

Caring

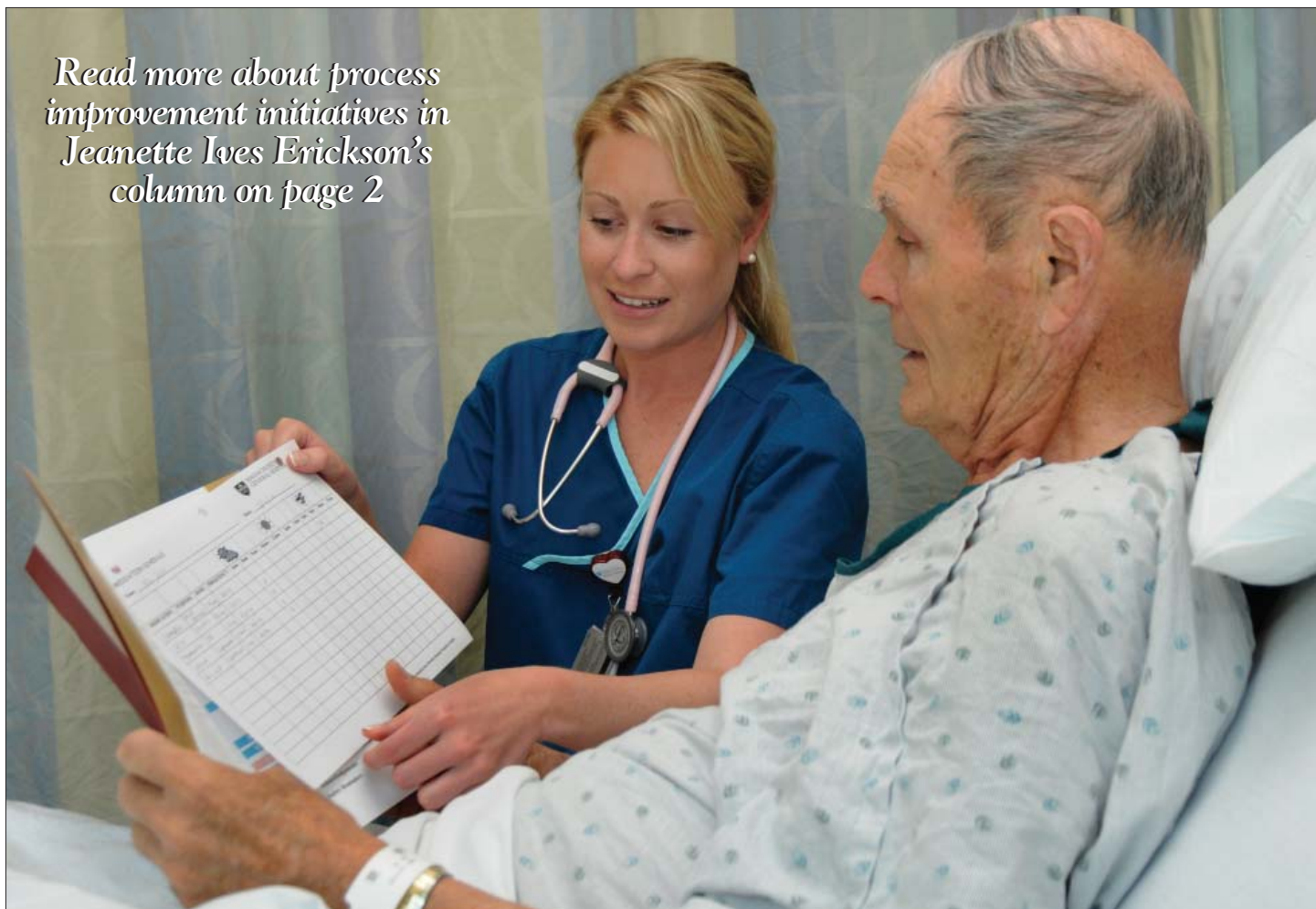
Headlines

March 15, 2012

Medication reconciliation: one of four key hospital-wide

Process Improvement Initiatives

Read more about process improvement initiatives in Jeanette Ives Erickson's column on page 2



Ellison | cardiac nurse, Erica Lessard, RN, reviews medication list with patient, Donald Jolie, to ensure up-to-date medication reconciliation.

Process Improvement Initiatives support Excellence Every Day

I think it's fair to say that the The Joint Commission's interests, goals, and concerns are closely aligned with, if not identical to, our own.

When I think about The Joint Commission, I think of an organization whose only goal is to help improve quality and safety for patients and families. Consider this passage from their website: "Joint Commission accreditation... is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting performance standards. Our mission is to continuously improve health care for the public in collaboration with other stakeholders by evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value."

Where have I heard that before? What about the mission of Patient Care Services:

As nurses, health professionals and Patient Care Services support staff, our every action is guided by knowledge, enabled by skill, and motivated by compassion. Patients are our primary focus and the way we deliver care reflects that focus every day.

We believe in creating a practice environment that has no barriers, is built on a spirit of inquiry, and reflects a culturally competent workforce supportive of the patient-focused values of this institution.

I think it's fair to say that the The Joint Commission's interests, goals, and concerns are closely aligned with, if not identical to, our own.



