Big Papi helps MGH celebrate Latino Heritage Month

(See story on page 6)
Care with dignity:
*a look at the complex issue of obesity in America*

When we hear the words, ‘culturally competent care,’ our minds no doubt go to some subgroup of the dominant or mainstream population, such as African American, Muslim, gay, elderly, or disabled individuals. How many of us think of obese patients when we hear the words culturally competent care? With a dramatic increase in the incidence of obesity in the United States over the past 20 years, there is a growing need for open dialogue and education around this greatly misunderstood condition.

According to former US Surgeon General, David Satcher, MD, obesity may not be an infectious disease, but, “it has reached epidemic proportions in the United States, and if the situation is not reversed, it could wipe out the gains we have made in areas such as heart disease, diabetes, several forms of cancer, and other chronic health problems.”

As healthcare providers, we are committed to providing care that meets the individual needs of every patient who comes through our doors. As healthcare providers, we are uniquely positioned to have a positive impact on the health and wellness of patients and families. The problem of obesity didn’t materialize overnight, and it won’t be solved that way, either. A unified, comprehensive approach is needed to educate ourselves and our patients, to change patterns and behaviors, and to begin thinking differently about health, fitness, eating, how we talk to patients about obesity, and safe patient-handling techniques.

Some information you should know about obesity:
- Obesity is defined as having a very high amount of body fat in relation to lean body mass, or a body mass index (BMI) of 30 or higher
- Overweight and obese individuals are at increased risk for hypertension, osteoarthritis, high cholesterol, Type 2 diabetes, coronary heart disease, stroke, gall-bladder disease, sleep apnea, respiratory problems, and some cancers
- Obesity affects people of all backgrounds, age, race, gender, economic status, ethnicity, profession, education, and geographic location
- Statistics around childhood obesity are especially troubling: over the past four decades, childhood obesity rates have soared, with children 6–11 years old increasing almost five-fold (that translates to 25
Many obese patients avoid seeking health care altogether for these reasons. The challenge for us is to care for overweight and obese patients in a sensitive, compassionate way, in an environment that supports their physical, emotional, and psychological needs.

And as we well know, we are hindered in our efforts by the pervasive, multi-billion-dollar food and beverage industry targeting adults and children with non-stop ads for high-calorie, high-fat, nutrient-poor food products.

There is a problem in this country. That means there's a problem right here in our hospital. To let the issue of obesity go un-addressed is to contribute to the problem. What are we going to do about it?

Recently, I had the opportunity to attend a national summit on, "Obesity in America," hosted by the Robert Wood Johnson Executive Nurse Fellows Program. I was accompanied by my colleagues, Gaurdia Banister, RN, director of The Institute for Patient Care; Deborah Washington, RN, director of PCS Diversity; and Jan Bellack, RN, president of the MGH Institute of Health Professions.

The take-home message from this summit was that obesity in America is an epidemic that requires the attention, participation, and resources of the entire healthcare community. If not us, who?

Are we ready to educate ourselves and familiarize ourselves with the evidence related to obesity and its associated illnesses?

Are we ready to have crucial dialogues with each other, our patients, and their families about obesity, good health practices, and how to make better choices?

Are we ready to face our own prejudices and biases about obesity and move beyond them to provide non-judgmental, culturally competent care to all our patients?

Are we ready to take a hard look at our own environment and make changes that support healthier lifestyles? Do we really need soda at meetings? Are potato chips the best choice for a snack on the run? Can we carve out time for ourselves to exercise every day?

At a Schwartz Center Rounds in 2001 entitled, “Obesity: the Last Bastion of Prejudice,” clinicians shared these ideas:

- ask patients’ permission to talk about their weight
- ask patients to talk about how their weight impacts their lives
- assure patients that obesity is not their fault; it is the result of a disease
- purchase the proper equipment, furniture, garments, and instruments to accommodate and support the care of severely obese patients

I urge you to continue this dialogue with your colleagues and co-workers. Share your ideas and best practices. When MGH clinicians put their minds to something, there’s no limit to what we can accomplish. Let’s break down that ‘last bastion of prejudice’ and make sure every patient receives care with dignity.
Helping parents cope with perinatal loss: nurse-to-nurse collaboration

— by Connie Wilson, RN, staff nurse, Blake 14; Kelly Coleman, RN, staff nurse, Blake 14; and Cynthia Ann LaSala, RN, clinical nurse specialist, Phillips 20 and 21

Approximately 50% of all stillbirths occur prior to the onset of labor and in uncomplicated pregnancies. For these parents, what is anticipated to be a joyous event can suddenly become a situation of profound loss, emotional stress, despair, and confusion.

