Caring Headlines
December 2, 2010

Re-Designing Collaborative Governance

2011 will see changes to the collaborative governance committee structure

See story on page 4

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Planning ahead

Partners 2011 strategic goals: positioning ourselves to meet the challenges of the future

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

As I think about the year ahead, many important issues come to mind. In 2011, MGH will celebrate its 200th anniversary, a major milestone in our great history. Numerous events and activities are planned to mark this momentous occasion. As we take this time to celebrate our past, it's also an opportunity to think about the future. In the coming year, no issue will be more important than the Patient Affordability Act, more commonly known as national healthcare reform. Hand-in-hand with national healthcare reform is the continuing evolution of our own state healthcare situation. Massachusetts has already achieved near-universal health-insurance coverage. Now we need to reduce costs while continuing to provide the exceptional care that is our hallmark. You may recall that Massachusetts recently adopted a package of healthcare cost reforms. We now know that more cost-control legislation is coming our way.

Massachusetts has already achieved near-universal health-insurance coverage. Now we need to reduce costs while continuing to provide the exceptional care that is our hallmark.

Last January, recognizing the challenges that lay ahead, Partners president and CEO, Gary Gottlieb, MD, initiated a strategic planning process with the leaders of Partners institutions. As a result of that work, initiatives were developed to ensure we're positioned to meet those challenges. I would like to share with you the elements of the Partners-wide strategic plan and ask for your help.

Phase one of the plan includes three areas of concentration:

- *Care re-design*

  This work will build on the clinical systems already in place throughout Partners institutions to design and deliver more integrated patient and family-centered care. Care re-design will include a focus on specific conditions and episodes, not just procedures, patient visits, and admissions. Multi-disciplinary teams will focus on colon cancer, coronary disease (AMI and CABG), stroke, diabetes, and primary care. The goal is to achieve a seamless continuum of care and lead the way in promoting payment systems that support improved care delivery.

continued on next page

Many MGH nurses, physicians, and therapists will be part of these teams.

- *Affordability*
  It will be imperative to preserve patient affordability while fulfilling our mission to provide quality care. The strategy for preserving affordability is to improve process flow, re-design systems to make our work more efficient, reduce overhead costs, improve patient flow, and explore other viable cost-management ideas. Improving timely access to care and enhancing patient-referral systems will be part of this work. Currently, teams are being developed to focus on three areas: the inpatient setting, the perioperative setting, and the Emergency Department. I will co-lead this initiative along with Michael Gustafsen, MD, from BWH. Many members of our clinical and administrative community will serve on these teams.

- *Reputation*
  Partners has earned a reputation as a world-class healthcare system. The 2011 strategic plan calls for increased emphasis on Partners commitment to community programs and a greater concentration of quality-focused messages by way of a public education campaign.

Several other projects will complement this strategic plan. A team that includes MGH senior vice president for Human Resources, Jeff Davis, will look at ways to re-design our employee health insurance. Across Partners institutions, we insure more than 90,000 employees and their families. This team is charged with ensuring that the plans we offer are the most innovative and cost-effective possible.

Another team is preparing proposals for two new federal healthcare pilots—the Medicare accountable care organization (ACO) pilot, and the Health Care Innovation Zone pilot. We want to be at the forefront of these opportunities to assess whether they can be of help in improving patient care and lowering costs.

Phase two of the Partners strategic plan will include a focus on research, improving community health, and continuing to build world-class training programs. That work will begin later in the year.

The challenges associated with healthcare reform—cutting costs while improving care—may seem daunting. But we employ the best clinicians in the world whose knowledge and expertise are unparalleled in health care today. You are our greatest asset as we face these challenges. Your thoughts, ideas, and suggestions will drive the way we re-design care. So let me hear from you. Together, we will meet and overcome these challenges.

I will keep you updated on this important work. And I'll soon be sharing Patient Care Service's strategic goals for 2011, which are also being shaped by healthcare reform and the ongoing needs of our patients and families.