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

It's not unusual during Joint Commission visits for surveyors to ask staff about their knowledge of hospital-wide improvement efforts, of which we have many. Perhaps the most visible right now are the process-improvement initiatives related to:

- *Medication reconciliation*—Medication reconciliation, both for patients admitted to the hospital and those coming to the hospital for ambulatory care, means collecting and documenting a complete list of medications being taken by each patient. For ambulatory patients, the medication list is updated during each visit and reconciled to reflect any changes. Patients are given copies of their reconciled medication lists for their own records.
- *Universal protocol*—Universal protocol must be employed before all surgical and other invasive procedures that expose patients to more than minimal risk. Universal protocol ensures that the right patient receives the right procedure at the right site.

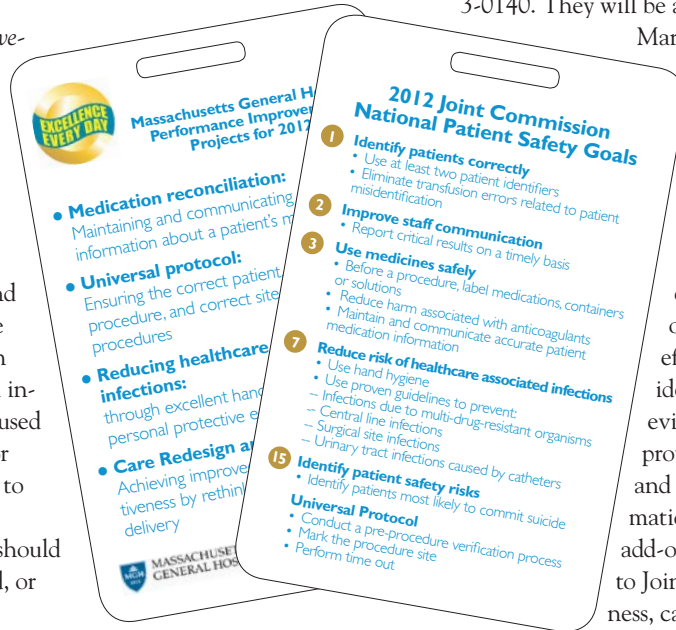
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One side of the badge lists the Performance Improvement Initiatives I just mentioned; the other side lists the 2012 National Patient Safety Goals. These badges are being created for Patient Care Services staff but any MGH employee who would like to receive one may do so by calling 3-0140. They will be available beginning March 26th.

The three components of universal protocol are:

- 1) pre-procedure verification
- 2) procedural site marking
- 3) a hard stop time-out

- **Reducing hospital-acquired infections**—MGH has focused a great deal on decreasing healthcare-associated infections through diligent hand-hygiene practices before and after patient contact and through the appropriate use of protective gloves, garments, and equipment
- **Efficiency and effectiveness**—A wide range of care redesign initiatives, including the implementation of innovation units, is helping us achieve greater efficiency and effectiveness in care delivery. Innovation units are designated inpatient units being used as testing grounds for change, allowing us to quickly determine whether new ideas should be adopted, adapted, or abandoned.



Recently, the PCS Office of Quality & Safety developed an updated version of the Excellence Every Day ID-badge 'add-on' to help staff keep these initiatives fresh in their minds. One side of the badge lists the Performance Improvement Initiatives I just mentioned; the other side lists the 2012 National Patient Safety Goals. These badges are being created for Patient Care Services staff but any MGH employee who would like to receive one may do so by calling 3-0140. They will be available beginning March 26th.

The Joint Commission will visit MGH some time between now and August 31, 2012. Our commitment to Excellence Every Day is visible in everything we do—from our quality and safety efforts, to our innovative ideas, to the exquisite, evidence-based care we provide to every patient and family. For more information about the ID-badge add-ons or anything related to Joint Commission readiness, call 3-0140.

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Social work embodies spirit of innovation

—by Marie Elena Gioiella, LICSW, director, Social Service, and Ellen Forman, LICSW, program manager, Social Service

Social workers are mental health professionals who provide supportive counseling to patients and families. They help people problem-solve, improve attitudes, and change behaviors that can negatively impact health.

As the first hospital-based Social Service Department in the nation, the spirit of innovation—of learning by doing—is part of our cultural heritage. As we celebrate National Social Work Month, we look back to our founding and ahead to exciting changes in store. Our first director, Ida Cannon, along with Dr. Richard Cabot, collaborated to create the field of Social Work in health care. It was created in a working, teaching hospital in response to the real needs of real people.

Cannon is known to have kept a drawing of the Dodo bird from Lewis Carroll's *Alice in Wonderland* on her desk. The caption read, "Why, 'said the Dodo, 'The best way to explain it is to do it.'" That sentiment exemplifies Cannon's approach to developing a new service in what she described (in the early 1900s) as a conservative, tradition-bound institution. And that spirit has inspired the evolution of the clinical social worker role through the years.

Today, staff are privileged to contribute to the important work taking place on Innovation Units and look forward to learning alongside our colleagues in other disciplines. How can social workers help foster relationship-based care? What can we offer to increase patient and family participation, to enhance continuity of care, and strengthen inter-disciplinary teamwork?