Bereavement is a process of grief and mourning in response to the loss of a close relationship. It has been described as the period following a loss during which people experience feelings of deprivation or suffering due to the loss or death of a loved one. The death of a child while inside the mother’s womb or shortly following birth causes deep sorrow and pain frequently associated with feelings of anger, hostility, hopelessness, lack of self-worth, and physiological distress (loss of appetite, overeating, altered sleeping patterns, etc.)

Parents can experience a loss of self-esteem and lack confidence in their ability to produce a healthy child. Nurses play a critical role in a parent’s psychosocial and spiritual recovery by providing compassionate care, advocating for parental concerns, creating a safe environment for parents to discuss their loss, and acknowledging gender and cultural differences. Patients often endure hours of labor to deliver a stillborn child just as they would for a healthy baby.

Nurses examine the contents of a memory box at recent inservice training session presented by the Obstetrics Bereavement Committee.

Continued on next page
In losses of less than 22 weeks, patients can be discharged within hours of delivery. In cases involving later-term losses when additional medical treatment is required, patients are often transferred to the Phillips House. During the initial period following perinatal loss, staying on a unit where new parents are caring for their babies is psychologically difficult for these patients and families.

The Obstetrics Bereavement Committee was formed in an effort to ensure that patients receive optimal care that addresses both physical and emotional needs. The committee discusses practice issues, implements policies regarding perinatal loss, and provides bereavement presentations on an ongoing basis. The primary objective of these presentations is to teach nurses about issues specific to perinatal loss so they can provide the best possible care to patients and their families.

Discussions between the nursing directors for Blake 14 and Phillips 20 and 21 identified a need to educate staff nurses on Phillips 20 and 21 about the care of patients who experience loss during pregnancy or immediately after delivery. A series of inservice training sessions was developed and implemented in collaboration with the clinical nurse specialists on these units. The sessions review causes of fetal loss and the medical, psychosocial, and cultural issues involved. Whether the situation involves the induction of labor for a fetal demise or a termination due to fetal or maternal complications, grief is overwhelming. Nurses play a critical role in the healing process for these patients and families.

In bereavement training sessions, the stages of grief and common feelings and issues regarding subsequent pregnancies are discussed. Patients often have to deal with physical sensations such as ‘feeling the baby move’ or ‘hearing the baby cry.’ It’s important for patients to know and understand that these are normal responses, similar to phantom pain in an amputee. Patients can demonstrate signs of depression and an aversion to major holidays and anniversaries. The importance of listening to patients rather than trying to say the right thing is also explored.

The following interventions can be helpful to patients and families:
- Encourage parents to see and hold the baby to aid in the healing process
- Provide memory boxes containing photos of the baby, measurements, footprints, etc.
- Recommend grief therapy
- Provide or refer patients to support groups
- Refer patients to appropriate websites and written resources
- Encourage patient to express themselves through journaling, creating a memory garden, etc.

Given the diversity of our patient population, nurses must be aware of the different rituals and customs associated with fetal death and bereavement in different cultures and religions. Bereavement training provides an overview of some of the major cultures and religions including Hispanic, Asian, African, Middle Eastern, Christian, Muslim, Hindu, and Jewish.

Other topics focus on preparing for discharge and returning home. Parents may be faced with taking down a nursery and the insensitivity of some people regarding their loss. It’s not uncommon for fetal loss to have an effect on a couple’s marriage.

Bereavement training sessions offered by the Obstetrics Bereavement Committee is a collaborative effort that helps nurses share knowledge and resources across patient care units. It is an example of how nurses work together to share expertise ensuring patients have the most comprehensive care we have to offer.

Building on this cooperative spirit, nurses from Phillips 20 and 21 and Blake 14 plan to develop a bereavement resource manual for patients and staff that will include information related to perinatal loss. Bereavement training sessions are available as needed to meet the needs of staff regarding these challenging issues.

For more information, contact Cynthia LaSala, RN, clinical nurse specialist, at 3-0481.
The first of two Latino Heritage Month celebrations took place Thursday, September 27, 2007, marking the seventh Latino Heritage Month celebration at MGH. More than 250 employees from various departments and role groups filled O’Keeffe Auditorium to hear Red Sox slugger and hometown favorite, David ‘Big Papi’ Ortiz, speak. Ortiz, who went straight from MGH to Fenway Park after his speech, entered to a roaring standing ovation and left the same way. Addressing a crowd of predominantly Latino employees, Ortiz gave the majority of his remarks in Spanish. Following are excerpts from Ortiz’ speech:

Good morning. My name is David Ortiz. You may know me better as ‘Big Papi.’

