

Car^{ing}

Headlines

June 14, 2012

Quiet Time



When it comes to the well-being of their patients, staff on the White 7 Surgical Unit take newly implemented Quiet Time very seriously. See story on page 8.

Nursing Documentation

*Making sure we're all on the
same page*

We document care to ensure consistency and a clear understanding among caregivers of the interventions we've provided and the plan of care we intend based on patients' responses. In order to do that effectively, we all need to be 'on the same page,' so to speak.

Documentation has evolved over the years along with our efforts to improve care, our changing knowledge of health conditions and treatments, and continual advancements in technology, both biomedical and administrative. But the *reason* we document care has not changed. We document care to ensure consistency and a clear understanding among caregivers of the interventions we've provided and the plan of care we intend based on patients' responses. In order to do that effectively, we all need to be 'on the same page,' so to speak.

We take great care in monitoring and evaluating our documentation processes, always looking for ways to improve and/or streamline the work to make care more efficient. During a recent mock survey, we discovered some inconsistencies in the way clinicians were using the Problem/Outcome/Intervention sheet. This form was originally created to identify, update, and resolve active nursing problems. The mock survey showed a disparity in completion rates and in how forms were being used as a care-planning tool.

After a thoughtful review, and in light of the fact that we'll soon be transitioning to an electronic medical record, an interim plan was developed. Effective immediately, Problem/Outcome/Intervention sheets are considered guiding or reference documents only. They are not required to be included in the medical



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

record. Going forward, Progress Notes are the primary source of information for all care-planning activities. Progress Notes should contain the identified interventions, the patient's responses to the interventions, and the plan of care for resolution. The overall process should look like this:

- Step 1: Complete the Nursing Data Set upon admission
- Step 2: Develop an individualized plan of care using Problem/Outcome/Intervention sheets as a reference
- Step 3: Document the plan in Progress Notes
- Step 4: Continue to use Progress Notes to update the patient's plan of care, including responses to interventions and progression toward goals
- Step 5: Final Progress Note should reflect the discharge plan of care

To avoid disparities and inconsistencies in documentation, it's very important to use the most current version of documentation forms. Forms change period-

continued on next page

ically to reflect updates or changes in practice, so it's a good idea to check in with the PCS Office of Quality & Safety (3-0140) at regular intervals to make sure the forms you're using are current.

Also of note, the Nursing Data Set now includes questions related to a patient's risk for suicide. The impetus for this is that suicide has ranked in the top five events most frequently reported to The Joint Commission since 1995, and many patients who kill themselves in general hospitals are not in psychiatric units nor do they have a history of attempted suicide.

To help reduce the risk of suicide on general care units, clinicians need to be able to distinguish between long-term, established risk factors and certain behaviors that could be considered 'red flags' for the potential to attempt suicide. The questions that have been added to the Nursing Data Set are intended to help clinicians recognize these warning signs.

Non-Behavioral Restraint Stickers have been revised to read, "Restraint on patient evaluated *minimally* every two hours." Prior language stating patients were evaluated every two hours didn't reflect the individual-

ized nature of the assessment. Adding the word, 'minimally,' reflects a more patient-specific approach, indicating nurses will evaluate the patient at whatever frequency the patient may need, not exceeding two-hour intervals.

And finally, Nursing Flow Sheets have been updated to include the normal reference ranges for blood glucose.

I'd like to thank all the individuals who were instrumental in identifying these inconsistencies, who acted quickly to make revisions, and who are helping to communicate these changes to staff. Precise documentation and up-to-date medical records are the lynch pins of effective communication among caregivers. And like everything else in health care, documentation is a dynamic, evolving process that demands our constant attention and vigilance.

Update

I'm pleased to announce that Arlene Kelleher, RN, has assumed the position of nursing director for the Pediatric Intensive Care Unit.

Precise documentation and up-to-date medical records are the lynch pins of effective communication among caregivers. And like everything else in health care, documentation is a dynamic, evolving process that demands our constant attention and vigilance.

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The Clinical Leadership Collaborative for Diversity in Nursing

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care

On April 25, 2012, the Clinical Leadership Collaborative for Diversity in Nursing (CLCDN), a partnership between Partners HealthCare and the UMass-Boston, College of Nursing and Health Sciences, held its annual educational event. Presentations

focused on coping skills, attitudes about inclusion, and imparting knowledge and skills to help students, advanced practice nurses, and mentors flourish in a non-majority environment.

Oswald 'Oz' Mondejar, vice president for Human

Resources, Community Relations, and Communications for Partners Continuing Care, spoke about his own childhood and career in a compelling narrative about strategies he used to be accepted. A Cuban immigrant born with no right hand and a deformed left hand, Mondejar spoke about having to adjust to the culture you're working in without losing your sense of identity, without losing your sense of self.

Juan Nunez, chief diversity officer for the Office of Diversity and Inclusion at UMass-Boston gave a quiz on inclusion that most members of the audience failed. He described a number of strategies for promoting diversity in the workplace, noting that diversity training is just a small part of an overall diversity

plan. Nunez made no distinction between attitudes related to disability, race, class, and gender. He referred to the totality of individuals who are unfairly excluded from industries and endeavors. It was a good reminder for healthcare organizations to do the same.

The evening allowed mentors to renew their relationships with students, create new and expanded networks, and share plans and ideas for the future. MGH is a key supporter of the CLCDN and has hired a number of graduates from the program. For more information, call Gaurdia Banister, RN, executive director, The Institute for Patient Care, at 4-1266.

Below: Juan Nunez, chief diversity officer, Office of Diversity and Inclusion, UMass-Boston, speaks at CLCDN event.

At right: (seated l-r): CLCDN students, Nikia Roberson, Phoi Ly Kit, Yee Chong (back row); Cindy Anilus (guest), Fariyda Mulrain, and Serina Pen.