Social workers:

- help patients and families cope with illness, injury, hospitalization, death, and grief
- evaluate instances of abuse, neglect, and domestic violence
- assist patients and families to make informed decisions regarding treatment goals and the plan of care
- assist patients and families in addressing stressful issues such as caregiver concerns, financial hardship, substance abuse, relationship issues, mental-health issues, social isolation, inadequate self-care, and homelessness
- work with patients, families, and staff to raise cultural awareness and foster a welcoming environment for all
- refer patients and families to services and community resources such as support groups, public benefits, and other non-medical services

Social workers are mental health professionals who provide supportive counseling to patients and families. They help people problem-solve, improve attitudes, and change behaviors that can negatively impact health. They can have a positive effect on patient satisfaction by helping to develop self-advocacy skills and link patients and families to vital resources in the hospital and in the community.

Some recent examples show how traditional social work practice is aligned with the goals of Innovation Units.

Hand-Overs and Continuity of Care

An outpatient pediatric social worker received a referral from an inpatient social work colleague who had been working with first-time parents whose baby was born with a medical condition requiring extensive hos-

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Social Service (continued)

pitalization. To facilitate a smooth hand-over, the inpatient social worker invited the outpatient social worker to meet with the parents prior to discharge. This enabled them to build on the work the parents had begun with their inpatient social worker when they met again a few weeks later at their first outpatient appointment. The couple had been struggling with dashed hopes and feelings of isolation when friends and loved ones had difficulty relating to their new situation. Social workers helped identify what each parent needed to cope with the challenges they were facing. Creating an environment that gives parents permission to unburden themselves is often invaluable. The outpatient social worker affirmed this family's honesty, bravery, commitment, and strength, and offered ongoing support as they continued to receive care on an outpatient basis.

Patient-Centered Care

Mr. C had been in a motorcycle accident that left him with damaged nerves and no use of one of his arms. After many unsuccessful treatments, Mr. C came to MGH from his home in the Caribbean to undergo surgery to restore function to his arm. Mr. C was accompanied by his mother and was very worried about where they would stay while in Boston for follow-up care. To their great relief, the social worker helped Mr. C and his mother address their lodging and transportation concerns. Mr. C's nurse observed that many pa-

tients who come from far away for cutting-edge medical care seem more concerned about finding a safe, comfortable place to stay while they're in town. Resolving this concern reassured Mr. C and allowed him to devote more energy and attention to his health and rehabilitation. Seemingly small details like this can make all the difference to a patient and family in this situation. Though this type of concrete assistance doesn't demonstrate the full range of social work skills and practice, it does let the patient and family know their concerns are taken seriously. It also establishes trust, paving the way for other interventions.

Social workers are key members of the inter-disciplinary team. Early social work referrals allow social workers to:

- assess the patient and family's understanding of illness, treatment, care requirements, and the discharge plan
- identify potential barriers to care and safe discharge (assess family's ability and readiness to provide ongoing care at home)
- ensure the care team's awareness of these factors and collaborate to resolve problems
- reinforce patient and family education regarding illness, treatment, family caregiver responsibilities, discharge plan, etc.
- strengthen patient and family coping skills to allow them to transition to this new reality to the best of their ability
- improve patient satisfaction by ensuring effective communication

Whether on an Innovation Unit or in any other setting, social workers play an integral part in improving the patient and staff experience. For more information, call 617-726-2643, or go to: www.mghsocialwork.org.



Above: clinical social worker, Amy Corveleyn, LICSW, with patient. At right: clinical social worker, Rachel Stronge, LICSW (front left), with (l-r): case manager, Kathie Capeless, RN; attending nurses, Gina Chan, RN, and Elaine McNeil, RN; and case manager, Merry Dance, RN.



(Photos by Joe Ferraro)

Child Life Specialists

helping children face health challenges through play, preparation, education, and self-expression

—submitted by MassGeneral Hospital for Children child life specialists

Child Life Team
(standing l-r):
Ashley Reardon,
Hillary D'Amato,
Sacha Field, Marilyn
Gifford, Jamie Rossi,
and Melissa Whitty.
(Seated): Anne Pizzano
and Heather Peach
Not pictured: Caroline
Armington, Eva Mintz-
Bacon, and Katie Weagle

Child life specialists are healthcare professionals trained to help children and families overcome challenging life events through play, preparation, education, and self-expression. They collaborate with nurses, social workers, physicians, and therapists to facilitate positive hospital experiences, and they work with inter-disciplinary teams to create programs for the entire family both during hospitalization and after discharge.

One such program is geared toward patients with autism and their families. A multi-disciplinary group led by

pediatric resident, Sarabeth Broder-Fingert, MD, brought occupational therapists, physicians, social workers, parents, and child life specialists together in an effort to improve the hospital experience for this population. The team developed the Autism Care Plan, a standardized questionnaire designed to help caregivers assess patients' communication styles and sensory sensitivities and identify any hospital interventions that might not be well tolerated by children with autism. The completed Autism Care Plan becomes part of the patients' medical record and a valuable source of information for the care team. While this tool was initially used primarily on inpatient units, child life specialists in the outpatient setting are contacting families over the phone and completing the Autism Care Plan prior to visits to the Same Day Surgical Unit and other outpatient areas.

The same multi-disciplinary team has designed and created special materials to help facilitate communication between staff and patients with autism. Child life specialists and occupational therapists are facilitating the use of these materials in the hope of reaching all families of and/or patients with autism.