I’ve been to this hospital about ten times now, four as a patient and six to visit sick children and people who, when I walk into their rooms, they smile. It makes them feel good. And that means a lot to me.

When I was here last year for a check-up, I didn’t see very many Latino nurses or doctors. I thought it was a little strange. But now I see you were just waiting for today to have everyone all together in one place (audience cheers).

I am 31 years old. And I am getting older. You and I come from places where people are good, where people are humble, where people work hard, and where people have good hearts. But we come from places where people do not have opportunities; we do not have what we need to achieve the ‘American dream.’ But sometimes, if you do the right thing you can be somebody in the future. This is what I have lived. When I came here, I came alone. I was 17 years old. I come from a small family, but we were very tight. Back then I said, “Papi, Mami, I have to go.” Our families are like birds. As soon as a young bird can fly, he leaves the nest and begins his own life. The majority of our families depend on us. That’s why it is so important to give back to your people and do the right thing.

Many times we encounter difficult situations. That is part of life. The way I view life is: It doesn’t matter how many times you get knocked down, what’s important is how many times you get back up.

Continue to work hard. I know you’re proud of your baseball team. But I want you to know that, we, the Red Sox, are proud of you, too. You are our pride.
Q&As

Patients First: working hard to prevent patient falls

**Question:** What is Patients First?

**Jeanette:** Patients First is a quality and safety initiative that was endorsed by the Massachusetts Hospital Association and the Massachusetts Organization of Nurse Executives in January, 2005. It was established to ensure that hospitals are providing a work environment that supports caregivers, promotes patient safety, helps ensure effective staffing, advances best practices, and involves patients and the public in improving that care.

**Question:** What role do hospitals play?

**Jeanette:** Hospitals commit to use a common framework to measure and report pre-identified performance indicators and agree to publicly report a common set of nursing-sensitive, evidence-based indicators.

**Question:** What indicators are included?

**Jeanette:** We will be reporting on nursing hours per patient day, fall rates, fall rates with injury, and pressure ulcer rates. This information will be available to the public on the Patients First website, patientsfirstma.org.

**Question:** When will the data be available for the public?

**Jeanette:** Data on nursing hours per patient day is already available on the website; fall rates will be available in late October; and pressure ulcer rates by the end of 2007.

**Question:** What is considered a patient fall?

**Jeanette:** The National Database of Nursing Quality Indicators defines a patient fall as an unplanned descent to the floor with or without injury to the patient. All falls are included whether they result from physiological reasons (fainting) or environmental reasons (slippery floors). Also included are assisted falls, when a staff member attempts to minimize the impact of a patient fall.

**Question:** How does MGH compare to other hospitals in regard to patient falls?

**Jeanette:** I’m pleased to report that our fall rate with injury is lower than the state norm. Our data shows opportunities for improvement in our overall fall rate, particularly in the medical-surgical area, which includes the neuroscience units.

**Question:** What are we doing to address patient falls?

**Jeanette:** A Tiger Team was created specifically to focus on patient falls. This multi-disciplinary group, chaired by associate chief nurse, Theresa Gallivan, RN, has initiated installation of ceiling lifts on ten inpatient units and a revision of RL Solutions™ fall reporting fields. Work is underway to evaluate bed and chair alarms, develop new teaching tools, evaluate fall-prevention products, and re-visit Patients First category groupings. For more information on the work of this team, contact Theresa Gallivan at 4-1767.
New nurse learns that world-class care comes with world-class teamwork

My name is Kate Keller, and I am a nurse on the Ellison 8 Cardiac Surgical Unit. Nurses symbolize hope; hope that healing will come and pain will go away. MGH is known the world over for its clinical excellence, groundbreaking research, and unparalleled patient care. But what the rest of the world doesn’t see is the family that exists within this institution that makes everything else work. We weave ourselves together to support and guide one another through the best of times and the worst of times. We celebrate together, and we grieve together. We teach each other, and we support each other.

Mr. T had already suffered several post-operative complications, but he remained ‘in good spirits’ as we say. On the day he was supposed to return home, he suffered a heart attack. He spent two weeks on the Coronary Care Unit before undergoing heart surgery that was technically a success, but the events that transpired after his surgery would challenge every resource MGH had to offer.

