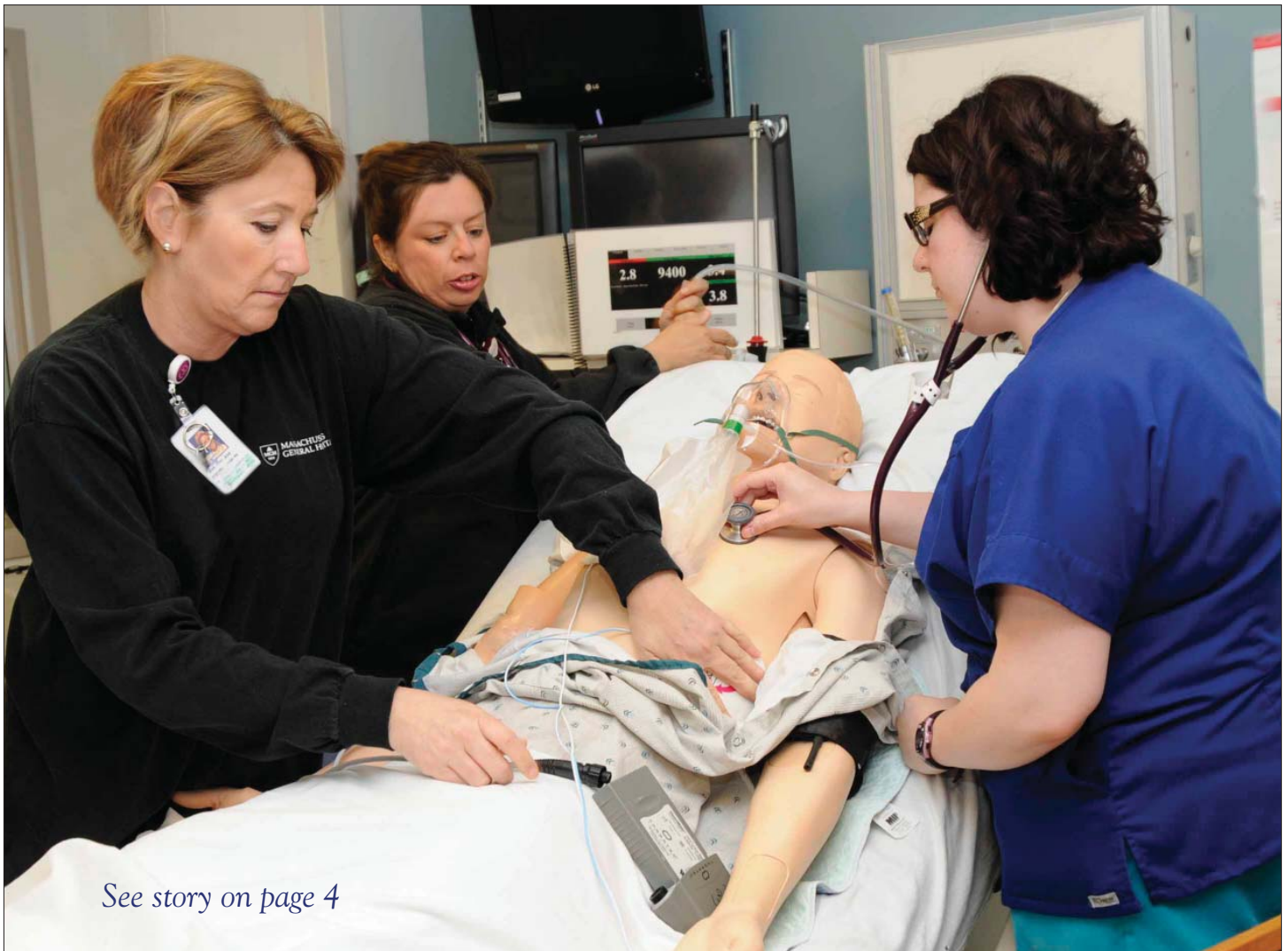


Caring

Headlines

May 10, 2012

Innovative thinking: partnering to advance clinical practice



See story on page 4

In collaboration with the Knight Simulation Program, nurses in the Cardiac Step-Down Unit developed a new LVAD education program. Above, staff nurses (l-r): Mary Jean Malinowski, RN; Angela Abate, RN; and Angelica Tringale, RN, simulate care of patient with a lethal arrhythmia.

Innovation Units *an update*

Which is why, on March 19, 2012, we launched 12 innovation units in an attempt to challenge existing paradigms and test new ways to deliver care. We're using this opportunity to create new care-delivery models to quickly determine whether new ideas should be adopted or abandoned.

Real change cannot be achieved through business as usual. Meaningful change comes from new ideas, new ways of thinking, and new ways of doing business. Which is why, on March 19, 2012, we launched 12 innovation units in an attempt to challenge existing paradigms and test new ways to deliver care. We're using this opportunity to create new care-delivery models to quickly determine whether new ideas should be adopted or abandoned.

The 12 innovation units are: Bigelow 14, Vascular; White 7, Surgical; Lunder 9, Oncology; Ellison 16, Medical; White 6, Orthopaedics/Oral & Maxillofacial/Urology; Ellison 17 and 18, Pediatrics; Blake 13, Obstetrics; Blake 10, Neonatal ICU; Blake 11, Psychiatry; Ellison 9, Cardiac ICU; and the Blake 12 ICU.