Two inter-disciplinary support groups doing excellent work to support families are Club STAR and SibShops. Club STAR (Sharing Together and Remembering) is a monthly bereavement group for children 5–18 years old who've experienced the loss of a sibling or parent. The group is a collaboration between Child Life and Social Service supported by the Ladies Visiting Committee. Club STAR provides a healing space for parents, children, and caregivers to come together with other families coping with similar losses. At the beginning of each group, children and family members place a smooth stone



(Photos by Paul Batista and Joe Ferraro)

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Child Life Specialists (continued)

into a glass bowl and share a special memory of their loved one. Child life specialists lead young children and teens in creative projects and memory-making activities to facilitate the sharing of feelings and personal stories. And parents and family members have an opportunity to share thoughts and concerns with knowledgeable social workers. Club STAR's mission is to facilitate opportunities for grieving children, teens, and parents to connect and learn from one another. Meetings end with a clasped-hand circle where participants pass along a squeeze of hope to each member of the group.

Working in collaboration with Social Service and Nursing, child life specialists help facilitate the SibShops and TeenShops support groups. These programs give siblings peer support and education in the context of a recreational experience. They're designed to be unique and off-beat and appeal to a wide range of abilities. SibShops and TeenShops give parents and professionals an opportunity to hear the concerns of siblings of children with special health and/or developmental needs. SibShops supports children ages 8–12 years old age; TeenShops supports children 13–17 years old.

For more information about the work of child life specialists or support groups offered by MassGeneral Hospital for Children, call 617-724-5727.

The Child Life Team:

- Caroline Armington, CCLS, Pediatric Hematology-Oncology
- Hillary D'Amato, CCLS, Pediatric ICU and the ED
- Sacha Field, CCLS, Ellison 18



- Marilyn Gifford, CCLS, Ellison 17
- Eva Mintz-Bacon, CCLS, Ellison 17
- Heather Peach, CCLS, Pediatric Hematology-Oncology and the Francis H. Burr Proton Therapy Center
- Anne Pizzano, CCLS, Ellison 18
- Ashley Reardon, CCLS, Ellison 17
- Jamie Rossi, CCLS, Pediatric Endoscopy
- Katie Weagle, CCLS, Pediatric Imaging
- Melissa Whitty, CCLS, Pediatric Same Day Surgical Unit



Above: As mom looks on, child life specialist, Caroline Armington, CCLS (right), collaborates with nurse to start IV for 6-year-old, Jacob, using an iPad2 to provide procedural support and diversion.

Far left: Child life specialist, Melissa Whitty, CCLS, assists 3-year-old, Keven Goncalves, in the Same Day Surgical Unit to decorate his anesthesia mask with colorful stickers to help him become more comfortable with the surgical setting.

Left: This art work, created by MGH/FC artist-in-residence, Joan Drescher, adorns the space where monthly Club STAR meetings are held. Stars have been decorated by children and teens in honor of loved ones who've died.

Social work practice showcases inter-disciplinary, relationship-based care

My work with Camilla focused largely on identifying and strengthening her existing coping mechanisms. Due to the chronic and fatal nature of her illness, our work included many conversations about Camilla's goals for herself and her medical care.

“I just want this all to be over,” she said as she closed her eyes and rolled over in bed, turning her back to me. I stayed seated and continued the conversation. I asked what she meant. “I don’t want to keep taking all these medications,” she said. “I can’t do anything. I’m either home or here. Why am I doing this?”

My name is Caitlin Laidlaw, and I’m a clinical social worker. ‘Why am I doing this?’ was a question ‘Camilla’ had asked many times before. And each time, I struggled with how to help her answer it. We had talked about why she continued to take medications, deal with a restricted lifestyle, and endure repeated admissions to the hospital. I reminded her of her interest in a long-dreamed-about trip to the mountains and her relationship with her new girlfriend. Camilla shrugged her shoulders and retreated deeper under the covers.

This conversation took place a year after I met Camilla. Having lived her entire life in another state, tense family relationships and the hope of a fresh start brought Camilla to Massachusetts where she settled with her father and step-mother and their three young children. Shortly after arriving, Camilla was diagnosed with a cardiomyopathy and systolic heart failure. Over the next year, she was repeatedly admitted to MGH with abdominal pain and volume overload. Due to her



Caitlin Laidlaw, LICSW, clinical social worker

frequent and often lengthy admissions, I had the opportunity to work somewhat steadily with Camilla and her team of inter-disciplinary caregivers.

Camilla led a fairly isolated life with few friends and little contact with family members. Although she lived with her father and step-mother, they never visited while she was hospitalized and, from Camilla’s perspective, couldn’t be relied upon for support due to their work and other parenting responsibilities. Camilla’s primary interactions were through on-line video games with unseen opponents and on-line social networking. She had met her girlfriend on-line, and while they communicated frequently by phone and e-mail, they rarely saw each other. Camilla was essentially alone in her illness and hospitalizations.

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When anxious at home, Camilla would close herself in a dark room and turn on a fan to blow cool air on her face. This helped her 'zone out and calm down.' We brought a miniature fan into Camilla's room and closed the curtains around her bed when she started to feel overwhelmed.