I met Mr. T on his first night out of the Cardiac Surgical ICU. I was a year and a half out of nursing school and was beginning the first of a series of night shifts. Mr. T had lost one leg and was already scheduled to have his other leg amputated as a result of a rare post-operative complication. To my surprise, I found him animated and inspiring. We talked about his work, his family, his life, and his future. I immediately signed on to be Mr. T’s primary nurse by placing a magnet with my name on it next to his name on our census board. It was a simple act that would change my life as a nurse.

As a novice, there was so much I’d never seen and only read about in order to pass an exam. When Mr. T returned to Ellison 8 after his second amputation, I again placed my name next to his. As I spent Christmas with Mr. T and his family, I noticed his breathing was labored, ever so slightly. His vital signs and oxygen saturations told me he was breathing sufficiently, but I had a feeling something wasn’t right. When I returned to work days later, I was told he had suffered from respiratory distress requiring re-intubation. Over the next week he would have a tracheostomy for failure to wean off the ventilator. I always wondered if I had missed something. Should I have seen something that could have prevented these events?

I had taken respiratory care classes here at the hospital. I had spent time in the CSICU with a respiratory therapist learning about ventilators and suctioning. When Mr. T returned to Ellison 8, so did my name next to his on the board. I leaned on more experienced clinicians to help me cope with my fears about the new machine. They taught me what to look for should there be an issue with the machine. Respiratory therapy...
pists reminded me about suctioning and arterial blood gases. As a team, we developed a plan to help Mr. T wean off the ventilator. Every day he would scribble on a piece of paper, “I want my voice back.” Every day we worked to make that happen. When he finally was successfully weaned, I was taken aback by the sound of his voice. I had become accustomed to acting out charades, deciphering his drawings, and using the cue cards we made with his 15-year-old daughter. I was constantly learning about respiratory care and syndromes, tracheostomies, feeding tubes, and how to help a family cope in such a rare and unimaginable situation. My circle of resources began to include physical therapists, occupational therapist, speech-language pathologists, nutritionists, and social workers.

Every time one obstacle was cleared, a new one appeared. As a team, we weaned Mr. T off the ventilator to a trach mask and eventually a trach button. Soon, he was fit for a prosthesis. His already complex discharge planning had begun when Mr. T suffered a GI bleed requiring another trip to the ICU.

Upon his return to Ellison 8, the pressure ulcer on his sacrum had become deeper, making it almost impossible for him to sit up with his new prosthesis. A new plan was developed. He required intense pulmonary care once again, but this time I knew what to do. I began sharing the information I was learning with other nurses on the unit and teaching them my newfound techniques and skills.

Mr. T had a total of six re-admissions to the Cardiac Surgical ICU for respiratory distress, GI bleeding, infections, and even partial sternum removal. Being uprooted to a new environment seemed to take a mental and spiritual toll on him and his family. As a team, we determined we’d try to do whatever it took to keep him on Ellison 8 until he was ready for discharge. We met weekly as a multidisciplinary team to set new goals: keep his heart healthy with electrolytes and close cardiac monitoring; keep his wounds clean and dry; and continue with intense pulmonary, physical, and occupational therapy.

Then came Mr. T’s biggest setback of all. I called the physician’s assistant caring for Mr. T to assess and confirm what felt like impending doom. His breathing was slow and shallow, his color was ashen, and his heart rate hovered at around 150 beats per minute. His blood pressure and urine output were dropping rapidly. Something had to be done. This is what we’d been preparing for. We called the attending physician and respiratory therapist.

Attempting to remain calm and remember all I had learned in the last several months, I went into action. I moved tables to allow the ventilator to fit easily. I piled suction tubing, IV fluids, and emergency medications and carefully placed them in his room while we waited for the rest of the team to arrive. My resource nurse asked how she could help but gave me the nod letting me know she had confidence in my ability to handle the situation knowing I’d call for help if necessary. I delegated the care of my other patient and turned my focus to Mr. T. The situation was grave. The interventions necessary were usually performed in the ICU, but we wanted to keep Mr. T with us if at all possible. The environment was controlled. We could do it, but we had to do it together.