(Photos provided by staff)

CLCDN and NERBNA team up to support community health

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care

On May 10, 2012, the Clinical Leadership Collaborative for Diversity in Nursing (CLCDN) and the New England Regional Black Nurses Association (NERBNA) joined forces with the Boston chapter of Links, Inc., to launch a three-year project with the Martin Luther King, Jr., K-8 School in Dorchester. The program, called, Fit for the King: a Health and Wellness Project, will offer comprehensive fitness, nutrition, and wellness programs for the King School community designed to promote healthy living for students and parents alike.

Studies show that black and Latino residents experience higher levels of chronic disease, mortality, and

poor health outcomes than white residents. At the May 10th event, diverse nurses and students provided blood-pressure screening, vision testing, glucose testing, health assessments, and teaching for residents who attended. Minnie Baylor-Henry, worldwide vice president for Regulatory Affairs at Johnson & Johnson, was thrilled to see the long line of residents interested in health screenings.

Carol Johnson, superintendent of Boston Public Schools, was impressed with the number of nurses willing to volunteer their time to make a difference in this community. And make a difference, they did. The CLCDN and NERBNA are committed to addressing the needs of diverse communities and to developing diverse leaders for the challenges that lay ahead.

For more information, call Gaurdia Banister, RN, executive director, The Institute for Patient Care, at 4-1266.

The CLCDN and NERBNA join forces to promote health and wellness in the community.



(Photo provided by staff)

PCS Inter-Disciplinary Advisory Committee

—by Michael Sullivan, PT, director of Physical and Occupational Therapy,
and Kevin Whitney, RN, associate chief nurse, on behalf of the PCS Executive Committee

In times of change, the need for clear, consistent communication is paramount. To augment existing communication vehicles, we will be implementing a PCS Inter-Disciplinary Advisory Committee comprised of representatives from all the PCS disciplines.

During the fall and winter of 2011, as the Patient Care Services Executive Committee was developing its 2012 strategic plan, it was clear that health care was experiencing unprecedented change. As we speak, many of our colleagues are involved in projects to make care more affordable, while others are working to re-design care-delivery. Both are initiatives that emerged from our strategic planning process.

In times of change, the need for clear, consistent communication is paramount. To augment existing communication vehicles, Patient Care Services will be implementing an Inter-Disciplinary Advisory Committee comprised of representatives from all the PCS disciplines: Nursing, Respiratory Care, Social Work, Physical Therapy, Occupational Therapy, Speech-Language Pathology, Chaplaincy, and Medical Interpreters. And Case Management will also be represented.

The goal of advisory committees is to inform and be informed by staff. To help facilitate this process, guiding principles were established for the Inter-Disciplinary Advisory Committee. They are:

- to provide a routine and on-going forum for PCS staff to identify issues important to their practice
- to provide a forum for communication about organizational changes affecting PCS staff and patient care
- to promote and invigorate inter-disciplinary collaboration and effectiveness in patient care, education, research, and community outreach
- to further engage staff in initiatives that promote and sustain regulatory readiness (Excellence Every Day)

As health care continues to evolve, our ability to provide patient-centered care will be essential, and teamwork is a key element of seamless, coordinated care. The strength of Patient Care Services is the diversity and depth of talent we possess among all our clinical disciplines. These diverse professional experiences provide an array of perspectives on issues that impact clinical practice, professional development, and personal fulfillment. The PCS Inter-Disciplinary Staff Advisory Committee will provide a forum for communication among PCS leadership and clinicians and enhance inter-disciplinary collaboration and discussions.

In the coming months, where they have not previously existed, departmental advisory committees will be formed. Each department will establish a framework consistent with its organizational structure and philosophy and meet monthly. The PCS Inter-Disciplinary Advisory Committee will be comprised of members of each departmental advisory committee. It will meet quarterly in January, April, July, and October. Meetings will be chaired by senior vice president for Patient Care, Jeanette Ives Erickson, RN.

We are engaged in important work. Patient Care Services has long been at the forefront of change within the organization. Through feedback and practice, PCS staff influence the direction of our quality and safety initiatives and the care we provide. Departmental and inter-disciplinary advisory committees will be a valuable tool in keeping both staff and leadership informed and engaged in this important work.

For more information about the PCS Inter-Disciplinary Advisory Committee, call 6-3100.

Riding for Beth, MGH, and a cure

—by Georgia Peirce, project manager

Lots of MGH clinicians go the extra mile for their patients and families. But going an extra 180 miles—that's something else again. This month, MGH nurse, Kristin Beauparlant, RN, will bicycle from the White Mountains of New Hampshire, 180 miles to the coast to honor the dying wish of a former patient. Her inspiration, Elizabeth 'Beth' Bennett Rice, was a vibrant woman diagnosed with a rare and aggressive cancer in 2005. Even before being diagnosed, Bennett Rice had been a long-standing participant in the 190-mile Pan Mass Challenge, the

country's largest sports-related cancer fund-raiser. She knew the cure would one day be found through research and education.

As Bennett Rice's disease progressed, she spent many hours in her hospital bed at work on her laptop computer. She envisioned an organization that would benefit research and education at MGH—she envisioned the 'Madam Ovary Foundation.' And now, three years after her death, her vision is a reality.

June 15–17th, in a fitting inaugural event, Bennett Rice's nurse, Kristin Beauparlant, and her husband, Peter, will bike the 180-mile route through New Hamp-

Below left: Beth Bennett Rice and her husband, Peter
Below right: Kristin Beauparlant, RN, prepares to ride with Beth's bike.

shire to raise money for the foundation she created. The money they raise will help fund research in ovarian cancer at MGH.

As an added tribute, Beauparlant will make the journey riding Bennett Rice's bicycle. Husband, Peter, will carry his wife's signature pearl necklace, the one she wore on so many other charity rides over the years.