Because interest in this initiative is so high, I'd like to use this column to provide a brief, *early* update. As of May 1st, with only a few exceptions, most innovation units have adopted all of the test interventions, which include:

- building relationship-based care into educational curriculum
- implementing new attending nurse role
- enhancing hand-over communication including use of SBAR tool (Situation; Background; Assessment; Recommendations)
- enhancing pre-admission data-collection including a revised Admitting Face Sheet
- creating a Welcome Packet for patients
- updating domains of practice to ensure across-the-board understanding of each discipline's scope of practice



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

- implementing inter-disciplinary team rounds to ensure effective communication between all members of the care team
- making use of supporting technology, including specially programmed cell phones, electronic whiteboards, and portable electronic devices (laptops)
- being proactive in discharge planning and readiness including implementation of a new discharge checklist tool
- implementing new Discharge Follow-up Phone Call Program

Some innovation units have implemented additional interventions, such as Quiet Hours, providing dedicated time and/or space for reduced noise and minimal interruptions. This supports the relationship-based care intervention, respecting patients' need for rest and a calm, healing environment. One unit is using signs that say: "Quiet time: resting is healing." The pediatric units will be hanging a painting created by their artist-in-residence that reads, "Quiet please. Children are healing."

continued on next page

These are precisely the kind of outcomes we were hoping for and the kind of proactive problem-solving we expected... Staff on the innovation units are energized by this important work, and I'm energized by their passion and determination to succeed.

Anecdotal feedback from participating units speaks louder than statistics. This is what we're hearing:

- Having a dedicated patient advocate allows us to address issues more proactively
- The visibility of our patient advocate has been great for patients and staff
- Operations associates and unit service associates are now wearing role-identifying uniforms to make it easier and less confusing for patients and families
- A re-admitted patient returned to MGH with an up-to-date Patient-Family Notebook. The re-admitting physicians found this enormously helpful
- Attending nurses are connecting with late admissions in the Pre-Admission Testing Area to ensure continuity. Patients and staff are thrilled with this intervention
- Having an attending nurse's business card and contact information enhances patient satisfaction
- The SBAR (Situation, Background, Assessment, and Recommendations) communication format is being used in e-mails and notes as well as during hand-offs. Even unit service associates are using it
- Weekly staff meetings provide a great forum for capturing questions and feedback and brain-storming solutions

These are precisely the kind of outcomes we were hoping for and the kind of proactive problem-solving

we expected. It's exhilarating to be part of something new—something that enhances care for patients and families and streamlines cumbersome systems. Staff on the innovation units are energized by this important work, and I'm energized by their passion and determination to succeed. I'll keep you informed as we continue to learn and adapt our care and services. In the meantime, for more information, visit the Innovations Unit Web Portal at www.mghpcs.org/innovation_units.

An update on Care Re-Design Teams

Related to our work around innovation units and re-thinking the way we deliver care, MGH recently launched five more care re-design teams that will focus on chronic obstructive pulmonary disease; back pain; premature neonates; psychosis; and rheumatoid arthritis. These new teams join the 11 existing teams that have been working over the past year to streamline systems, eliminate duplication, and decrease costs. The existing teams are: acute myocardial infarction (heart attack); coronary bypass surgery; colon cancer; diabetes; primary care; stroke; endovascular procedures; lung cancer; total joint replacement; transplantation; and vaginal delivery. These multi-disciplinary teams have generated numerous recommendations about how systems can operate more effectively and efficiently. For more information about care re-design and patient affordability, go to: <http://priorities.massgeneral.org/>.

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All hands on deck: working in partnership to advance clinical practice

—by Kate Whalen, RN, clinical nurse specialist, and Barbara Blakeney, RN, innovation specialist

Clinical nurse specialist, Kate Whalen, RN, wanted to create a skills-development program for clinical staff that was both sustainable and within safe practice parameters. A review of the literature showed very little from which to draw, so Whalen started from scratch.

A left ventricular assist device (LVAD) is a mechanical device that's implanted in patients to partially or completely replace the function of a failing heart. Some LVADs are intended for short-term use, others for long-term or permanent placement. Patients with LVADs are routinely transferred from the Cardiac Surgical Intensive Care Unit (CSICU) to the Cardiac Step-Down Unit (Ellison 8) where nurses have specialized knowledge to help develop individualized plans of nursing care.

Staff nurses on Ellison 8 are integral members of the inter-professional team and play an important role in preparing LVAD patients for discharge. Patient-education is designed to support patients as well as home-based caregivers. Primary nurses provide consistent collaboration and communication among team members, recognizing the psycho-social and cognitive conditions necessary for patients to manage LVAD therapy.

Clinical nurse specialist, Kate Whalen, RN, wanted to create a skills-development program for clinical staff that was both sustainable and within safe practice parameters. A review of the literature showed very little from which to draw, so Whalen started from scratch.

Whalen and others had attended the five-part program, *Creating an Environment of Innovation*, sponsored by the Center for Innovations in Care Delivery in 2010–11. The program, which explored the characteristics of an innovative environment—creativity, environment, and innovation—provided Whalen and

her team with the inspiration and encouragement to develop a unique new curriculum.