My work with Camilla focused largely on identifying and strengthening her existing coping mechanisms. Due to the chronic and fatal nature of her illness, our work included many conversations about Camilla's goals for herself and her medical care. These talks were augmented by her conversations with Palliative Care. Beyond my direct work with Camilla, an important part of my role was touching base with other members of her inter-disciplinary team to share information and ensure we were adequately addressing Camilla's needs according to each of our specialties.

Camilla frequently became anxious and scared. She would get worked up to the point of experiencing such severe chest pain she'd assume she was dying, which only worsened her feelings of fear and stress. These episodes were more frequent when Camilla was hospitalized, so I tried to help her re-create some aspects of her home environment in the hope she'd be able to soothe herself more readily. When anxious at home, Camilla would close herself in a dark room and turn on a fan to blow cool air on her face. This helped her 'zone out and calm down.' We brought a miniature fan into Camilla's room and closed the curtains around her bed when she started to feel overwhelmed. To drown out hospital noises, I encouraged Camilla to use her iPod and listen to the same music she listened to at home when she felt calm. This helped normalize the range of emotions she was experiencing, and we continued to introduce interventions to minimize some of Camilla's most uncomfortable symptoms.

The psych clinical nurse specialist on the team, whom I spoke with often, had engaged in guided-imagery exercises that Camilla found helpful. Together, we decided that I'd take over the guided imagery sessions, and the psych CNS would take on a more advisory role. She suggested we make a recording of one of the exercises so Camilla could have it to play in the middle of the night or when she went home. I was happy that Camilla was open to the idea, and we recorded several guided-imagery and breathing exercises on her phone.

Using Cognitive Behavioral Therapy as a theoretical framework, I attempted to help Camilla become more aware of her thoughts and how they were linked to her mood. For example, she would dwell on the most negative parts of conversations with her cardiolo-

gist, which would make her upset and anxious for the rest of the day. My hope was that as Camilla became more aware of how her thoughts negatively influenced her mood and ability to cope, she could try to re-direct herself to a more positive line of thinking. We made some progress in this area, but it was challenging for Camilla to stay with a positive train of thought; she needed many reminders.

We learned that Camilla was calmer if I or one of her nurses was present when having important conversations with her cardiologist. We also discovered that Camilla benefitted from taking notes during these conversations, which helped her stay centered and in the moment rather than imagining worst-case scenarios.

Ultimately, Camilla moved back to her home state, as staying with her father and step-mother became untenable. I was disappointed to see her go, as I had enjoyed working with her. I felt we had made progress, though there was still more work to be done, particularly in terms of her care goals. Camilla was well aware of her prognosis. It frustrated her to feel she was working so hard to stave off heart failure, all the while knowing her efforts would ultimately be futile.

I hope Camilla has settled into life in her home town. I hope she's working with a new team of caregivers who can continue the work we started at MGH. I wish I could have seen her get to a place where she felt at peace with her plan of care, but I'm hopeful she has some new tools to build on as she faces the challenges ahead.

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

Camilla's was an unfortunate situation, facing a terminal illness with few close friends or family members. But she was fortunate to have a team of clinicians who cared for her holistically. Caitlin beautifully tailored her interventions to meet Camilla's needs, helping her find inner strength, calm, and a renewed ability to cope. So often, we lose touch with patients when they move or return to homes far away. I hope Camilla is able to benefit from the strong foundation that Caitlin and her colleagues helped her build.

Thank-you, Caitlin.

Veteran nurse a paragon of advocacy, compassion, and patient-centered care

I was assigned to care for Mike shortly after he had an orchiectomy (testicle removal) and central-line insertion. He had been diagnosed with metastatic testicular cancer, and his tumor burden was large.

My name is Kathie Pazola, and I am a pediatric nurse. In my 42 years of nursing, I've had many fulfilling patient-care experiences. Caring for Michael was one of them. This exemplar, describes the care of an adolescent boy from diagnosis, to relapse, to stem-cell transplant, to end-of-life care.

I was assigned to care for 'Mike' shortly after he had an orchiectomy (testicle removal) and central-line insertion. He had been diagnosed with metastatic testicular cancer, and his tumor burden was large. He would soon begin a vigorous course of chemotherapy to try to shrink the tumors, which were obstructing his kidney and causing abdominal pain. Along with post-operative care, I began teaching Mike about his central line and the chemotherapy regimen he would be undergoing.

Teaching Mike was a challenge accentuated by the fact that he had Asberger's syndrome; he took special classes for learning issues. Mike's parents were understandably anxious and worried and open to my teaching. I relied on them to let me know if Mike had trouble understanding what I was teaching. Mike was 'a man of few words,' so it was hard to know what he thought and felt about this new diagnosis and the changes in his life. I tried to give emotional support to him and his parents. I signed up to be his primary nurse, and soon a team formed to care for him: Karen Darocha, RN; and Emily Forger, RN; Trisha Mahoney, RN; and Lisa Tufts, RN.



Kathie Pazola, RN, pediatric staff nurse

To facilitate Mike's return to school, with his permission, I sent a referral to the school nurse explaining his treatment plan and letting her know I was available if she had any questions.

Mike came in regularly for chemotherapy, and we got to know each other better. Unfortunately, his tumor markers showed he wasn't responding to treatment and would need two stem-cell transplants. This was a major challenge because there's a lot you need to know and endure when having a transplant.