For more information or to check their progress, go to: www.madamovary.org.



(Photos provided by staff)

Quiet Time

White 7's journey to implement dedicated hours for rest and healing

—by Keith Marple, administrative fellow

“Unnecessary noise is the most cruel abuse of care which can be inflicted on either the sick or the well.”

—Florence Nightingale, *Notes on Nursing*, 1859

At 2:00pm, Capodilupo dimmed the lights. The change was dramatic. Noise at the nurses' station and disruptions in patients' rooms dropped significantly. Staff had a chance to catch up on documentation, and patients slept peacefully.

As Theresa Capodilupo, RN, White 7 nursing director, Keith Marple, administrative fellow, and Sally Morton, RN, attending nurse, reviewed their patient-satisfaction data, one number jumped out. 28%. That was the percentage of patients who described the unit as quiet at night. No one was surprised.

Morton and Marple reviewed the literature. They found evidence that hospital noise reduces sleep quality, raises blood pressure, and impedes wound-healing. They found a number of interventions—some feasible (door maintenance, TV headphones), some not so feasible (building re-design, private rooms).

They consulted Rick Evans, senior director of Service Improvement, who advised them to implement Quiet Time. Marple met with Lori Pugsley, RN, nursing director of OB, where Quiet Time had already been implemented with favorable results.

Pugsley explained that Quiet Time involves:

- dedicated hours for patients to rest (in the afternoon and evening)
- 'cluster care' before or after Quiet Time, unless otherwise medically necessary
- dimmed lights
- closed doors when possible
- library voices
- hallway signage
- emergency-only overhead paging

As Capodilupo, Morton, and Marple began to explore options for dedicated Quiet Time, there didn't seem to be a two-hour time slot where they could meet all the criteria. Northeastern student intern, Bryan Jones, counted 360 entrances to patient rooms between 2:00 and 4:00pm.

They began to get discouraged, but Pugsley confided, “We had trouble finding the right time too. Don't let perfect be the enemy of good.”

They revised their plan. They would try Quiet Time from 2:00–4:00pm and through the night. They couldn't guarantee un-interrupted rest, but they could do everything in their power to make the environment quieter.

On April 24, 2012, they went live. Operations managers, Jim Travers and Awilda Del Valle, re-worked the pager process to reduce overhead calls. Marple designed and posted signs. Capodilupo introduced a hand signal to remind folks to keep noise to a minimum.

At 2:00pm, Capodilupo dimmed the lights. The change was dramatic. Noise at the nurses' station and disruptions in patients' rooms dropped significantly. Staff had a chance to catch up on documentation, and patients slept peacefully.

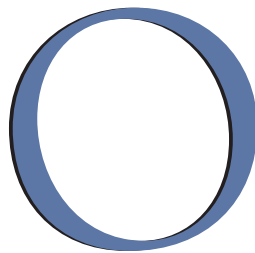
“It really is like a library,” said patient care associate, Farah Andre.

Quiet Time is part of the culture now on White 7. “Some days are quieter than others,” says Capodilupo, “but it's much better than it was. We'll continue to look for ways to create a more restful and healing environment for patients and families on White 7.”

For more information, call administrative fellow, Keith Marple at 857-225-1655.

Clinical Ethics Residency for Nurses

—by Ellen M. Robinson, RN clinical nurse specialist in Ethics



On May 3, 2012, at a special reception in their honor, 17 MGH nurses, six BWH nurses, one North Shore Medical Center nurse, and a faculty member from the University of Tennessee Medical Center in Knoxville, received certificates for completing the

2011-2012 Clinical Ethics Residency for Nurses (CERN).

This innovative program is designed to increase the number of registered nurses possessing specialized knowledge, skill, and competency in clinical ethics so they can be more effective facilitators of ethics rounds, participate on ethics committees, and begin to learn skills in ethics consultation.

At right:
members of the
CERN Project Team
Below: 2012
CERN graduates

Since the program began in 2010, feedback has been very positive, with nurses reporting increased knowledge, skill, and comfort in talking with patients, families, and colleagues about difficult ethical issues.

The CERN program is possible through a grant from the US Department of Health and Human Services Division of Nursing and is based in The Institute for

Patient Care Ethics Program. The Knight Nursing Center, Simulation Center, and The Yvonne L. Munn Center for Nursing Research also provide support for this program. Ellen Robinson, RN, clinical nurse specialist in Ethics, is project director, and

collaborating faculty come from the Clinical Pastoral Education Program, the MassGeneral Hospital for Children, the Boston College William F. Connell School of Nursing, and the BWH Clinical Ethics Service.

Applications are now being accepted for the fall CERN program (see page 19 for details). For more information, call 6-1854.



(Photo by Paul Batista)

Five minutes in the ED

Sometimes, that's all it takes

I received a call from the triage nurse letting me know that a patient was coming directly back to Urgent A without being evaluated by a screening physician because she was being loud, uncooperative, and was under the influence of alcohol.

My name is Hilary Levinson, and I am a staff nurse in the Emergency Department. Five minutes. 300 seconds. One twelfth of an hour. A moment in time. Sometimes, that's all a nurse has to make a decision about a patient's care. Sometimes, five minutes feels like a lifetime; sometimes like the blink of an eye, hardly enough time to make a difference in the life of a patient.

It was a busy Monday, and I was the throughput nurse in Urgent A. Urgent A is a 16-room treatment area in the ED where patients with various medical and surgical conditions are cared for. One of the responsibilities of the throughput nurse is to ensure the area runs 'like a well oiled machine,' which isn't always easy when it's busy. About five minutes before the end of my shift, I received a call from the triage nurse letting me know that a patient was coming directly back to Urgent A without being evaluated by a screening physician because she was being loud, uncooperative, and was under the influence of alcohol.