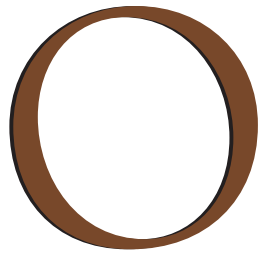
They realized that in order to maintain an ongoing educational program, they needed to develop a core group of nurses with a specific combination of knowledge and skills. The group became content experts, participating in two intensive, industry-level, instructional programs. The same group became versed in the art and science of simulation through the support of The Knight Simulation Program. The greatest challenge was finding relevant evidence, as traditional LVAD education didn't include simulation. Mindful of innovation concepts and evidence-based practice, and with the support of Knight simulation staff, patient scenarios were created from actual nurse-patient experiences. Props were developed to mirror the technical skills needed to manage LVAD patients. Audible alarms were incorporated into problem-focused scenarios to enhance the realism of the simulation.

The MGH LVAD Education Program is the first of its kind in the country and an excellent example of the synergy that comes from bringing diverse perspectives together to design cutting-edge interventions to advance clinical practice. Innovation, simulation, and evidence-based practice contributed to improved patient care on Ellison 8. An example of all-hands-on-deck teamwork at its best.

For more information about the LVAD Education Program or the Center for Innovations in Care Delivery, call Barbara Blakeney, RN, at 4-7468.

MGH Heart Center hosts visiting scholar for Cardiac Nursing

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



On April 12 and 13, 2012, in recognition of the distinctive contributions of clinicians who care for cardiac patients, Patient Care Services welcomed Cynthia Dougherty, RN, the seventh visiting scholar to the MGH Heart

Center. Dougherty's visit included presentations, a panel discussion, a poster session, and rounds on the Cardiac Step-Down Unit, cardiac surgical units, and Electrophysiology Lab.

Dougherty is a professor at the University of Washington School of Nursing in Seattle, Washington, and principal investigator on a number of research projects funded by the National Institutes of Health. Her program of research focuses on patients with implantable cardioverter defibrillators (ICDs) and their partners. Dougherty is also a nurse practi-

tioner in the ICD clinic, part of the Puget Sound VA healthcare system.

Dougherty's first presentation, "Physical and Mental Health of Significant Others is Impacted by ICD Implantation," focused on physical and mental-health outcomes, impact on relationships, and utilization of patients and their significant others for health care. She has devised a nursing intervention for patients and their significant others, implemented during the first three months following ICD implant. The intervention addresses psychological ramifications, the impact of the ICD on relationships, and how to manage care demands at home.

The second presentation, "ICD Care in Advanced Heart Disease," focused on advanced heart-disease trajectory and opening channels of communication around advance care planning and ICD de-activation.

A well-attended panel discussion, "Heart Failure: One Man's Experience Across the Care Continuum," provided an opportunity for Donna Lawrence, RN; Alysia Monaco, RN; Kathryn Shea, RN; and Mary Orencole, RN, to share narratives about one patient for whom all had provided care. Each narrative described the experience of caring for a patient with heart failure on his 20-year trajectory from medical management to heart transplant to post-transplant care, with commentary by Dougherty.

Nine posters were displayed outside O'Keefe Auditorium highlighting the innovative clinical practice of staff in the many different settings where cardiac care is provided. Members of the Cardiac Practice Committee, chaired by Leann Otis, RN, had a chance to engage in conversation with Dougherty regarding care of ICD patients. For more information, contact Diane Carroll, RN, nurse researcher, at 4-4934.

Below: visiting cardiac scholar, Cynthia Dougherty, RN, presents.

Below right: panelists share narratives chronicling 20-year trajectory of heart-failure patient.



Youth scholars experience health care through Knight Simulation Program

—by Susan Leahy, communications manager, center for Community Health Improvement

The Knight Simulation Program has provided hands-on education to MGH clinicians of all experience levels since 2004. This spring, students in the MGH Youth Scholars Program had an opportunity to see first-hand how the human respiratory system functions thanks to a number of scenarios played out in the Knight Simulation Program. The MGH Youth

Scholars Program is a four-year program for Boston high-school students interested in Science, Technology, Engineering, and Math (STEM) with a focus on health care and college readiness. Students learn about various careers through job-shadowing and high-level internships. Nurse educators in the Knight Simulation Program prepared a four-week curriculum for these high-school juniors to augment their school curriculum. Sixteen students applied their science knowledge to real-life clinical situations such as asthma, alcohol intoxication,

and the effects of inhalants. Students learned about various clinical role groups and some of the tools used in emergent clinical situations.

Says Brian French, RN, director of The Knight Simulation Program, “Staff of the Knight Simulation Program developed a classroom model for this innovative new program. We met with biology, chemistry, and anatomy teachers to ensure the curriculum was aligned with a healthcare perspective. And we chose to develop scenarios that focused on problems in the community, such as substance abuse.”

Christy Egun, director of MGH Boston Partnerships, reports, “Once students understood how the equipment worked, they were thrilled to apply what they learned in the various simulation scenarios. The Knight Simulation Program for Youth Scholars is a perfect example of innovative ways to enhance community support.”

For more information about the Knight Simulation Program, call 4-7843. For information about the MGH Youth Scholars Program, call 617-726-7866.



Nurse educators (clockwise from top): Beth Nagle, RN; Jeanne McHale, RN; Mary O'Brien, RN; and Gail Alexander, RN, work with MGH youth scholars in the Knight Simulation Program.