We placed Mr. T on a ventilator and started Neosynephrine after exhausting all other options. He stabilized, and we started antibiotics. Over the next few days the team met to discuss options. Every day was more intense and exhausting. Finally, the antibiotics started working. The medications were weaned, and his respiratory status improved. I know I could not have contributed in such an emergent situation without my colleagues and the resources and teaching they had provided in the preceding months.

The recovery Mr. T made in the months after that fateful week was remarkable. His nutrition slowly improved. His pulmonary status recovered and his trach was removed. His mental status declined, but his personality was still apparent. Nurses and volunteers took him outside on warm days, listened to his favorite show, Prairie Home Companion, on the radio, and celebrated his birthday on the unit. Case managers worked relentlessly to find a suitable rehabilitation facility for Mr. T.

On the six-month anniversary of my introduction to Mr. T, I discharged him to rehab. The hallways of Ellison 8 were lined with people who had taken care of him or heard his incredible story. Mr. T left us with a big smile and two thumbs up.

The lessons I learned from Mr. T and my colleagues are invaluable. My clinical knowledge has advanced in every area of my practice. My assessment skills are more acute and focused. Prioritization and organization are still improving. More importantly, I learned how to holistically care for my patients and my colleagues. I learned about the power of hope and the importance of support for patients, families, and staff. I learned to be creative with the care of my patients and to adapt to unexpected changes. I know I am a better nurse and a better person today, not just because of Mr. T, but because of the family of colleagues that helped me learn and care for him every day.

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

Wow. This narrative is full of lessons and insights. Kate’s involvement with Mr. T speaks to accountability, organizational skills, delegation, acquisition of knowledge and technical skills, confidence, use of resources, and teamwork. They say our patients are our greatest teachers, and this narrative is certainly a wonderful example of that. Kate learned to trust herself, find her voice, and take clinical risks as she gained clinical knowledge and skill. If this is what Kate was capable of as a novice, I look forward to reading her narratives as she advances in her career.

Thank-you, Kate.
Wikipedia defines compassion as: “an emotion, a sense of shared suffering, most often combined with a desire to alleviate or reduce the suffering of others; to show special kindness to those who suffer.”

Compassion is in great supply among employees of MGH. Comforting our patients with a smile or kind word is a common occurrence among clinicians and support staff throughout the hospital.

To help support families during these difficult times, the department of Nutrition & Food Services provides the Compassionate Food Service Program. Consisting of light fare, snacks, and beverages, compassionate food service is one way to express condolences and support on behalf of the hospital.

It is especially important during times of loss. It can be difficult to know what to say or how to acknowledge a family’s pain when death is imminent. We all feel a sense of helplessness.

To help support families during these difficult times, the department of Nutrition & Food Services provides the Compassionate Food Service Program. Consisting of light fare, snacks, and beverages, compassionate food service is one way to express condolences and support on behalf of the hospital. It is, indeed, a gesture of compassion.

While this is not a new program, feedback from a number of units has made it clear that many clinicians are unaware that this service is available. At the risk of being redundant, we want to remind staff about some of the benefits of the Compassionate Food Service Program.

Requests for compassionate food service must be authorized by a unit’s nursing director. Orders are placed by calling 4-Food (4-3663) and the associated cost is charged to the unit’s cost center. Requests can be made for up to ten people. There is no limit as to how often the service can be provided for a given family; orders are placed at the discretion of the nursing director. Compassionate food service is available from 7:30am–11:00pm. Though we try to process requests as quickly as possible, we ask that you allow up to an hour for delivery.

Compassionate food service in the morning consists of a continental breakfast (assorted muffins, bagels, beverages, etc.) Later in the day, assorted sandwiches, desserts, fruit, and beverages are offered.

Based on valuable feedback from nurses and others, we have been re-evaluating the program, standardizing offerings, and assessing what should and should not be offered. Please continue to share your thoughts and ideas to help us provide the best customer service possible.

For more information about the Compassionate Food Service Program, contact Sue Doyle, senior manager of Patient Food Services, at 6-2579.
On October 31, 2007, MGH will submit written evidence to the American Nurses Credentialing Center (ANCC) to complete Phase I of becoming re-designated as a Magnet hospital. (Phase II is a site visit.) The ANCC has established 14 forces of Magnetism, or characteristics of exemplary nursing practice that define what it means to be a Magnet hospital. In a series of articles that began in June, Caring Headlines is highlighting each of the forces of magnetism.

**Force 9: Autonomy**

Nurses are supported and encouraged to practice autonomously, consistent with professional standards. Independent judgment is expected to be exercised within the context of a multidisciplinary approach to patient care.