It was my responsibility to determine where this patient would receive care. I knew we had no 'official beds' available. I could use a hallway stretcher to initiate care. It wasn't an ideal option for a loud patient under the influence of alcohol. Over-stimulation would certainly be an issue. But sight unseen, these were the 'knowns' in a multitude of unknowns.

Within seconds, the patient was brought back by a team of EMTs. I saw a very distraught Hispanic woman,



Hilary Levinson, RN, staff nurse,
Emergency Department

53 years old, crying and intermittently telling the EMTs (and everyone else) to go away and leave her alone. She spoke loudly. She cried. She rambled about wanting to be with her son, wanting to see him again, she missed him. The EMTs informed me that they'd been called to a bar where it was presumed the patient, AR, had had a seizure. She was sitting on the floor beside a bar stool, crying. Witnesses said she never lost consciousness; there was no indication she had hit her head. She acknowledged she had epilepsy and was diabetic. But she wasn't incontinent, and there was no sign of oral trauma, both side-effects that can occur with seizures.

I wasn't convinced AR had had a seizure. But she had been found on the floor, so ensuring there was no acute injury was a priority. Her eyes met mine. I held her hand. I told her my name was Hilary, that I was a nurse, and I was going to try my best to help her. The EMTs reiterated that she was intoxicated, emotionally distraught, and intermittently angry. I assumed responsibility for AR, and the EMTs left her in my care.

continued on next page

The five people you meet in Heaven, by Mitch Albom... has become a guiding principle for the care I provide. I've been given the opportunity to care for people at the most vulnerable times, and everything I do, everything I say, can change their lives.

"Hilary. Like Clinton, right?" she said. "That's how I'll remember you. They took my son. The streets took my son. You'll bring him to me, right? I need you to bring him to me. I miss him so much."

She said those words over and over, her hand squeezing mine, her eyes locked on mine. What could I say? I couldn't bring her son back (if, indeed, he was dead). Maybe he was missing, or a runaway. Losing a child is unfathomable. If it was sudden or violent, I could only imagine the torment she must be going through. I had to ask. I didn't know how she'd respond, but I would deal with that as it came.

AR stopped crying and looked at me. She said the streets had taken her son. Drugs. He had died three months ago. His birthday was tomorrow. My response was slow to come. I apologized. I'm so sorry for your loss. I empathized. I've never lost a child. I can imagine how painful this must be.

She nodded, then went back to her mantra: "They took my son; you'll bring him back, right? I can't do this any more."

I needed to be supportive, but honest. I repeated what she said. Then I replied, "If the streets took your son, there's no way I can bring him back. Right?"

"You are right," she said softly. She brought my hand to her chest. "But it pains me so much, you know. I miss him so much." And the tears began again.

"I understand. I can see how sad you are, how much you miss him. But you have him in your heart, in your soul. You carry him with you always."

She thought about this and through her tears, said, "I know, but I miss him. Can you help me bring him back?"

I told her I couldn't bring him back, though I wished I could. Soon, she needed to use the bathroom, and I helped her with this basic need. I saw that she had bruises on her legs and torso. This would need to be addressed, too, but not just yet. I asked AR if drinking helped her deal with the loss. She said it does at the time, but ultimately it just makes her feel worse. I told her we could work together to find better ways to deal with this traumatic loss. But first, I needed to make sure she was safe.

"AR, are you so sad that you want to hurt yourself?" I said.

"Maybe," she said. "I'm not sure."

I knew that until she was sober, we had to keep her safe, and I needed to get the attending physician to determine whether she needed to be 'sectioned' (a legal classification that allows us to keep her against her will for her own safety if the need arises). Although she was under the influence, she was able to listen and follow directions. It didn't appear she'd had a seizure. I assessed her cervical neck by palpating for pain. The bruising would need attention. And her alco-

hol abuse needed to be addressed. With all that, I needed to let AR know it was likely she'd be in the ED for a few hours, if not longer. In my experience, not having a clear expectation can cause frustration, which can escalate bad behavior. I kept it simple. I told her she'd need to change into hospital pajamas, blood would need to be drawn, and some other caregivers would be in to talk with her about the things she had told me.

"You won't be my nurse?" she said.

"Unfortunately, I won't. But someone will help you."

"But not you? That makes me sad."

I assured her there were many good people to help her. It would be okay.

My interaction with AR probably lasted five minutes. The incoming nurse arrived, and I introduced her to AR. AR took my hand, put it to her chest and said, "Thank-you."

A tear fell from my eye. I smiled and, said, "No. Thank-you."

Though this was just a five-minute interaction, I believe the impact may last much longer. The nurse who assumed responsibility for AR came to me the next morning to tell me how much AR had talked about Hilary. "You know, Mrs. Clinton, the nurse." At the time, we don't think we're having an impact on patients. But I think many people hold on to the words we say, and the impact can be profound.

In the book, *The five people you meet in Heaven*, Mitch Albom talks about the people you meet and the impact you have on them without ever really knowing. It has become a guiding principle for the care I provide. I've been given the opportunity to care for people at the most vulnerable times, and everything I do, everything I say, can change their lives.

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

The knowns and unknowns. Intoxication. Seizure. Grief. What the patient is saying versus what she really means. And all of this processed by a nurse... in minutes. As Hilary (Mrs. Clinton!) well knows, the lines between intuition and skill blur, and you act on instinct—on the years of experience that brought you to this patient and this situation. Hilary's expertise is visible in every intervention, every pointed question, every caring gesture. I have no doubt that the five minutes Hilary spent with her will be remembered by AR for a long time to come.

Thank-you, Hilary.

Symptoms of Pulmonary Artery Hypertension

—submitted by the Research & Evidence-Based Practice Committee

On March 28, 2012, the Research & Evidence-Based Practice Committee Journal Club hosted nurse scientist, Annette McDonough, RN, who presented her original research on, “The Symptom Experience of Pulmonary Artery Hypertension: a Qualitative Descriptive Study,” published in 2011 in *Clinical Nursing Research*. The study revealed specific concerns related to the symptom experience of pulmonary-artery-hypertension patients and how they re-define their lives to accommodate these symptoms.