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In this Issue

Collaborative Governance Re-Design

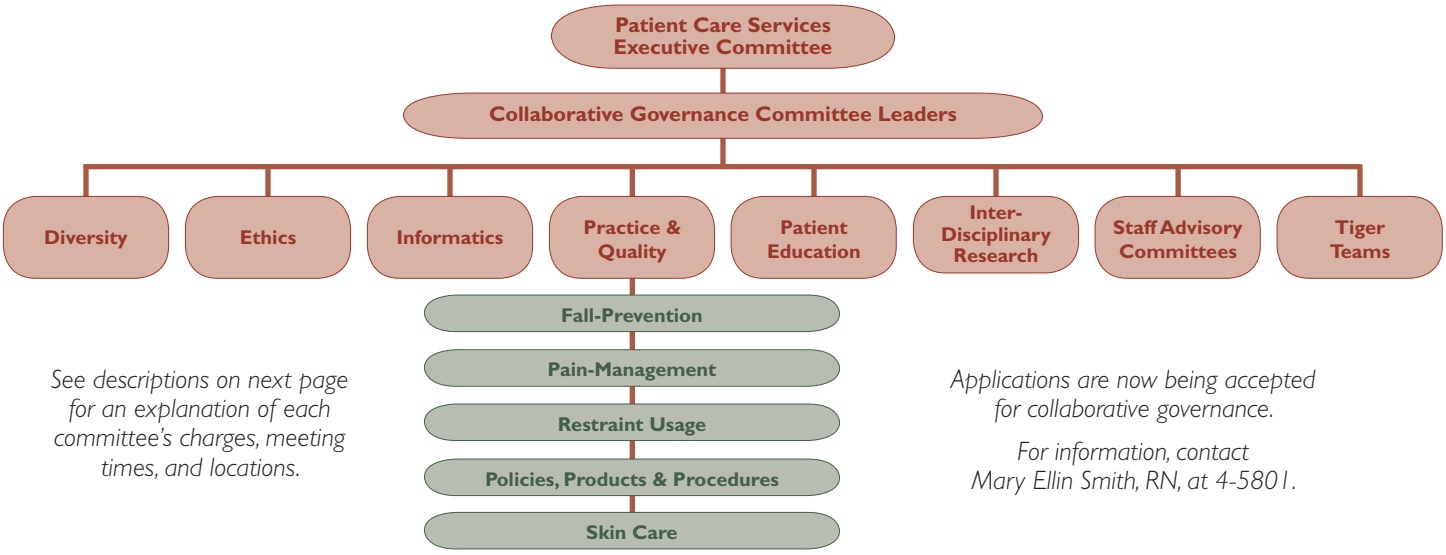
Collaborative governance has been a critical factor in the success of Patient Care Services. Collaborative governance places the decision-making authority, responsibility, and accountability for patient care with the practicing clinician. Since launching the collaborative governance committee structure 13 years ago, much has changed in health care, technology, and the evolving needs of our patients and staff. If we are to continue to provide the best care and services to patients and families, our collaborative governance structure must continue to evolve to reflect those changes.

Recently, after a comprehensive review and much deliberation, the collaborative governance committee structure was re-designed to ensure that their work is aligned with our current reality and with Patient Care Services' strategic goals.

The diagram on this page and the committee descriptions on the next page will give you an idea of what the new collaborative governance structure will look like beginning in 2011. Enrollment has been extended to December 17, 2010. The major changes include:

- The Nursing Practice and Quality committees will merge to become the Practice & Quality Committee, which will have five sub-committees:
  - Fall Prevention
  - Pain Management
  - Policies, Products & Procedures
  - Restraint Usage
  - Skin Care
- A new Informatics Committee has been created
- The Nursing Research committee will become an inter-disciplinary research committee

Current members of the Nursing Practice and Quality committees are encouraged to apply for membership in one of the sub-committees or another committee. Excellence Every Day champions are encouraged to apply for collaborative governance when their term as EED champions ends, December 31, 2010. For information on becoming a collaborative governance champion, speak to your supervisor or send e-mail to: pcscollaborativegovernance@partners.org.



See descriptions on next page for an explanation of each committee's charges, meeting times, and locations.

Applications are now being accepted for collaborative governance.

For information, contact Mary Ellin Smith, RN, at 4-5801.

Collaborative Governance Committees

The Diversity Committee supports the PCS goal of creating an inclusive and welcoming environment for patients, families, and staff through professional development, student outreach, community outreach, and culturally competent care programs. Champions will increase their knowledge of cultures, ethnicity, traditions, and life experience and how they impact patients' responses to illness, health, work, and social situations. Meets on the first and third Tuesdays of the month, 12:00–1:00pm, Founders House 311.

The Ethics Committee develops and implements programs to further clinicians' understanding of ethical aspects of patient care and identifies strategies to integrate ethical judgment into professional practice. Champions will gain better understanding, recognition, and articulation of ethical issues. Meets on the first Wednesday of the month, 1:00–3:00pm, Founders 1, ED conference room.

The Informatics Committee evaluates and makes recommendations related to new technology and its application to clinical practice. Champions should have an interest in learning about and sharing information related to technology and its impact on clinical practice and care delivery. Meeting time and location to be announced.

The Inter-Disciplinary Research Committee fosters a spirit of inquiry around clinical practice through the dissemination of evidence-based knowledge and research findings. Champions should have an interest in learning how to find, appraise, and share current research as the basis for clinical decision-making. Meets on the first Monday of the month, 1:00–2:30pm, Blake 8 Conference Room.