The Patient Care Delivery Model at MGH fosters an environment of care that places the authority, responsibility, and accountability for nursing care directly with nurses at the bedside. Direct-care nurses use their knowledge to support independent decision-making and manage practice in a way that improves outcomes for patients and families. In the 2006 Staff Perceptions of the Professional Practice Environment Survey, 87% of staff nurses responded that they strongly agreed or agreed with the statement: “I have freedom to make important patient-care and work decisions.”

When collaborative governance, the communication and decision-making structure for Patient Care Services, was launched in 1997, Jeanette Ives Erickson, RN, senior vice president for Patient Care, noted a continuum of decision-making that nurses can use as a guide. At one end of the continuum, nurses make decisions alone and inform others of their decision. On the other end of the continuum, depending on the type of decision, final judgment rests with the Patient Care Services Executive Committee, which is charged with setting the strategic direction for Patient Care Services and making new policy and procedure decisions.

Levels of decision-making include:
- decide alone but inform others of the decision
- decide alone but seek input from colleagues and leadership (e.g., nursing directors, clinical nurse specialists or operations coordinators)
- decide jointly with colleagues across entities or service lines
- decide with agreement of associate chief nurse
- decide with agreement of chief nurse
- Patient Care Services Executive Committee decides

**Force 10: Community and the healthcare organization**

Organizations that are best able to recruit and retain nurses also maintain a strong community presence. A community presence is seen in a variety of ongoing, long-term outreach programs. These outreach programs result in the organization being perceived as a strong, positive and productive corporate citizen.

One of the requirements of our Magnet evidence submission is to describe nurse involvement in the community. Given the volume and depth of service by nurses at all levels of the organization, a sampling yielded more than 200 examples. Nurses at MGH make their presence and leadership known throughout their local communities through their work with schools, church groups, fund-raising, mentoring, and health education to name a few.

Nurses are not only involved in community outreach programs on their own time, they’re involved in many community benefit programs sponsored by MGH. Some of these programs include the annual flu shot clinic at the State House; the Children’s Health Fair with more than 2,500 children and parents participating; and the MGH Avon Breast Care Program, providing care for patients from under-served populations through preventive screenings and follow-up treatment.

Support for autonomous decision-making and nurses making a difference in the community are two more ways in which MGH is a Magnet hospital.

For more information, contact Suzanne Cassidy, senior project specialist, at 6-0368.
In 1978, the first plasmapheresis was performed at MGH in the Hemodialysis Unit. As the number of pheresis patients increased, a pheresis unit evolved within the Transfusion Service in the Blood Donor Center. Once again, the Hemodialysis Unit is participating in the pheresis program as part of a protocol for highly sensitized, ABO-incompatible, pre-transplant patients who have living donors available. Sensitization is a condition that occurs as a result of exposure to blood transfusion, pregnancy, or transplant. The most significant barrier to renal transplantation is specific antibody development to donor human leukocyte antigens.

Therapeutic plasmapheresis, or plasma exchange, is a process that removes specific components or pathogenic materials from the plasma that can cause or exacerbate a disease process. Plasmapheresis has been a prescribed therapy for patients with autoimmune disease (such as myasthenia gravis, Good Pastures syndrome, Graves disease, Guillain Barre syndrome and lupus). Renal patients who have an antibody to potential renal donors human leukocyte antigen (HLA), have plasmapheresis in preparation for transplant. In this case, plasmapheresis removes the plasma from the blood thereby removing the antibodies that would attack the newly implanted kidney.

The plasma is replaced with 5% albumin and normal saline in a 2:1 ratio. Treatments are performed both pre- and post-transplant. The protocol includes not only plasmapheresis but the administration of intravenous immunoglobulin (IVIG) to prevent repeated antibody development. IVIG is a potent inhibitor of the anti-HLA antibodies. The number of treatments required depends on the patient’s degree of sensitization. This process increases potential access to other-
wise inaccessible donor kidneys by reducing the risk of rejection while improving both mental and physical quality of life for organ recipients.

Five hemodialysis nurses have had prior experience performing plasmapheresis. In preparation for the re-institution of a pheresis program, those nurses participated in a review program. This provided a core group of nurses proficient in the care and management of pheresis patients.