(Photos by Paul Batista)

Results of the 2012 Norman Knight Nursing Center Learning Needs Survey

—by Gino Chisari RN, director, and Mary McAdams RN, professional development specialist,
The Norman Knight Nursing Center for Clinical & Professional Development

The survey was developed to determine the learning needs of MGH nurses providing direct patient care... Most of the areas addressed in the 2012 survey showed an improvement in staff preparedness over 2010 results.

The Evaluation of the Professional Learning Environment for Nurses, or what we informally refer to as the “learning needs survey,” was designed in 2010 by the Norman Knight Nursing Center and clinical nurse specialists on the

Continuing Education Re-Design Task Force. The survey was developed to determine the learning needs of MGH nurses providing direct patient care. It was sent to all direct-care nurses in inpatient and outpatient settings, including advanced practice nurses. Completed in February of 2012, the survey was helpful in:

- determining the perceived learning needs of nurses at MGH
- identifying the best learning methods to enhance knowledge retention
- identifying general learning preferences of MGH nurses
- identifying the best time frame(s) for face-to-face, facilitated learning events

The survey response rate was approximately 43%. The majority of respondents were female (94% female; 6% male). The average age of nurses who completed the survey was 41 years old with 18 years of nursing experience (12 of those years at MGH). 81% of respondents had a bachelor’s degree or higher. Most of the areas addressed in the 2012 survey showed an improvement in staff preparedness over 2010 results.

Areas where staff want more education include:

- Management of Aggressive Behavior
- Managing Workplace Violence
- Managing Family Conflicts
- Prevention/Management of Malnutrition
- Code Status Conflict
- Non-Invasive Mechanical Ventilation
- Understanding Substance Abuse
- End-of-Life Ethical Dilemmas
- Advanced EKG Analysis

Nurses reported that areas where they need less education include:

- Management of Infection
- Physical Assessment (Adult)
- Interpretation of Lab Values
- Care of Patient with Diabetes
- Fetal Heart Monitoring
- Pediatric Emergencies
- How to Use & Manage E-mail
- Basic Computer Keyboarding and Microsoft Office Features

The Norman Knight Nursing Center thanks nurses for participating in the survey and providing us with data we can use to develop new programs and evaluate the current calendar for opportunities to improve. Your feedback is crucial if we are to continue to provide meaningful educational offerings. So don’t hesitate to reach out to us with ideas, suggestions, or recommendations. For more information, call 6-3111, visit www.mghpcs.org/knightcenter, or follow us on Twitter and Facebook.

New nurse comes full circle with compassionate, end-of-life care

What made Fred's hospitalization so frustrating was that he hadn't had any co-morbidities prior to the onset of recent symptoms.

He was a 43-year-old man who walked into the ED at his local hospital complaining of stomach pains.

My name is Molly Murphy, and I am a new graduate nurse in the Blake 12 Intensive Care Unit. I think many of us who worked together in the New Graduate Critical Care Nursing Program are all thinking the same thing: I can't believe it's been a whole year. In a way, it's been the longest and shortest year of my life. As I reflect back on all the experiences I've had, the friends I've met, the mistakes I've made (and learned from), I find myself, a year later, still so excited to work at MGH. Writing this narrative could not have come at a more significant time. The situation I'm writing about happened a little over a week ago, but started back in August during my preceptorship in the Medical ICU.

About ten days ago, I walked into the Blake 12 ICU and was disheartened to see 'Fred's' name on the whiteboard. Not because of any negative feelings toward him, but because I couldn't believe he was back in the ICU. In the locker room, I was met by my nursing colleague, Christa. With wide eyes and a somber look, she informed me that Fred's family had decided it was time to withdraw support. He was too sick, and



Molly Murphy, RN, new graduate nurse, Blake 12 ICU

they couldn't put him through this anymore. Enough was enough. Support would be withdrawn during my shift.

Fred had had an extensive stay at MGH, battling complication after complication, including DVTs (blood clots), septic shock, pneumonia, and recurrent infectious abdominal abscesses following surgery, to name only a few. After an initial diagnosis of cholecystitis, he was unable to wean from the ventilator, so he was trached and sent to the Respiratory Acute Care Unit, the first in a long line of transfers and re-admissions.

What made Fred's hospitalization so frustrating was that he hadn't had any co-morbidities prior to the onset of recent symptoms. He was a 43-year-old man who walked into the ED at his local hospital complaining of

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Often, we can't make sense of things that happen, why bad things happen to good people, why a seemingly healthy person suddenly develops a terminal condition. I said a final prayer for Fred. I couldn't help think that, while the bigger picture of his illness didn't make sense to me, my role as his nurse that night did.

stomach pains. He was transferred to MGH when a scan showed an enlarged gall-bladder and a possible need for surgery. Fred's brother, best friend, and health-care agent, wanted his care to be managed here, since their mother had recently had gallbladder surgery at another hospital and hadn't recovered. He wanted a better outcome for his brother. He wanted him here at MGH.

I knew all this because I had been the nurse back in August who admitted Fred from the transferring hospital. Tonight, as I took Fred on as my patient once again, I couldn't help feel a sense of divine intervention. I had been the one who admitted Fred to MGH, and now I would be the one to let him go.

