assessments and Sports Injury Consults," at the Lutheran Church of our Redeemer Health Fair in Foxborough, March 20, 2011.

Blanchard presents

Howard Blanchard, RN, clinical nurse specialist, Knight Center for Interventional Cardiovascular Therapy, presented, "Grading the Evidence: Education to Advance Innovations in Practice," at the 2011 Annual Conference of the National Association of Clinical Nurse Specialists, in Baltimore, March 10, 2011.

Barlow Gall presents

Gail Barlow Gall, RN, nurse practitioner, MGH Chelsea HealthCare Center, presented, "Access to Breast and Cervical Cancer Screening by Black Women in the Boston REACH 2010 Women's Health Demonstration Project," at the 23rd annual Scientific Session of the Eastern Nursing Research Society, in Philadelphia, March 25, 2011.

Mahony presents

Carol Harmon Mahony, OTR/L, occupational therapist, presented, "Cheiroarthropathy, the Limited Joint Mobility Associates with Diabetes Type I," at the Study of the Epidemiology of Diabetes Interventions and Complications meeting of the National Institutes of Health in Miami, March 3, 2011.

Carroll presents

Diane Carroll, RN, nurse researcher, presented the keynote address, "Evolution of the Nursing Research Program at Massachusetts General Hospital," at the Yale-New Haven Hospital Research Conference, in New Haven, Connecticut, March 17, 2011.

Carroll also presented, "The Continuum of Heart Failure," at the 23rd annual Scientific Session of the Eastern Nursing Research Society, in Philadelphia, March 24, 2011.

Bjarnason

and LaSala publish

Dana Bjarnason, RN, and Cynthia LaSala, RN, authored the article, "Moral Leadership in Nursing," in the *Journal of Radiology Nursing*, March 2011.

Roche presents

Constance Roche, RN, nurse practitioner, Surgical Oncology, presented, "Cancer Risk Counseling: Getting Started," and "Breast-Cancer Risk-Assessment: Beyond the Gail Model," at the Heredity Breast and Ovarian Cancer Conference in Las Vegas, March 12–16, 2011.

Silvestri presents

Sandra Silvestri, RN, clinical nurse specialist, presented, "Multi-Disciplinary Approach to Decreasing OR Positioning Injuries," at the Annual Congress of the Association of Perioperative Registered Nurses, in Philadelphia, March 22, 2011.

Stefancyk presents

Amanda Stefancyk, RN, nursing director, presented, "Value-Added Care," at the Aligning Forces for Quality Initiative in Wisconsin Dells, Wisconsin, March 25, 2011.

Hultman presents

Todd Hultman, RN, nurse practitioner, Palliative Care, presented, "The Role of Nursing in Palliative Care," at The National Palliative Care Summit at Jefferson University in Philadelphia, March 14, 2011.

Miller and Peltier-Saxe present

Kathleen Miller, RN, director of the Wellness Center; and Donna Peltier-Saxe, RN, special projects coordinator, at MGH Community Health Associates, presented, "Holistic Nursing Interventions for Chronic Disease in a Community Health Setting," at the First Annual Northeast AHNA Conference of the American Holistic Nurses Association, in Manchester, New Hampshire, March 25, 2011.

Levin honored

Barbara Levin, RN, received the Stryker Scholarship Award from the National Association of Orthopaedic Nurses in March, 2011.

Blakeney appointed

Barbara Blakeney, RN, innovation specialist, was appointed public policy fellow of the National Academies of Practice, in Washington, DC, March 25, 2011.

Tyksieski presents poster

Carol Tyksieski, RN, nurse practitioner, Hemodialysis Unit, presented her poster, "Patient Safety and Hemodialysis Catheters: Avoiding Medical Errors," at the 42nd National Symposium of the American Nephrology Nurses' Association, March 27–30, 2011.

Townsend presents

Elise Townsend, PT, physical therapist, presented, "Powered Standing Mobility in Boys with Duchenne Muscular Dystrophy," at the 27th International Seating Symposium of the Department of Health and Rehabilitation Sciences at the University of Pittsburgh, in Nashville, March 4, 2011.

Arroyo presents award-winning poster

Jacqueline Arroyo, RN, staff nurse, Main Operating Room, presented her poster, "Transapical Aortic Valve Implantation," at the 58th Congress of the Association of Perioperative Registered Nurses in Philadelphia, March 19, 2011. Her poster won the 2011 Clinical Excellence Award.

Team presents poster

Sandra Silvestri, RN; Jesse Ehrenfeld, MD; Maureen Hemingway, RN; Laurie Lynch, RN; Lisa Morrissey, RN; Kathleen Myers, RN; Charlene O'Connor, RN; and Jill Pedro, RN, presented their poster, "Multi-Disciplinary Approach to Decreasing OR Positioning Injuries," at the Annual Congress of the Association of Perioperative Registered Nurses, in Philadelphia, March 19–24, 2011.

Announcements

Blum Center events

Book Talk:

The Love Response
Monday, May 9, 2011
presented by
Eva Selhub, MD

National Health Observances
Series:

"Preventing and Treating Stroke"
Thursday, May 12, 2011
presented by
Mary Amatangelo, RN

Healthy Living Series:

"Managing High Blood Pressure"
Tuesday, May 31, 2011
presented by
Claire Lamorte, RN, and
Deb Krivitsky RD

All events held in the Blum
Center from 12:00–1:00pm

For more information,
call Jen Searl at 4-3823.