Mike's nursing team met to discuss his care. Another nurse and I decided to have a patient-care conference with the evening and night staff to educate everyone about Mike. Testicular cancer is not a common pediatric diagnosis, so I planned a bulletin board with information on testicular cancer to educate staff.

Mike coped well with the two stem-cell transplants. Though miserable, he got through the physical challenges, and we supported his family, who leaned on us quite a bit. Child life specialists decorated his room in a guitar theme, which Mike enjoyed; he was a really good guitar player. I admired his ability to cope. He didn't like what he had to deal with, but he cooper-

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Our end-of-life care plan was detailed so all staff would be more comfortable caring for him. When he was close to death, we created a 'family bed' so they could all be close together. His death was gentle. It was loving. It was peaceful. And it was the next day.

ated, was able to make choices and have some control. Of note, Mike's transplants occurred the week the new interns arrived. We worked closely with them to treat and stabilize Mike, letting our knowledge of the patient drive his relationship-based care.

The 4th of July was a favorite holiday for Mike and his family, but he needed to stay in his room to avoid potential infections. We advocated for him to be allowed out of his room, briefly, so he and his family could watch the fireworks from one of our spectacular viewing areas in the Ellison tower. I found a good spot, made sure it was clean to decrease germs, made it safe for Mike, and tried to make it a happy event for all of them. His parents were very grateful.

When Mike was discharged after the transplants, I sent a group e-mail to the nursing team to validate how working together had helped make the experience a positive one. I felt it was important to acknowledge the unity and good work of the team.

Unfortunately, a couple of months later, Mike's disease came back with a vengeance. There was nothing more we could offer him at MGH. His parents pursued a Phase 1 drug trial at another hospital, but it was unsuccessful.

One Sunday, shortly thereafter, Mike had a grand mal seizure at home. He was rushed to MGH and brought to the Neuro ICU. A CT-scan showed large, inoperable tumors in his brain. Doctors informed the family, and they chose to put a DNR (Do not resuscitate) order in place. Because they had a relationship with the staff on Ellison 18, the family wanted Mike to come back to our unit. And a new challenge began.

End-of-life care was initiated, and our nursing team came together again to care for Mike. We advocated for minimally intrusive care: no monitors, no blood tests, and a morphine PCA (patient-controlled analgesia). One of the other nurses got his room ready, including a bed for his family. She put on soft music and removed all the equipment we wouldn't be using.

I welcomed Mike from the ICU and began the difficult task of talking to his parents about end-of-life care. I tried to prepare them for what Mike's final days would be like, so they'd know what to expect. I listened to their sadness and concern. Our common goal was a good death for Mike.

Mike was awake off and on, very calm, and didn't ask any questions. He trusted. His parents and family surrounded him with love, and he was able to be

peaceful. His mom asked me for advice about what to say to him and how to prepare his siblings. I commended her for her maternal care and instincts.

We tried to keep the family eating, sleeping, and calm, so they could be there for Mike. We let his parents choose when they wanted him to be turned or medicated.

Mike drifted in and out of sleep. At one point, he said to his nurse and mom: "I'm going home tomorrow."

On some level, we felt he would die soon.

Once again, his nurses functioned as a cohesive team. We collaborated each shift to make sure we were anticipating and meeting his every need. We were unified in our goals. We role-modeled care for the new residents, nurtured his parents and siblings so they could nurture Mike in his final hours. Our end-of-life care plan was detailed so all staff would be more comfortable caring for him. When he was close to death, we created a 'family bed' so they could all be close together. His death was gentle. It was loving. It was peaceful. And it was the next day.

I sent an e-mail to the team acknowledging the beauty of Mike and the fulfillment of creating a 'good death' for him. I thanked staff for supporting us and taking assignments so we could spend time with Mike and his family. We sent the family a comfort basket with a letter signed by his team and the social worker who continued to follow the family.

Caring for Mike was a rewarding experience for me from his first admission to his last. This all occurred within ten months. My final act was to go to Oncology inter-disciplinary rounds to bear witness to Mike's life and process the experience of caring for him.

The cycle was complete.

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

Kathie's years of wisdom and experience are evident in every intervention she describes in this poignant narrative. We get the impression she knew what Mike and his family needed even before they did. Kathie and her team constantly monitored and adjusted the plan to support Mike and his family through every pivotal stage of his illness. If the goal was to ensure a 'good death' for this young cancer patient, they did that and more. I'm sure Mike's family will long remember all that Kathie and her fellow caregivers did to make the last day of Mike's life, and his passing, so peaceful.

Thank-you, Kathie.

Doctoral Nursing Research Forum welcomes Terry Fulmer

—by Donna Perry, RN, professional development coordinator

Fulmer is internationally recognized as an expert in geriatrics, best known for her research in the area of elder abuse and neglect funded by the National Institute on Aging and the National Institute for Nursing Research.

On February 23, 2012, MGH Nursing welcomed long-time friend, Terry Fulmer, RN, back for a special event hosted by the Doctoral Nursing Research Forum of the Yvonne L. Munn Center for Nursing Research. Fulmer was recently named professor and dean of the Bouvé College of Health Sciences and professor of Public Policy and Urban Affairs in the College of Social Sciences and Humanities at Northeastern University. She is internationally recognized as an expert in geriatrics, best known for her research in the area of elder abuse and neglect funded by the National Institute on Aging and the National Institute for Nursing Research. Fulmer has a long history with MGH, including her current appointment as nurse scientist in the Munn Center.