My preceptorship in the MICU had been a whirlwind of nerves, new experiences, building confidence, and defining myself. Every day brought new challenges, and my amazing preceptor, Michael, guided me every step of the way. But it wasn't until I started admitting patients to the MICU on my own that I started to feel legitimate. I started to feel as though the patients were mine—a sense of ownership, so to speak.

So Fred, naturally, had always felt like my patient, regardless of what unit he was on. When I started in the new Blake 12 ICU, everything was new again—it was like pressing a reset button on the routines I had learned in the MICU. Then one night, I came in, and Fred's name was on the whiteboard. My patient. It was like seeing an old friend.

He remembered me. We caught up. I visited with his brothers, and despite being heartbroken at his lack of clinical progress, I was happy to see him. But this night was going to be different, as Christa had informed me in the locker room. During official report, I learned that Fred had finally made it to rehab, had come in for a follow-up appointment with an elevated temperature. Then, as quickly as he'd been re-admitted, he spiraled into full-blown septic shock. He became sicker than he'd ever been during his prior eight-month stay. He maxed out on three different vasopressor medications; his lactate level was sky-high; and his pH was precipitously low. He was sick with no reserves left.

When his brothers and sisters were informed of this new turn, they knew this was it. As his seven siblings gathered in the waiting room, I knew it was important to have one last family meeting to explain the process of withdrawing support. I wanted them to know there was no immediate rush, that withdrawing support could be driven by their readiness to do so. The doctor, nurse practitioner, and I called a meeting. We explained the decisions, the process, and opened it up for questions. My goal was to make this tragic experience a little less scary and overwhelming. I knew a family meeting would help.

After preparing the room with Courtney, another nurse, we brought Fred's family in to be by his side. They had arranged for their family priest to administer Last Rites (or the Sacrament of the Anointing of the Sick). Fred passed away peacefully some time later, surrounded by those who cared for him the most.

I felt privileged to be part of this process. I didn't feel like a stranger in the room, because I knew Fred, and I knew his family. It felt like I belonged there, like I was meant to be there. Things had come full circle. Often, we can't make sense of things that happen, why bad things happen to good people, why a seemingly healthy person suddenly develops a terminal condition. I said a final prayer for Fred. I couldn't help think that, while the bigger picture of his illness didn't make sense to me, my role as his nurse that night did.

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

This is a charming narrative by a new nurse experiencing that sense of 'legitimacy and ownership' for the first time. I'm sure all veteran clinicians can relate to that universal rite of passage. Molly felt a sense of personal responsibility to be present for Fred in his final hours and to usher his family through the experience with support and compassion. We *can't* always make sense of illness and death. But as Molly so aptly found out, we can always make sense of doing right by our patients.

Thank-you, Molly.

Some changes to the portfolio for advanced clinicians and clinical scholars

—by Ann Jampel, PT, and Christine E. McCarthy, RN, co-chairs of the Clinical Recognition Review Board

Beginning September 1, 2012, some changes will go into effect regarding the preparation of portfolios for those applying for recognition as advanced clinicians and clinical scholars in the PCS Clinical Recognition Program.

Beginning September 1, 2012, some changes will go into effect regarding the preparation of portfolios for those applying for recognition as advanced clinicians and clinical scholars in the PCS Clinical Recognition Program. After a thoughtful review process, a Tiger Team comprised of staff and leadership of all disciplines participating in the Clinical Recognition Program, the CRP Review Board, and the CRP Steering Committee, announced the following changes:

- Three letters of support will be required for both the advanced-clinician and clinical-scholar levels (four letters were previously required for the clinical-scholar level)
- For both levels, one letter of support must come from the unit or department leadership of the applicant's own discipline
- For nurses, the letter of support required from outside their discipline may include: nurse practitioners; nurse midwives; psychiatric clinical nurse specialists; and certified registered nurse anesthetists

The decision to decrease the number of letters required for clinical scholars is in direct response to last year's survey which revealed that clinicians perceived the application process as too laden with 'paperwork.'

Requiring a letter of support from the applicant's own unit or department leadership provides an oppor-

tunity for that important perspective and knowledge of the clinician's practice to be included in the portfolio.

Finally, the decision to identify certain advanced practice nurses as 'outside the discipline' reflects the evolution of these clinicians as direct-care providers and acknowledges their collaborative work with staff nurses.

Effective September 1, 2012, portfolios for advanced clinician and clinical scholars should include:

- cover letter
- clinical narrative
- resume
- endorsement of his/her director
- two letters of support from within the discipline, one of which must come from unit or department leadership
- one letter from outside the discipline, which for nursing applicants may include the role groups mentioned above

For more information about these changes, contact Ann Jampel, PT, clinical education coordinator, at 4-0128, or Christine E. McCarthy, RN, staff nurse, at cemccarthy@partners.org.

For information about the Clinical Recognition Program, go to: <http://www.mghpcs.org/IPC/Programs/Recognition/Index.asp>.

Advance Care Planning Booth sees another successful year

—by staff nurses, Anastasia Tsiantoulas, RN, and Billie Jo Watson, RN,
for the Ethics in Clinical Practice Committee

Members of the PCS Ethics in Clinical Practice Committee staff educational booth in the Main Corridor to raise awareness about advance care planning.