Senior HealthWISE events

Lecture Series

"The Driving Decision"
Thursday, May 19, 2011
11:00am–12:00pm
Haber Conference Room
Speaker: Michele Ellicks,
Community Outreach
Coordinator, Registry of Motor
Vehicles

Book Club

Thursday, May 19, 2011,
3:00–4:00pm,
West End Library
*Always Something Doing: Boston's
Infamous Scollay Square*
by David Kruh
Light refreshments provided

Hypertension Screening
Monday, May 23, 2011
1:30–2:30pm

West End Library
Free blood pressure check

For more information,
call 4-6756.

Neuroscience Nurse Week

May 15–21, 2011, is National
Neuroscience Nurse Week. MGH
neuroscience nurses will staff a
stroke-education table in the Main
Corridor on May 17th.

For information, call 6-5298.

Nursing Grand Rounds

"Save Our Skin" a Strategic
Imperative and Hospital-Wide
Campaign to Eliminate Hospital-
Acquired Pressure Ulcers

May 19, 2011
1:30–2:20pm
O'Keeffe Auditorium
For more information,
call 6-5334.

AMMP scholarships

Applications available on-line

Starting in the fall, the MGH
Institute of Health Professions
(IHP) will partner with the AMMP
Scholarship Program to offer a
three-credit scholarship. Awardees
are required to volunteer a
minimum of 20 hours at the IHP.
Scholarship is available in Nursing,
Physical Therapy, and Speech-
Language Pathology.

For more information,
call 4-4424.

Support Service Employee Grant

Applications are now available.
Deadline for applications is
Wednesday, June 1, 2011.

The Support Service Employee
Grant Program provides an
opportunity for eligible employees
to receive up to \$1,500 toward
the cost of continuing education.
Applicants must be employed at
MGH for a minimum of two years
and meet eligibility requirements.

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

2011 MGH College Fair

Representatives from local
colleges will be at MGH for the
annual MGH College Fair

May 11, 2011
12:00–3:00pm

Under the Bulfinch Tent

For more information,
call 4-3368.

An Ounce of Prevention

a women's health fair

MGH and the department of
Obstetrics & Gynecology are
celebrating National Women's
Health Week by sponsoring
An Ounce of Prevention,
a day-long health fair with
opportunities to learn how
to stay healthy throughout
the life cycle.

Providers will be on hand
to answer questions.

Door prizes will be raffled off.

May 11, 2011
8:00am–4:00pm

Under the Bullfinch tent

For information, call 3-5420.

National Neuropathy Week

May 16–20, 2011

The Neuromuscular Diagnostic
Center will host a booth

Thursday May 19th
8:30am–4:00pm

in the Main Corridor

Learn about carpal tunnel,
peripheral neuropathy, ALS, CIDP,
small-fiber neuropathy, cervical or
lumbar radiculopathy, and other
muscle and nerve diseases.

For more information,
call 4-7013.

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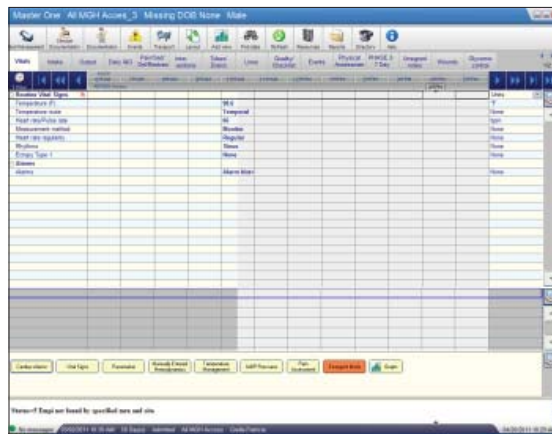
May 26, 2011

Preparing for the Electronic Medical Record

—by Pat Grella, RN, and Gino Chisari, RN

Beginning in 2012, the Electronic Medical Record, also called Acute Care Documentation (ACD), will be introduced in the patient-care setting.

When it comes to planning a comprehensive project such as the roll-out of the Electronic Medical Record (EMR), good communication is key. Beginning in 2012 (which is closer than you think!) the Electronic Medical Record, also called Acute Care Documenta-



tion (ACD), will be introduced in the patient-care setting. As clinicians, we're already familiar with some components of the Electronic Medical Record from logging on to POE, the Discharge Module, and EMAR.

Traditionally, documentation of patient care has been discipline-specific, such as nurses' progress notes, physical therapy notes, physicians' notes, and nutritional notes, etc. With e-charting, documentation is patient-specific, as it should be. E-charts allow clinicians to share information with colleagues without the need for green books or gray charts.

E-charting promotes inter-disciplinary communication, which contributes to a more coordinated delivery of high-quality, patient-centered care. With e-charts, clinicians are able to make up-to-the-minute, informed decisions having comprehensive information at their fingertips.

You'll hear more about e-charting in the coming months and learn how this innovative technology will improve and streamline the documentation of patient care. For more information, call 3-6530.



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