The Patient Education Committee supports staff in developing their role in culturally appropriate, patient-education activities. Champions facilitate and generate knowledge of patient-education materials to improve care and enhance the environment in which clinicians shape their practice. Champions should have an interest in learning how verbal and written materials enhance patients' participation in decision-making. Meets on the second and fourth Wednesdays of the month, 1:30–3:00pm, Sweet Conference Room, GRB 432.

Staff Advisory Committees serve as forums for sharing information between clinicians and leadership. Champions should have an interest in bringing their own and colleagues' issues and ideas to a dynamic dialogue with leadership. Those interested in joining should notify their unit/department leadership. (Champions are appointed to these committees.)

Staff Nurse Advisory Committee meets on the first Tuesday of the month, 11:30am–12:30pm, Trustees Room.

Physical and Occupational Therapy Advisory Committees meet monthly (contact department leadership for schedule of meetings).

Social Work Advisory Committee meets on the second Friday of the month, 10:00–11:00am, Social Services Conference Room.

The Practice & Quality Oversight Committee is comprised of the leaders of its five sub-committees; it provides coordination and alignment of subcommittee goals and tactics. Meets monthly.

Practice & Quality sub-committees:

The Fall-Prevention Committee strives to provide a safe environment for all patients and develop individualized plans of care for those at risk for falling. Champions empower staff with evidence-based knowledge to assess risk and implement fall-prevention care plans; provide staff with guidelines for fall-prevention, intervention, and post-fall care. Champions should be interested in creating a safe environment by recognizing warning signs of patients at risk for falling and have an interest in sharing that knowledge with colleagues. Meets on the third Thursday of the month, 1:00–3:00pm, Yawkey 7-980.

The Pain-Management Committee assists in developing and disseminating materials that give clinicians the knowledge, resources, and skills to address and treat pain. Champions serve as resources to colleagues, and should have a desire to influence and learn more about pain-management, both pharmacologically and holistically. Meets on the first Tuesday of the month, 1:00–3:00pm, Yawkey 2-210.

The Policies, Products & Procedures Committee reviews and approves all policies and procedures to ensure they are appropriately vetted and evidence-based; reviews and approves products and plans for product roll-out. Champions should have an interest in influencing how policies and procedures are reviewed and implemented and in decisions to purchase and trial products in the clinical area. Meets on the second Tuesday of the month, 1:00–3:00pm, Yawkey 2-210.

The Restraint Usage Committee identifies evidenced-based interventions to reduce the use of restraints. Champions will gain knowledge in identifying and intervening effectively to minimize the likelihood of restraints being used. Champions should have an interest in minimizing the use of restraints through early identification of patients at risk, collaboration with the patient's family, and use of alternative therapies and interventions. Meets on the third Tuesday of the month, 1:00–3:00pm, Yawkey 2-210.

The Skin Care Committee ensures that clinicians have the knowledge, resources, and skill to maintain skin integrity and prevent and treat hospital-acquired pressure ulcers. Champions will collaborate to develop and update guidelines and resources; serve as a consultant to colleagues; and collaborate with unit/department leadership to track, analyze, and try to prevent skin breakdown. Meets on the fourth Tuesday of the month, 1:00–3:00pm, Yawkey 2-210.

Tiger Teams will be formed as needed to address and make recommendations on issues identified by the Patient Care Services Executive Committee.

All in a night's work

As a member of the Neonatal Transport Team, respiratory therapist helps MedFlight sick infant to MGH

Perhaps the most challenging part of transporting sick babies is the transition from one system to another—specifically, from the sophisticated ventilator equipment of the NICU to the comparatively crude ventilator used during transport.

My name is Steven Mason, and I am a staff respiratory therapist. I work primarily in the Neonatal Intensive Care Unit (NICU) and have for the last 25 years—the better part of my career at MGH. I'm also a member of our Neonatal Transport Team, transporting very sick infants from outlying hospitals to MGH either by ambulance or MedFlight helicopter.

During one night shift, we received a call for a transport at about 4:00am. It involved MedFlighting a very sick newborn from a hospital in the western part of the state. We needed to fly out there via helicopter, pick up the sick infant and transport her back to our NICU without incident. We assembled our equipment. The plan was to drive to Hanscom Air Force Base, load the equipment onto the chopper and leave from there to our destination. The team was fresh and ready to go. I jumped in the ambulance for the ride to Hanscom.

Upon arrival, we assembled our equipment and introduced ourselves to the MedFlight crew who briefed us on the nuances of flying in a chopper. We donned our head gear, strapped ourselves into place and prepared for take-off. By now it was early morning, and the scenery was quite beautiful. But my mind was on what lay ahead.

Steven Mason, RRT, staff respiratory therapist

At the destination hospital, we were quickly ushered to the NICU to meet our sick patient. The infant was one day old, in respiratory failure, receiving nitric oxide on extremely high ventilator settings, and poorly saturated with teary-eyed parents at her bedside. Our team, two MedFlight nurses, a neonatologist, and I slowly gathered ourselves at the bedside to evaluate and prepare the baby for the flight to MGH.