On April 16, 2012, the PCS Ethics in Clinical Practice Committee hosted another successful Advance Care Planning booth for patients, visitors, and staff. Now in its 12th year, the booth provides information on advance care planning, types of advance directives, considerations when selecting a healthcare proxy, and other important concerns. Packets containing Massachusetts Health Care Proxy forms, a list of Internet resources, and the MGH patient-education brochure, *Preparing in Advance for your Health Care and Preparing to be a Health Care Agent*, were available. The date of the Advance Care Planning booth coincides with National Health

Care Decisions Day, which is observed annually on April 16th to heighten awareness of the importance of advance care planning. Proclamations from Governor Patrick and Mayor Menino were on display to highlight the importance of these efforts and this aspect of care at MGH.

Conversations related to healthcare decision-making are best addressed before the onset of a life-threatening condition. Having a continuing dialogue about advance care planning is essential in the event an individual becomes unable to speak for himself (a family member, or significant other).

Studies show that less than 50% of severely or terminally ill patients have an advance directive in their medical records. Only 12% of patients who have advance directives received input from their physicians in developing it. And 65–76% of physicians whose patients have advance directives were not aware they existed.

There has been progress in recent years:

- Last year, more than 2.2 million medical staff, employees, or organizational members received education on advance directives or information about National Health Care Decisions Day
- More than 17,500 advance directives were executed on National Health Care Decisions Days alone

To download the Massachusetts Health Care Proxy form (in English and other languages) or to review the process for using an interpreter go to: Partners Applications>PCS Resources>Health Care Proxy forms.

To obtain copies of the brochures, *Preparing in Advance for your Health Care* and *Preparing to be a Health Care Agent*, follow the links in PCOI: Patient Information> Senior Health or End of life>Advance Care. These brochures are also available in color through Standard Register (SR document # 84669).

For more information, contact Anastasia Tsiantoulas, RN, at 8-5600.



(Photo by Joe Ferraro)

Blood transfusion and labeling at the bedside

Question: Why is labeling laboratory specimens in the presence of the patient so important?

Jeanette: Labeling errors can have serious consequences. Labeling specimens in the presence of the patient is a safety measure and one more way to ensure we have the right patient, the right sample, and the right result.

Question: Who is qualified to participate in the verification process prior to initiating a transfusion?

Jeanette: Verification must be performed by:

- two registered nurses, one of who must have completed MGH Transfusion Therapy Training and demonstrated competence, and another who has completed the Verification Education Program, or
- a physician and a registered nurse who has completed the Verification Education Program

Question: Where is the verification process documented?

Jeanette: The verification process is documented in the Transfusion Record. It's important that each step outlined on the form be checked off individually and that the record be signed with the name and licensure of the clinicians who participated in the verification process.

Question: Who is qualified to initiate transfusions of blood and blood products?

Jeanette: Transfusions must be administered by a physician, a registered nurse, a nurse practitioner, or a physician assistant who has completed Transfusion Therapy Training and demonstrated competence. Respiratory therapists certified in ECMO who have completed Transfusion Therapy Training may administer transfusions during ECMO procedures.

Question: How are patients monitored for signs of transfusion reaction?

Jeanette: Patients are monitored before, during, and after transfusion.

The nurse obtains vital signs (blood pressure, pulse, respiratory rate, and temperature) before the transfusion begins. It is recommended that vital signs be obtained at the time blood is requisitioned.

A registered nurse must stay with the patient for five minutes after initiating a blood transfusion to monitor for signs of a serious reaction and stop the transfusion should a reaction occur.

Vital signs are taken 15 minutes after the start of the transfusion (no later), 45 minutes to an hour after the first check, every hour while the transfusion is running, and within 60 minutes after the transfusion is discontinued.

Question: Where can I find more information about blood transfusion protocols?

Jeanette: See "Blood Transfusion" in the *Clinical Policy and Procedure Manual*, and "Transfusion Therapy Overview," in the *Nursing Procedure Manual*. For more information, call 6-6940.

Identifying patients' preferred language for healthcare discussions

Question: Why is it important to identify a patient's preferred language for healthcare discussions?

Jeanette: Being able to communicate with patients and families in their preferred language improves communication, enhances the delivery of patient- and family-centered care, and is an important component of cultural competence. In some cases, a patient's preferred language for healthcare interactions may be different from his or her primary language. The Joint Commission requires hospitals to identify patients' communication needs. To do so, clinicians need to identify the language in which patients prefer to discuss healthcare information.

Question: How do we determine a patient's preferred language?

Jeanette: During registration, patients are asked, "In what language do you prefer to discuss your health-related concerns?" That language is documented in the patient's registration record.

Question: What about children who are fluent in English, but their parents or guardians aren't?

Jeanette: Since parents and guardians have the legal authority to make decisions on the child's behalf, we need to meet the needs of the patient's parents, guardians, or surrogate decision-makers by providing them with an interpreter in their preferred language.

Question: Some patients speak some English, but they've identified another language as their preferred language to communicate with their caregivers. Should interpreters be requested for these patients?

Jeanette: Patients have the right to a professional medical interpreter even if they speak some English. Patients may have a basic understanding of English and be able to make an appointment or check in on their own. But their ability to fully participate in a healthcare discussion may be limited. They may not be fluent enough to verbalize complex thoughts or information.

Question: Are there any tools to help patients communicate their language needs?

Jeanette: Yes. Interpreter Services has developed language cards in the 23 most requested languages, including American Sign Language (ASL). Patients can use the cards to identify their preferred language, and the cards contain contact information for Interpreter Services. Patients simply show the card to a staff member so that an interpreter can be requested.