Annette McDonough, RN (right), presents at recent meeting of the Research & Evidence-Based Practice Committee Journal Club.

Pulmonary artery hypertension is a disease that affects an estimated 100,000 people in the United States. Research has focused on treatment to slow disease progression and increase survival time, but limited research has been conducted on the symptom experience of patients living with the condition. The most common symptoms of pulmonary artery hypertension are shortness of breath, dyspnea with exertion, and fatigue.

Two major themes emerged from the study: coping with uncertainty and adapting to a chronic illness. Participants described coping mechanisms such as using the Internet to learn more about the disease, making memories with family, having a sense of humor, relying on spirituality, and participating in support groups.

Study participants described oxygen therapy as ‘more burdensome than intravenous medications.’

The study identified two overarching themes: holding back and re-defining life. Holding back encompassed the sub-themes: fear, anticipation of worsening symptoms, and treatment effects. Shortness of breath impacted every aspect of patients’ lives including the need to hold back or take it slow.

The study provided insight and greater understanding of the effects that symptoms have on health outcomes. It also provides a basis for larger, quantitative studies to examine the extent of symptom impact on daily life.

For more information, contact Laurene Dynan, RN, at 4-9879.



(Photo by Paul Batista)

Jill Nelson Burke, NP, Advanced Practice Nursing Award

Award recipient, Michelle Knowles, RN (center right) with (l-r): Debra Burke, RN; Noopur Raje, MD; Terry McDonnell, RN; Jill Nelson Burke, RN; Andrew Zhu, MD; Mara Bloom; and David Ryan, MD.

On April 26, 2012, members of the MGH Cancer Center and Patient Care Services gathered to celebrate the inaugural presentation of the Jill Nelson Burke, NP, Advanced Practice Nursing Award to Michelle Knowles, APRN, a nurse practitioner in the Tucker Gosnell Center for Gastrointestinal Cancers. Said Jill Nelson Burke, NP, after

whom the award is named, "I eat, breathe, and live nursing. Thank-you for this honor."

Funded by a grateful family, the award was created to recognize oncology nurse practitioners who provide exceptional care and support while pursuing clinical research and continuing-education opportunities. The award will be given annually.

Says Terry McDonnell, NP, nurse director of clinical practices for the Cancer Center, "It's fitting that this award was named for someone with a heart of gold, and

the first recipient has a heart of gold, too."

David Ryan, MD, clinical director of the the Cancer Center and associate chief of Hematology/Oncology; Noopur Raje, MD, director of the Center for Multiple Myeloma and Burke's collaborating physician; and Andrew Zhu, MD, medical oncologist in the Tucker Gosnell Center for Gastrointestinal Cancers and Knowles' collaborating physician, spoke at the event.

For more information, call Michelle Fileteau at 4-6410.



(Photo by Joe Ferraro)

Organ and tissue donation

Some recent changes to the Uniform Anatomical Gift Act

UAGA stands for Uniform Anatomical Gift Act. It is the law that governs organ and tissue donation, and it's an important legislation in terms of helping increase organ and tissue donation and make laws related to donation more uniform.

Question: What is the UAGA?

Jeanette: UAGA stands for Uniform Anatomical Gift Act. It is the law that governs organ and tissue donation, and it's an important legislation in terms of helping to increase organ and tissue donation and make laws related to donation more uniform. In February of 2012, revisions to the UAGA were signed into law in Massachusetts.

Question: What has changed?

Jeanette: One of the most significant changes is the delineation of decision-makers in cases where the patient is not a registered donor. If a patient is not a registered organ donor, the decision to provide consent falls to the healthcare proxy. If there is no healthcare proxy, the decision fall to the following people (in this order):

- spouse
- adult child
- parent
- adult sibling
- adult grandchild
- grandparent
- adult who exhibited special care and concern for the deceased person
- person who was acting as a guardian of the deceased person at the time of death
- any other person having the authority to dispose of the deceased person's body

Other changes decrease some of the technical and procedural barriers in hopes that more people will become organ and tissue donors. Education will be offered at the Registry of Motor Vehicles and in driver education classes to encourage enrollment as organ donors.

And as with previous versions of the law, an individual's decision to donate his/her organs or tissues after death does not require the consent or agreement of any other individual after the donor's death.

Question: When a potential organ donor dies, who should talk to the family about organ donation?

Jeanette: According to our Organ and Tissue Donation Policy, MGH staff should work in collaboration with staff from the New England Organ Bank to discuss donation options with family members.

Question: What educational efforts for clinicians are underway at MGH?

Jeanette: Kristin Calheno, RN, in-house coordinator for the New England Organ Bank, provides training to a number of units on a quarterly and/or annual basis. Additional education for nurses is available through HealthStream.

For more information about organ and tissue donation, contact Kristin Calheno at: kristin_calheno@neob.org.

Changes to the CRP portfolio

Responding to feedback about how to improve the Clinical Recognition Program application process

The Tiger Team was asked to make recommendations as to what changes could be made to alleviate these concerns while still balancing the need for sufficient evidence of the applicant's level of practice.

Question: I read in a recent issue of *Caring Headlines* that there are going to be changes to the portfolio requirements for advanced clinicians and clinical scholars. What led to those changes?

Jeanette: You may recall that we surveyed clinicians throughout Patient Care Services, and we learned a lot about their perceptions of the Clinical Recognition Program application process. For instance, we learned that some respondents felt the application portfolio required too much paperwork. In response to this feedback, a Tiger Team was formed comprised of clinicians and leadership from all six disciplines representing three of the four levels of practice (clinician, advanced clinician, and clinical scholar). The Tiger Team was asked to make recommendations as to what changes could be made to alleviate these concerns while still balancing the need for sufficient evidence of the applicant's level of practice.