Fulmer presented, “The IOM Future of Nursing Report and the Potential Impact of Nurse-Led Change in Practice.” A member of the IOM, Fulmer reviewed the historical context that led to the landmark IOM Report and the impact of its release on healthcare reform and the Affordable Care Act of 2010. She emphasized the synergy of these events and the opportunity and responsibility nurses have to advance health care and influence policy-making.

Fulmer focused on four key recommendations of the IOM Report:

- Nurses should practice to the full extent of their education
- Nurses should achieve higher levels of education
- Nurses should be full partners with physicians and others in healthcare design

- Effective workforce planning requires better data-collection.

Fulmer described regional and national strategies to advance the goals of the IOM Report and shared exemplars from her own work in establishing an attending nurse model. These examples provided great insight as we prepare to implement the attending nurse role in innovation units here at MGH.

For more information about Fulmer’s presentation or the work of The Yvonne L. Munn Center for Nursing Research, call 3-0431.



New Joint Commission standard affects APRNs and PAs

Question: I heard The Joint Commission has changed its requirements around professional practice evaluation. Can you tell us about that?

Jeanette: Since 2007, the Joint Commission has published standards regarding ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) for physicians. The Joint Commission now requires the same processes to be applied to advanced practice nurses and physician assistants (APRNs and PAs). Organizations are required to evaluate the competency of all practitioners who have no documented evidence of their ability to perform at the privileged level (new appointees; newly privileged practitioners) or evaluate current privileges that fall below established thresholds.

Question: Who does this impact?

Jeanette: This new standard affects nurse practitioners, nurse midwives, nurse anesthetists, psychiatric clinical nurse specialists, and physician assistants. These role groups are privileged to practice by the medical staff process.

Question: How does this affect ongoing professional practice evaluation?

Jeanette: The intent is that organizations look at performance data for all practitioners with privileges on an ongoing basis rather than at two-year re-appointment intervals. This allows practitioners to take steps to improve performance in a more timely manner. The type of data collected is up to the organization based on the following areas of general competence: patient care; medical/clinical knowledge; practice-based learning and improvement; inter-personal and communication skills; professionalism; and systems-based practice.

Question: What metrics will be used to measure APRN and PA performance?

Jeanette: Peer review and chart/case review.

Question: How often will data be reviewed?

Jeanette: For FPPE, reviews will be conducted within the first three months of each new hire or newly assumed privilege. An FPPE action plan will be implemented if a practitioner evaluated for OPPE falls below established thresholds.

For OPPE, APRNs and PAs will be reviewed every six months.

Question: Who will review the data?

Jeanette: Data will be reviewed by the chief APRN or PA or the supervising physician within the department where the practitioner practices. The expectation is that APRNs and PAs will have peer reviews and chart/case reviews completed by March 20, 2012.

Question: How will this data be incorporated into the credentialing and re-credentialing process?

Jeanette: Data will be maintained by departments. At re-credentialing time, the decision to take action or continue a privilege will be submitted with re-credentialing applications.

For more information, contact Julie Goldman, RN, PCS credentialing coordinator at 4-2295.

Professional Nursing Certification

Certified Nurses Day is observed on March 19th every year. March 19th was the birthday of Margretta 'Gretta' Madden Styles, a champion of nursing certification before widespread awareness of its value had been achieved.

Question: What is Certified Nurses Day?

Jeanette: Certified Nurses Day is observed on March 19th every year. March 19th was the birthday of Margretta 'Gretta' Madden Styles, a champion of nursing certification before widespread awareness of its value had been achieved. Styles led the first comprehensive study of credentialing in the 1970s and was a leadership figure in a number of national and international nursing organizations. On this day, nurses who contribute to better patient outcomes by becoming board-certified in their specialties are honored worldwide. A nursing license (RN) allows nurses to practice. Certification attests to a nurse's advanced knowledge, skill, and practice in a particular specialty.

Question: What is certification?

Jeanette: The American Nurses Association defines certification as, "a process by which a non-governmental agency or association certifies that an individual licensed to practice a profession has met certain pre-determined standards specified by that profession for specialty practice. Its purpose is to assure various publics that an individual has mastered a body of knowledge and acquired skills in a particular specialty."

Question: How many nurses at MGH are certified?

Jeanette: Based on responses to our 2011 survey, 643 nurses in direct-care positions and 200 nurses in leadership positions are currently board-certified.

Question: What resources are available to support nurses in becoming certified?

Jeanette: Through The Norman Knight Nursing Center for Clinical & Professional Development, review classes are available to assist nurses in preparing for certification exams in Oncology, Neuroscience, Advanced Trauma Care, Gerontology, Cardiovascular, Medical-Surgical, and Adult Critical Care Nursing. Currently, a review course/study group is underway to prepare nurse leaders to take the Nurse Executive certification exam.

In addition to review courses, funding is available through the Demetri Souretis Fund and the Berke Gerontology Fund. These funds reimburse nurses for certification and re-certification test fees. The reimbursement form can be obtained from the Nursing Support Office in Bigelow 1034 or by e-mailing: pcsmsobig1034@partners.org.