Question: If a Deaf or Hard-of-Hearing patient's preferred language is ASL, in the absence of a professional medical interpreter, is it acceptable to communicate by writing or lip-reading?

Jeanette: It is important to provide a professional ASL medical interpreter for all medical appointments and conversations with Deaf or Hard-of-Hearing patients. Many Deaf or Hard-of-Hearing patients have only a basic understanding of written and verbal English, so written information can be grossly misunderstood. For the same reason, lip-reading is not an effective way to communicate. Many words 'look' the same when spoken (for example: pail, bail, and mail would all look the same when spoken). This can lead to misunderstandings.

For more information, contact Interpreter Services at 6-6966.

Mary C. Forshay Scholarship to Support ALS Care

—by Julie Goldman, RN, professional development program manager

Forshay scholarship recipient, Julie MacLean, OTR/L, (left center) with (l-r): Bob Forshay (Mary's husband); Mary Lou Kelleher, RN, former MGH CNS and family friend; and Eileen McCarthy Toti (Forshay's sister).

On April 11, 2012, Julie MacLean, OTR/L, senior occupational therapist, received this year's Mary C. Forshay Scholarship to Support ALS Care. MacLean was recognized for her compassion and advocacy in her care of ALS patients. Mary Forshay's husband and family established the scholarship in her memory to recognize exemplary care of ALS patients and promote educational opportunities for staff. While she was ill, Forshay was cared for in the Respiratory Acute Care

Unit and ALS Clinic. Her loved ones felt that offering a scholarship to enable caregivers to advance their knowledge and care of ALS patients was a fitting way to honor her life and career.

MacLean specializes in the rehabilitation of patients with neurological disorders. Said Occupational Therapy clinical director, Jane Evans, OTR/L, "Julie has a passion for occupational therapy and for her patients. She has a strong desire to develop her clinical knowledge so she can better serve her patients. She is a professional who always keeps the patient's needs at the center of her treatment."

Said Forshay's husband, Robert, "Before reading Julie's nomination packet, I didn't know that much about the care provided by occupational therapists. In reading about Julie, I was able to learn that occupational therapists help patients develop coping strategies and skills to move forward along the care continuum. As a family, we were honored to read the wonderful letters of nomination for Julie. This is the third year of Mary's Scholarship, and each year we are thrilled to have so many clinicians committed to the care and advocacy of ALS patients and families. We're happy to provide this scholarship so that each year a clinician can attend the National Conference to learn and come back and share that knowledge with their colleagues, patients, and families."

For more information about the Mary C. Forshay Scholarship to Support ALS Care, call Julie Goldman, RN, at 4-2295.



(Photo by Joe Ferraro)

Professional Achievements

Browne elected

Gerald Browne, RN, staff nurse, Cancer Center, was elected president of the New England Chapter of the American Assembly for Men in Nursing in March, 2012.

Larkin appointed

Mary Larkin, RN, clinical research manager, Diabetes Center, was appointed board member at large of the International Association of Clinical Research Nurses, January 1, 2012.

Drake honored

Thomas Drake, senior educational development and project specialist, was awarded the HealthStream User Group Excellence Award in Nashville in March, 2012.

Konner honored

Karon Konner, LICSW, social worker, received the Emerging Leader Award from the Massachusetts Chapter of the National Association of Social Workers, in March, 2012.

Cole presents

Elizabeth Cole, PT, physical therapist, presented, "Lymphedema and Swelling—How to Recognize and Treat," at the Rhode Island Chapter of the American Physical Therapy Association, in Pawtucket, March 14, 2012.

Mulligan certified

Janet Mulligan, RN, nursing director, IV Therapy, became certified in Infusion Nursing by the Infusion Nurse Certification Corporation and the Infusion Nursing Society, in March, 2012.

Nurses publish

Lea Ann Matura, RN; Annette McDonough, RN; and Diane Carroll, RN, authored the article, "Cluster Analysis of Symptoms in Pulmonary Arterial Hypertension: a Pilot Study," in a recent issue of the *European Journal of Cardiovascular Nursing*.

Nurses present poster

Todd Hultman, RN, nurse practitioner; Amanda Bulette Coakley, RN, staff specialist; Christine Donahue Annesse, RN, staff specialist; and Sharon Bouvier, RN, nursing director, presented their poster, "Factors Contributing to Sleep Disturbances in Patients in an Acute Hospital Setting," at the Eastern Nursing Research Society in New Haven on March 29, 2012.

Lowe presents

Colleen Lowe, OTR/L, occupational therapist, presented, "Sensation and Sensibility, Upper Extremity Course," at Tufts University, March 26, 2012.

Nurses present

Diane Carroll, RN, Patricia Dykes, RN, and Kumiko Ohashi, RN, presented, "Symposium on the Development and Implementation of Bedside Information Toolkits to Support Safe Patient-Centered Care," at the 24th annual scientific sessions of the Eastern Nursing Research Society, in New Haven, March 28, 2012.

Levin presents

Barbara Levin, RN, staff nurse, Orthopaedics, presented, "Untangling Charlotte's Web," and "Clinical and Legal Issues for Nurses," at the Massachusetts Nurses Association in Lenox in March, 2012.