Question: What changes were made?

Jeanette: The Clinical Recognition Program Steering Committee with the approval of the Clinical Recognition Program Review Board made the following changes:

- Three letters of support will be required for those applying to be advanced clinicians and clinical scholars (currently four letters of support are required for those applying to be clinical scholars)

- For both levels, one letter of support must be written by a member of leadership within the applicant's own discipline
- For Nursing, the letter of support required from outside the clinician's discipline has been expanded to include: nurse practitioners, nurse midwives, psychiatric clinical nurse specialists, and nurse anesthetists.

Question: Going forward, what needs to be included in the portfolio?

Jeanette: Effective September 1, 2012, portfolios for advanced clinicians and clinical scholars must include:

- a cover letter
- a clinical narrative
- your resume
- the endorsement of your director
- two (2) letters of support from within your discipline; one of those letters must be written by unit or department leadership
- one (1) letter from outside your discipline, which for nursing applicants may include the roles listed above

Question: How can I get more information about the Clinical Recognition Program and these changes?

Jeanette: For more information, go to the website: <http://www.mghpcs.org/IPC/Programs/Recognition/Index.asp>, or send e-mail to: PCSClinRec@partners.org.

The My Giving Helps Campaign

Combining efforts to support the MGH Fund and the United Way

In September, the MGH Fund and United Way campaigns will be combined into one effort, called: My Giving Helps: the MGH Fund + United Way... We wanted to support and celebrate the culture of philanthropy at MGH and at the same time make the process of donating easier and more streamlined.

Question: I've heard that the hospital is combining efforts to raise awareness about the MGH Fund and the United Way. How did that come about?

Jeanette: That's right. In September, the MGH Fund and United Way campaigns will be combined into one effort, called: My Giving Helps: the MGH Fund + United Way. I'm co-chairing the My Giving Helps Campaign along with my colleagues, Bill Banchiere, Scott Gazelle, MD, James Heffernan; Bonnie Michelman; and Stephanie Moore, MD. We wanted to support and celebrate the culture of philanthropy at MGH and at the same time make the process of donating easier and more streamlined.

Question: How does it work? Are people being asked to give to both organizations?

Jeanette: While a donation to both the MGH Fund and the United Way would be a meaningful way to help people, you may donate to one, the other, or both, in any amount you choose. Whatever you decide to do, your participation will be greatly appreciated.

Question: If I choose to support the MGH Fund, how will that money be used?

Jeanette: A gift to the MGH Fund provides unrestricted dollars that may be used in any clinical area of the hospital. Hospital leadership uses the MGH Fund to support research, improve safety and patient care, and foster healthcare initiatives locally, nationally, and internationally. Gifts to the MGH Fund allow us to respond quickly to pressing needs and seize opportunities to benefit our patients.

Question: And the United Way; how will that money be used?

Jeanette: A gift to the United Way supports more than 100 organizations in and around the Boston area. These organizations provide crucial services for children and families in need, many of who are our patients or colleagues. No other organization brings together with private foundations and an extensive network of volunteers working toward a common vision of helping people.

Question: Is there anything else we should know?

Jeanette: If you're interested, there are many opportunities to get involved with the campaign. To find out more, or to become a My Giving Helps champion, go to: massgeneral.org/mygivinghelps.org to sign up on-line.

The proper disposal of medications

Question: I understand there have been some changes regarding the disposal and handling of certain medications. Can you tell us more about that?

Jeanette: Yes, we're always looking for ways to make the patient-care environment safer, and improving our handling of hazardous medications is one way to do that. Hazardous medications require special handling and disposal. We've divided these meds into three groups, or tiers, and each tier has specific personal protective equipment (PPE) requirements:

- Tier I (IV medications): one or two pairs of long-cuffed, purple, nitrile gloves and non-absorbent, long-sleeved, disposable gown. A face shield should be worn if there's a risk of splash. An N-95 respirator must be worn to clean up spills
- Tier II (oral liquid medications): one or two pairs of long-cuffed, purple, nitrile gloves and non-absorbent, long-sleeved, disposable gown. A face shield should be worn if there's a risk of splash. An N-95 respirator must be worn to clean up spills. G-tube administration requires j-tip connector and blue chux
- Tier III (solid capsules, tablets, creams, ointments, and eye drops): one or two pairs of long-cuffed, purple, nitrile gloves (wear two pairs for ointments, creams, and eye drops). Do not crush, open, or dissolve capsules or tablets

Hazardous medications and hazardous waste should be disposed of in the appropriate receptacle (red, yellow or black) according to patient-specific pharmacy labels, the Pharmaceutical Waste Disposal Grid, and other guidelines. We will be updating the Pharmaceutical Waste Disposal Grid soon.

Question: What's the correct way to dispose of non-hazardous medications?

Jeanette: Staff should be aware of the proper receptacles for disposing of medications.

For disposal in sinks or drains:

- Normal saline (+/- electrolytes with no other medication additives)
- Dextrose solutions (+/- electrolytes with no other medication additives)

- Lactated ringers with or without dextrose (with no other medication additives)
- CVVH fluid (with no other medication additives)
- Hemo/peritoneal dialysate (with no other medication additives)
- Emesis/effluent/urine (remembering to use safe handling practices)

Note: needles, glass ampules, and empty syringes with needles attached should be discarded in sharps containers. And any used solutions listed above that contain medication additives should be discarded in a red medical waste container. 'Used' means the seal has been broken, it has been spiked by Nursing, it is a partial dose, or there has been patient contact (including medications brought into precaution rooms *whether there was direct contact with the patient or not*).

For disposal in regular trash:

- Non-hazardous, empty IV bags, tubing, and other types of packaging with no blood and no patient identifiers.