Most pre-transplant patients are receiving hemodialysis and the pheresis treatment is followed by hemodialysis. The plasmapheresis and hemodialysis session can take up to six hours. Nursing care during plasmapheresis exchange is intense. There is continuous monitoring of the effluent (plasma drainage), measuring the amount and balancing the fluid replacement. There is a potential for hypovolemia and hypotension when replacement does not equal the effluent drainage. Numbness and tingling of the extremities and perioral tingling are symptoms of hypocalcemia. A reduction in clotting mechanisms may also occur as a result of plasmapheresis exchange. This can lead to prolonged bleeding especially in patients who have a permanent vascular access such as an arteriovenous fistula or graft that is accessed for the procedure. Platelet counts are monitored on a regular basis. Hypothermia is frequently experienced by the patient during the exchange process due to the rapid removal of plasma and the replacement of fluids at room temperature. A blood warmer and heated blankets are used for the infusion of large volumes of replacement fluid.

The first patient to undergo plasmapheresis desensitization on our unit was Mr. D, a 50-year-old man who was receiving a living-unrelated donor kidney from his wife.

Mr. D began hemodialysis in December of 1983. He received a deceased donor kidney transplant in 1984. This kidney functioned until 1996 when there was recurrence of his primary disease, FSGS. Mr. D restarted hemodialysis at this time. In 2006, Mr. D, 100% sensitized to the potential donor kidney began desensitization. He’d been on the transplant list for ten years without being able to receive a transplant due to his sensitization. His wife presented as a donor and was the same blood group but had a positive cross-match with a titer of 1:4. Plasmapheresis was initiated and after the desensitization protocol was completed, there was a significant fall in his cross-match but it remained positive at 1:1. He was unable to receive the transplant at that time.

Mr. D returned for another plasmapheresis session followed by hemodialysis. As a result of the positive cross-match, the number of IVIG infusions was increased, and Mr. D underwent four more plasmapheresis sessions before his transplant.

IVIG contains antibodies. It helps desensitize suppression of auto-antibody production. Prior to transplant it is administered to the ABO-incompatible recipient to reduce high levels of anti-HLA antigens. IVIG was infused during the hemodialysis session so as not to remove it during pheresis.

Mr. D is a very pleasant, quiet man. He first came to the Hemodialysis Unit knowing he’d be having plasmapheresis for several sessions along with his hemodialysis treatment. Mr. D was aware that hemodialysis nurses were being re-oriented to the procedure. He didn’t appear nervous. Our honesty with him about the status of our program also helped build trust.

On November 8, 2006, Mr. D received his long awaited kidney transplant. He is feeling well and being followed closely in the Transplant Clinic.

For more information about the plasmapheresis program on the Hemodialysis Unit, contact Carol Tyksienski, RN, clinical nurse specialist, at 4-8082.
Conversations with Caregivers
An elder-care series sponsored by the MGH Geriatric Medicine Unit for staff, patients, families, and friends of the MGH community
“Alternatives to Home: Assisted Living, CCRC, and Nursing Homes”
October 23, 2007
Blum Patient & Family Learning Center
5:15–6:30 pm
Light refreshments No charge

Global health seminars
The MGH Center for Global Health is launching its global health seminar series. Seminars are designed to introduce salient global health topics and build a shared community around improving health in international, resource-poor areas.
“Health, Human Rights, and Social Justice” presented by Paul Farmer, MD, Maude and Lillian Presley professor of Social Medicine, Harvard Medical School, and founding director, Partners in Health
Thursday, November 1, 2007
5:00–6:30 pm
in the Ether Dome (space is limited)
“Global Implications of Human Trafficking and Modern Day Slavery” presented by Kevin Bales, president, Free the Slaves, and author of Disposable People: New Slavery in the Global Economy
Thursday, November 15, 2007
5:00–6:30 pm
O’Keeffe Auditorium
Seminars are free and open to the MGH community
For more information, contact Roy Ahn at rahn@partners.org.

16th Annual Deb Wing, RN, Memorial Conference
“Neurological Consequences of Stimulant Use and Abuse: Acute Care Implications”
Speaker: Susan Krupnick, MSN, APRN, BC, CARN
November 7, 2007
4:00–5:00 pm
Haber Conference Room
Reception to follow

CarePages
CarePages is a free, simple-to-use, interactive, on-line service that helps patients and families stay in touch day and night while a loved one is hospitalized. Patients and family members can send and receive messages from their entire network of friends simultaneously at their convenience.
Start a CarePage by visiting www.carepages.com/mgh.
For more information, call 4-9865.