Levin also presented, "Broken Bones," at the Orthopaedic Nursing Program at Regis College in April.

Whitney presents

Kevin Whitney, RN, associate chief nurse, presented, "An Update on the IOM Future of Nursing, Massachusetts Action Coalition," for the Robert Wood Johnson site visit at Children's Hospital, Massachusetts General Hospital, and the Massachusetts State House, March 19–20, 2012.

Winne and Cashavelly present

Maria Winne, RN, nursing director, RACU, and Barbara Cashavelly, RN, nursing director, Oncology, presented, "The Role of the Acute-Care Nurse Practitioner: New Models for Acute-Care Delivery in an Academic Medical Center," at the 45th annual meeting and exhibition of the American Organization of Nurse Executives, in Boston, March 22, 2012.

Nurses present poster

Diane Carroll, RN, nurse researcher; Erica Edwards, RN, staff nurse; and Lisa Davies Despotopoulos, RN, staff nurse, presented their poster, "Nurses' Perceptions of Family Presence in the Intensive Care Unit During Resuscitation and Invasive Procedures," at the 12th annual spring meeting of the Council of Cardiovascular Nurses and Allied Professionals European Society of Cardiology, in Copenhagen on March 17, 2012.

Levin elected

Barbara Levin, RN, staff nurse, Orthopaedics, was elected director of the National Association of Orthopaedic Nurses, in March, 2012.

Hylar certified

Rachael Hylar, RN, staff nurse, RACU, became certified in Medical-Surgical Nursing by the American Nurses Credentialing Center on March 21, 2012.

Roche presents poster

Constance Roche, RN, nurse practitioner, Surgical Oncology, presented her poster, "A Program to Increase Use of Chemoprevention for Women with High-Risk Breast Lesions," at the annual inter-disciplinary Breast Center Conference in Las Vegas, March 11, 2012.

Inter-Disciplinary team publishes

Catherine Beauharnais; Mary Larkin, RN; Adrian Zai, MD; Emily Boykin, RN; Jennifer Luttrell; and Deborah Wexler, MD, authored the article, "Efficacy and Cost-Effectiveness of an Automated Screening Algorithm in an Inpatient Clinical Trial," in the February 3, 2012, *Clinical Trials*.

Pardasaney publishes

Poonam Pardasaney, PT, physical therapist, authored the article, "Sensitivity to Change and Responsiveness of Four Balance Measures for Community-Dwelling Older Adults," in the March, 2012 issue of *Physical Therapy*.

Nurses publish

Laura Rossi, RN; Millie Leblanc, RN; Karen Miguel, RN; and Kathy Tobin, RN, co-authored the chapter, "The Joint Commission, National Patient Safety Goals, and Radiology: Making the Grade," in a recent issue of *Quality and Safety in Radiology*.

Inter-Disciplinary team publishes

Lori Laffel, MD; Nancy Chang, RN; Margaret Grey; Dan Hale, MD; Laurie Higgins, RD; Kathryn Hirst; Roberto Izquierdo, MD; Mary Larkin, RN; Christina Macha, RD; Trang Pham; Aimee Wauters, RD; and Ruth Weinstock, MD, authored the article, "Metformin Monotherapy in Youth with Recent Onset Type 2 Diabetes: Experience from the Pre-Randomization Run-In Phase of the TODAY Study," in the February 27, 2012, issue of *Pediatric Diabetes*.

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Submissions

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For more information, call: 617-724-1746

Next Publication

May 31, 2012

Announcements

ACLS Classes

Certification:

(Two-day program)

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

Day one: May 14, 2012
8:00am–3:00pm
O’Keeffe Auditorium

Day two: May 21st
8:00am–3:00pm
Thier Conference Room

Re-certification (one-day class):
June 11th
2:00–7:00pm
Founders 130

September 29th
8:00am–1:00pm
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

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>.

OB-GYN nursing scholarship offered

The von Metzsch Endowed Scholarship Program to advance nursing education in the Vincent Obstetrics and Gynecology Department is currently accepting applications from staff within the Vincent Obstetrics and Gynecology Department.

Applications must be submitted by May 30, 2012. Recipients will be announced July 17, 2012.

For more information, call 6-1392.

Blum Center Events

Shared Decision Making:
“Coping with Symptoms of Depression”

Thursday, May 10, 2012
12:00–1:00pm

A video and discussion with Albert Yeung, MD, and Timothy Petersen regarding options for coping with depression.

National Health Observance Series:

“Understanding Asthma”
Thursday, May 24th
12:00–1:00pm

Learn what asthma is, how it is treated, and more. Presented by Nancy Davis, RTT.

Programs are free and open to MGH staff and patients.

No registration required.

All sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

EAP Work-Life Seminars

“Choosing Child Care”

Partners Employee Assistance Program (EAP) and Partners Child Care Services present an educational roundtable discussion for those new to parenting and child care. Discussion will explore child-care options, costs, how to find and evaluate options, internal resources for care and back-up care. Presented by: Allison Lilly, LICSW, Partners EAP operations manager; and

Sheryl Lauber Weden, director of Business Development at Partners Child Care Services.

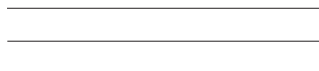
Tuesday, May 15, 2012
12:00–1:00pm

Bulfinch 222 Conference Room

For more information, call 6-6977.



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