Question: Does certification apply to other disciplines?

Jeanette: Certification boards associated with nationally recognized professional organizations develop and implement certification examinations and procedures for nurses and allied health professionals. More specific information about certification opportunities across the health professions can be found on this month's Excellence Every Day portal page (<http://www.mghpcs.org/eed>)

For more information, contact Gino Chisari, RN, director, Norman Knight Nursing Center, at 3-6530.

Announcements

New time for Ostomy Support Group

The Ostomy Support Group will meet at 6:00pm on the third Thursday of each month. Meetings held in the Wang 455 Surgical Clinic Conference Room

For more information, call 617-726-8853.

Blum Center Events

Book Talk:

Something in the Ether

Thursday, March 8, 2012

Author, Webster Bull, will talk about his narrative history of the development of MGH.

Registration required
Email pflc@partners.org
or call 4-3823

"Shared Decision-Making: Insomnia"

Thursday, March 15th

presented by Karen Carlson, MD, and Kathy Ulman

Sponsored by the Stoeckle Center.

National Health Observances Talk:

"Brain Aneurysms"

Thursday, March 22th

presented by Christopher Ogilvy, MD

Book Talk:

Beautiful Brain, Beautiful You

Thursday, March 29th

presented by Marie Pasinski, MD

Registration required

Email pflc@partners.org
or call 4-3823

Programs are free.

No registration required unless specified.

All sessions held in the Blum Patient & Family Learning Center from 12:00–1:00pm.

For more information, call 4-3823.

ACLS Classes

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

March 12, 2012

O'Keeffe Auditorium
8:00am–3:00pm

March 26th

Their Conference Room
8:00am–3:00pm

Re-certification classes

April 11th

5:30–10:00pm
Founders 130

May 9th

5:30–10:00pm
Founders 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

Advance Care Planning Information Booth

The PCS Ethics in Clinical Practice Committee is holding its 12th annual Advance Care Planning Information Booth

Monday, April 16, 2012

National Healthcare Decisions Day

8:00am–3:00pm

in the Main Corridor

The goal is to encourage patients to articulate their wishes regarding their healthcare decisions, increase awareness among healthcare providers about respecting those wishes, and emphasize the importance of providing information related to advance care planning for patients, families, and staff.

Copies of the Massachusetts Health Care Proxy form, a list of helpful websites, and consultations will be available.

For more information, call 643-0481

EAP Work-Life Seminars

"Understanding financial aid and college funding"

Seminar will explain college financial aid, student loans, and strategies for choosing the best financial-aid options for your situation.

Tuesday, April 24, 2012

Schiff Conference Center

Yawkey 4-910

12:30–1:30pm

presented by Tom Murphy, director of Student Services, Harvard University Employee Credit Union

Feel free to bring a lunch.

For more information, call 6-6976.

Call for Nominations

One Celebration of Many Stars

Take a moment to nominate a colleague

One nomination form for all awards listed below:

Anthony Kirvilaitis Jr. Partnership in Caring Award

Brian M. McEachern Extraordinary Care Award

Stephanie M. Macaluso, RN

Excellence in Clinical Practice Award

Jan M. Nardini, RN, Nurse Leader of Distinction Award

Marie C. Petrilli Oncology Nursing Award

Norman Knight Excellence in Clinical Support Award

Norman Knight Preceptor of Distinction

Nomination forms can be found at:

<http://sharepoint.partners.org/mgh/instituteformpatientcare/AwardsRecognition/default.aspx>

Fax completed nomination forms to Julie Goldman at 617-724-3754.

Nominations due by Wednesday, March 21, 2012, at 5:00pm.

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

Published by

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

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Submissions

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

Next Publication
April 5, 2012

Ellison 3 PACU celebrates diversity with fun, food and good friends

—by Thankam Tina George, RN

Staff of the Ellison 3 PACU celebrate diversity with a special multi-cultural luncheon.

Expanding on the observance of Black History Month, in many quarters February is considered Diversity Month. And since food is a unifying component of all cultures, staff of the Ellison 3 PACU decided to celebrate diversity by sharing traditional foods from their native countries. Staff nurse, Thankam Tina George, RN, a member of

the PCS Diversity Committee, organized a special luncheon for employees of all role groups who hail from countries as far away as Poland, Jamaica, Morocco, India, France, Ireland, Israel, England, the Dominican Republic, Haiti, Algeria, Bosnia, Croatia, Taiwan, and China.

Posters were created by Christine Clark and Anna Meade, RN. Multi-colored hands on a poster created

by Meade's sister represented the numerous cultures illuminated by the sun's rays, symbolizing that we're all connected.

Says George, "The luncheon was a great example of staff initiative and participation and how collaborative governance is brought back to the unit. Everyone shared their cultural heritages through food and stories. I've always thought that sharing a meal helps break down barriers and promote unity."

The luncheon was a source of laughter and smiles, and recipes were exchanged all day long and into the following week. It's safe to say, a good time was had by all.



Caring
Headlines
March 15, 2012

Returns only to:
Bigelow 10 Nursing Office,
MGH, 55 Fruit Street
Boston, MA 02114-2696

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US Postage Paid
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Boston, MA