Nominations now being accepted for Kirvilaitis Award
Nominations are now being accepted for the Anthony Kirvilaitis Jr. Partnership in Caring Award that recognizes non-clinical staff (operations associates, unit service associates, operating room assistants, unit service associates, patient service coordinators, ED admitting assistants, and patient care information associates) within Patient Care Services.
Deadline for nominations is 5:00 pm, October 19, 2007.
For more information, contact Tom Drake, senior training and development specialist, at 6-9148.

PCS Office of Quality & Safety
Keith Perleberg, RN, the new director of Patient Care Services’ Office of Quality & Safety, has officially taken residence in his new office on the 4th floor of the Professional Office Building on Cambridge Street. He can be reached at 3-0140.

Make your practice visible: submit a clinical narrative
Make your practice visible. Submit a narrative for publication in Caring Headlines. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Lunchtime Seminars
“Planning for the Holidays on a Shoestring” presented by Amy Perry, consumer finance educator with Consumer Credit Counseling Services
Learn about holiday savings tips, alternative gift ideas, how to plan ahead, and how to stay out of debt.
October 18, 2007
Thier Conference Room
12:00–1:00 pm
“Working and Breastfeeding” a free, informational seminar presented by Germaine Lambecks, MGH lactation consultant
November 6, 2007
Bulfinch 222 Conference Room
12:00–1:00 pm
Feel free to bring a lunch For more information, call 8-6976
Sponsored by the Employee Assistance Program

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Distribution
Please contact Ursula Hoehl at 726-9057
Submissions
All stories should be submitted to: ssabia@partners.org For more information, call: 617-724-1746
Next Publication November 1, 2007
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<thead>
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<th>Date</th>
<th>Event</th>
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<th>Contact Hours</th>
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<tr>
<td>October 24</td>
<td>Congenital Heart Disease</td>
<td>Haber Conference Room</td>
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<td>October 25</td>
<td>Nursing Grand Rounds “Case Management”</td>
<td>O’Keeffe Auditorium</td>
<td>1:30 – 2:30pm</td>
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<td>November  13, 19, 20, 26, 27</td>
<td>Greater Boston ICU Consortium Core Program</td>
<td>Faulkner Hospital</td>
<td>7:30am – 4:30pm</td>
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<td>October 27</td>
<td>Hip Pain: Diagnosis and Treatment</td>
<td>Haber Conference Room</td>
<td>8:00 – 11:30am</td>
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<td>October 29</td>
<td>Intra-Aortic Balloon Pump</td>
<td>Day 1: NEMC</td>
<td>7:30am – 4:30pm</td>
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<td>Day 2: Burr 5</td>
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<td>October 30</td>
<td>CPR Re-Certification</td>
<td>Founders 325</td>
<td>7:30 – 10:30am and 12:00–3:00pm</td>
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<td>November 2</td>
<td>BLS Certification for Healthcare Providers</td>
<td>Founders 325</td>
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<tr>
<td>November 14</td>
<td>CPR Re-Certification</td>
<td>Founders 325</td>
<td>7:30 – 10:30am and 12:00–3:00pm</td>
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<td>November 14</td>
<td>New Graduate RN Development Seminar I</td>
<td>Training Department Charles River Plaza</td>
<td>8:00am – 2:00pm</td>
<td>3.6 (for mentors only)</td>
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<td>November 14</td>
<td>Nursing Grand Rounds “Talking with Teens about Taking Care of Themselves”</td>
<td>Haber Conference Room</td>
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<td>November 14</td>
<td>OA/PCA/USA Connections “The Medical Record”</td>
<td>Bigelow 4 Amphitheater</td>
<td>1:30 – 2:30pm</td>
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<td>November 14</td>
<td>Nursing Research Committee’s Journal Club</td>
<td>Yawkey 10-660</td>
<td>4:00 – 5:00pm</td>
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For more information about educational offerings, go to: http://mghnursing.org, or call 6-3111
Wit and wisdom in the PACU

Madeleine McGarry, RN, and Nancy Graham, RN, want you to know...

In the PACU, everyone is involved in our push to achieve 100% hand-hygiene compliance. With more than 70 patients coming through our unit every day, each one receiving care from clinicians in different disciplines, we try to make our hand-hygiene goals as visible and memorable as possible. Dozens of nurses, USAs, PCAs and anesthesiologists have posed for our poster campaign. Posters have witty captions reminding staff to Cal Stat before and after contact with the patient or the patient’s environment. Our personal commitment, combined with friendly, professional reminders, has brought us closer to our goal of 100/100!