(Note: empty vials, empty syringes, and other medical waste may be placed in red medical waste containers when available)

For disposal in red medical waste containers:

- Witnessed waste of narcotics should be discarded (i.e., emptied/expelled from syringe) in red medical waste containers. Needles and syringes should be disposed of appropriately
- Used TPN.

Question: What about un-used medications?

Jeanette: Return *all* un-used medications to Pharmacy. (Un-used is defined as un-opened, damaged, or expired). Note: Medications brought into 'precaution rooms' are considered used and require red-bucket disposal.

For more information, contact Brian Smith, Environmental Health and Safety, at 4-8419, or Bill Banchiere, Environmental Services, at 6-2445.

Professional Achievements

Orroth presents

Amy Orroth, OTR/L, occupational therapist, presented, "Peripheral Nerve Injuries," for the Fellowship Program at Tufts University, in April, 2012.

Jeffries honored

Marian Jeffries, RN, thoracic clinical nurse specialist, received the Excellence in Action Award for Quality Improvement from MGH president, Peter Slavin, MD, April 26, 2012, for her involvement with the Safe Transport of the Artificial Airway Patient, and the MGH Sticker to Ride Program.

Davis certified

Steven Davis, senior analyst, PCS Financial Management, received the FHFMA designation from the Healthcare Financial Management Association, April 30, 2012.

Maciaga certified

Cynthia Maciaga, RN, became a certified oncology nurse by the Oncology Nursing Certification Corporation in April, 2012.

Drapek presents

Lorraine Drapek, RN, nurse practitioner, Radiation Oncology, presented, "Management of Radiation Side-Effects," at a meeting of the Boston Oncology Nursing Society, March 24, 2012.

Mannix publishes

Catherine Mannix, RN, nursing director, Radiation Oncology, authored the chapter, "Modality-Specific Management: Proton Beam Radiation Therapy," in the *Oncology Nursing Society's Manual for Radiation Oncology Nursing Practice and Education*, 4th edition.

Nurses present poster

Tara Jennings, RN, nurse practitioner, Neurology-Epilepsy Service, and Jean Fahey, RN, clinical nurse specialist, Neuroscience, presented their poster, "Assessment of Seizure Identification by Registered Nurses across Neuroscience Units in Three Large, University-Affiliated Medical Centers," at the 65th annual meeting of the American Epilepsy Society, in Baltimore, in April, 2012.

Fisher certified

Allison Fisher, RN, staff nurse, RACU, became a certified medical-surgical nurse by the American Nurses Credentialing Center in April, 2012.

Hylar certified

Rachael Hylar, RN, staff nurse, RACU, became a certified medical-surgical nurse by the American Nurses Credentialing Center in April, 2012.

Murphy certified

Michael Murphy, RN, staff nurse, Cardiac ICU, became a certified cardiac surgery nurse by the American Association of Critical-Care Nurses in April, 2012.

Cobau presents

Ellen Cobau, RN, case manager, presented, "Nurse-Facilitated Telemonitoring: Impact on Heart Failure Care Outcomes," at the 4th annual Christine Cameron Symposium on Evidence-Based Practice and Quality Care, From the Bedside to Virtual Nursing: Patient Care Keeps Passion Strong, in Boston, April 13, 2012.

Doyle presents

Diane Doyle, RN, nurse practitioner, Radiation Oncology, presented, "Lung Cancer 2012: Overview and Emerging Treatment," at the 29th annual Cancer Symposium at the MetroWest Medical Center, in Natick, March 26, 2012.

Nurse practitioners present

Radiation Oncology nurse practitioners, Diane Doyle, RN; Elene Viscosi, RN; and Lorraine Drapek, RN, presented, "Management of the Patient Undergoing Radiation: an Advanced Practice Approach," at the Hot Topics in Oncology Care meeting of the Boston Oncology Nursing Society, March 3, 2012.

Arnstein presents

Paul Arnstein, RN, pain clinical nurse specialist, presented the ASPMN Geriatric Pain Management Course at the Chicago Metropolitan Area Meeting of the American Society for Pain Management Nursing and the Hospice and Palliative Care Nursing chapters in Lisle, Illinois, April 20, 2012.

Bolton publishes

Rachel Bolton, RN, Radiation Oncology, authored the chapter, "Special Populations," in the *Oncology Nursing Society's Manual for Radiation Oncology Nursing Practice and Education*, 4th edition.

Vascular nurses publish

Vascular clinical nurse specialists, Virginia Capasso, RN, and Erin Cox, RN, and Vascular Unit nursing director, Sharon Bouvier, RN, authored the book, *Carotid Stenosis in Primary Care: a Collaborative Practice*, 4th edition.

Chase publishes

Barbara Chase, RN, nurse practitioner, Adult Medicine, MGH Chelsea Healthcare Center, authored the chapter, "Population Management in Primary Care," in *Primary Care: a Collaborative Practice*, 4th edition.

Russo publishes

Katherine Russo, OTR/L, occupational therapist, authored the article, "Dynamic Splinting with Early Motion Following Zone IV/V and T1 to T11 Extensor Tendon Repairs," in the *Journal of Hand Surgery*, in April, 2012.

Amatangelo presents poster

Mary Amatangelo, RN, nurse practitioner for the J. Philip Kistler Stroke Research Center, presented her posters, "Clinical Issues Post-Stroke: an Evolving Step Along the Continuum," and "Why You Do the Things You Do Related to Care of the Stroke Patient," at the 44th annual educational meeting of the American Association of Neuroscience Nurses, in Seattle, April 29–30, 2012.

Team presents fall-prevention poster

Diane Connor, RN, wellness nurse, Geriatric Medicine; Linda Connor Lacke, Trauma Injury Prevention Program; and Deborah D'Avolio, RN, nurse scientist, *65plus*, presented their poster, "Implementation of Fall-Prevention in Senior Housing to Increase Participation in Fall-Prevention Programs," at the annual meeting of the American Society of Aging in Washington, DC, March 30, 2012.

Karp honored

Roseanne Karp, RN, case manager, was selected as one of the One Hundred by the MGH Cancer Center, in April, 2012.

Pomerleau elected

Mary Pomerleau, RN, Obstetrics, is the new president-elect of the Association of Women's Health, Obstetrics, and Neonatal Nurses.

Team publishes

John Carroll; Michele Williams; and Theresa Gallivan, RN, authored the article, "The Ins and Outs of Change-of-Shift Hand-Offs Between Nurses: a Communication Challenge," in *BMJ Quality & Safety*, in March 2012.

Nurses publish

Laura Sumner, RN, clinical educator; Sheila Burke, RN, clinical educator; Lin-Ti Chang, RN, staff specialist; Mary McAdams, RN, clinical educator; and Dorothy Jones, RN, director of The Yvonne L. Munn Center for Nursing Research, authored the article, "Evaluation of Basic Arrhythmia Knowledge Retention and Clinical Application by Registered Nurses," in the *March/April Journal of Nurses in Staff Development*.

Inter-disciplinary team publishes

Teresa Vanderboom, RN; Patricia Arcari, RN; Mary E. Duffy, RN; Bhanusupriya Somarouthu; James Rabinov, MD; Albert Yoo, MD; and Joshua Hirsch, MD, authored the article, "Effects of a Music Intervention on Patients Undergoing Cerebral Angiography: a Pilot Study," in the *Journal of Neurointerventional Surgery*, in May, 2012.

Speakman presents

Elizabeth Speakman, LICSW, director of HAVEN at MGH, presented, "I Didn't Fight for my Life to be Treated Like This! Impacts of Cancer on Abusive Relationships," at the Futures Without Violence National Conference on Health and Domestic Violence, in San Francisco, March 30, 2012.

Speakman also presented her poster, "Engaging Physicians in Domestic Violence Advocacy," at the same conference.

Announcements

One-stop intranet site for strategic priorities

Want to know more about the Partners-MGH patient care re-design, patient affordability, and budget review initiatives? Wondering about the time line?

To read the latest articles about this work, or if you have a cost-reduction idea or better way to deliver patient care, visit the new MGH/MGPO intranet site:

<http://priorities.massgeneral.org>.

1st Annual MGH Global Health Expo

Save the date for the 1st annual MGH Global Health Expo, showcasing more than 20 departments, divisions, and organizations working in global health at MGH.

Thursday, June 21, 2012
3:00–6:00pm
Bulfinch Terrace

- Learn more about international and domestic opportunities
- Network with colleagues and meet new collaborators

Food and refreshments
All are welcome
Stop by throughout the afternoon

Sponsored by the Mass General Center for Global Health.

For more information, call 4-1215 or go to: www.massgeneralcenterforglobalhealth.org.

Memorial Service

A memorial service for cardiac technician, John Drake, a 48-year veteran of MGH, will be held

Wednesday, June 20, 2012
11:00am
in the MGH Chapel

All are welcome.

For more information, call 4-5305.

Clinical Ethics Residency for Nurses

Applications now being accepted

Applications for year three of the Clinical Ethics Residency for Nurses (CERN), are now being accepted. The program begins in September; applications should be submitted by July 16, 2012.

Applicants will be notified of their acceptance during the week of August 6th.

Participants attend 10 eight-hour sessions from September, 2012, through May, 2013. To obtain an application or learn more, e-mail Rosemarie Lemole (rlemole@partners.org).

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

ACLS Classes

Certification:

(Two-day program)

Day one: lecture and review
Day two: stations and testing)

Day one:
July 5, 2012
8:00am–3:00pm
Robbins Conference Room A
Founders 2

Day two:
July 6th
8:00am–12:00pm
Robbins Conference Room A
Founders 2

Re-certification (one-day class):

September 29th
8:00am–1:00pm
Founders Training Room 130

October 10th
5:30–10:00pm
Founders Training Room 130

For information, call 6-3905 or go to: <http://www.mgh.harvard.edu/emergencymedicine/education/acls.aspx>

To register, go to: http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf

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For more information, call: 617-724-1746

Next Publication

July 5, 2012

Clinical Pastoral Education

preparing clinicians and chaplain interns to better meet the religious and spiritual needs of patients, families, and staff

—by Angelika Zollfrank, MDiv, CPE supervisor

On May 17, 2012, in the MGH Chapel, four clinicians and two chaplain interns graduated from the inter-disciplinary Clinical Pastoral Education (CPE) program. David Coulter, MD; Margaret Hassey; Bebe Nixon, LICSW; Cynthia Johnson, RN; Michelle Sheri Jones, MD; and Reverend Catherine Perry, MDiv, trained for 19 weeks to prepare themselves to better meet the religious and spiritual needs of patients, families, and staff. Through didactic education, mentorship, seminars, extensive written work, and focused reflection, graduates expanded their ability to provide compassionate, culturally competent, faith-sensitive, spiritual care.

The CPE Program for Healthcare Providers is supported by the Schwartz Center and offers fellowships for members of all faiths and those of no religious affiliation who wish to integrate spiritual care-giving into their clinical practice. The Chaplaincy also offers basic and advanced programs in CPE for theological students, seminarians, and clergy of all faiths. Six students begin their summer rotation this month.

For more information about clinical pastoral education programs, contact Reverend Angelika Zollfrank, CPE supervisor, at 4-3227.



Reverend Angelika Zollfrank, MDiv, (back left) with CPE graduates (l-r): Cynthia Johnson, RN; Margaret Hassey; Michelle Sheri Johnson, MD; Reverend Catherine Perry, MDiv; David Coulter, MD; and Bebe Nixon, LICSW.

(Photo by Paul Battista)

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