Perhaps the most challenging part of transporting sick babies is the transition from one system to another—specifically, from the sophisticated ventilator equipment of the NICU to the comparatively crude ventilator used during transport. And this baby was on extreme ventilator settings. Even the neonatologist questioned whether the baby would be able to tolerate the conventional ventilator. I knew we had no choice. It was literally a 'do or die' situation. We needed to get

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this infant to MGH as soon as possible. And to complicate matters, the baby was also nitric-oxide dependent making it even more challenging to transition her to the transport ventilator.

I calibrated the nitric oxide, and as the critical moment approached, I set the transport ventilator to the same extreme settings as the ventilator at the bedside. I instructed the MedFlight nurse to disconnect the ventilator, and quickly but safely, along with the other life lines, tubes, and IVs, moved the infant toward me and the travel isolette. With tubing in hand, we quickly made the move, and I re-connected the baby to the transport ventilator. We all took a collective breath and waited to make sure the transition had been successful.

We were thrilled when the patient's vitals and other hemodynamics responded to our equipment. Once the baby was stabilized in the isolette, we gave the parents an opportunity to say good-bye and have some brief physical contact. We assured them that everything was going to be fine as we prepared to wheel the baby from the NICU to the helipad.

The walk through the corridors of the hospital and through the lobby seemed endless as I focused on the monitor and vital signs of the patient. If you looked inside the isolette, you'd have a hard time finding the patient, she was so small, with so many tubes and lines connected to her little body.

We slowly approached the helipad, lifted the isolette aboard the chopper, and locked it in place. Once again helmeted and strapped in, we made ready for the flight back to MGH. It was about 9:30 as we lifted off into the calm, clear sky toward Boston, again closely monitoring our patient for any signs of decompensation. Happily, the patient was very cooperative, and her vital signs remained remarkably stable throughout the flight. I was relieved, tired, and a bit stressed, but glad things had gone so smoothly.

The flight took about thirty minutes. It had been a while since I'd last flown, and the approach to the landing pad on the Ellison Building was nothing short of breathtaking. We landed and were met by Security, and quickly transported the patient to the NICU. Upon arrival, we were greeted by a team of clinicians who had gathered in anticipation of our new admission. After sorting out all the lines, IVs, and monitoring equipment, we transferred her from the transport isolette to her new temporary home in the NICU. The final move went like clockwork. I breathed a sigh of relief as I began to shut down and disassemble the transport equipment and isolette. I found the admitting respiratory therapist and gave her report on the new admit. The MedFlight team thanked me and the neonatologist for our efforts in making this potentially harrowing transport a successful one.

The baby remained quite ill over the next several hours. Ultimately, the decision was made to place her on ECMO (extra-corporeal membrane oxygenation) to facilitate her recovery. The treatment worked well, and the baby was weaned from the circuit approximately seven days later.

The baby remained quite ill over the next several hours. Ultimately, the decision was made to place her on ECMO (extra-corporeal membrane oxygenation) to facilitate her recovery. The treatment worked well, and the baby was weaned from the circuit approximately seven days later. And two days after that, she was transported back to her home hospital without incident.

The baby's parents thanked me personally and presented me with a CD that the father had made as a member of his local gospel choir. We had become good friends during their baby's stay at MGH, and I will remember them for their gratitude and support. It gives you a sense of satisfaction to know your efforts are appreciated by those who may not fully comprehend what you do every day as a respiratory therapist.

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

Any patient MedFlighted to MGH is in serious condition making it a stressful experience for all involved. But when that patient is only one day old, the stress is compounded exponentially. Steve gave us a glimpse into the risks and challenges associated with transporting critically ill infants via helicopter. Despite the fragility of the baby's condition, Steve and his colleagues made time for the family to connect with their child before taking off. Their split-second timing and vigilance in transitioning the baby on and off of the transport ventilator was critical to their success. This family was lucky, indeed, to have such skilled clinicians caring for their child.

Thank-you, Steve.

Leading the nation in geropalliative care with AgeWISE

In an effort to package the RN Residency Program in a way that would lend itself to duplication by other hospitals, the name was changed to AgeWISE, and some small changes were made to the curriculum to make it more accessible to a wider audience.

When the The RN Residency: Transitioning to Geriatrics and Palliative Care Program first received funding from the Health Resources and Services Administration in 2007, no one anticipated it would become the sought-after national model it is today. The RN Residency Program is a six-month program that trains nurses in geropalliative care. During its three-year funding period at MGH, more than 100 nurses completed the program, which employs a three-pronged approach: education, clinical practice, and retention. The RN Residency Program is designed to:

- strengthen the nursing workforce by improving knowledge, skills, and competencies in geropalliative care
- improve the quality of nursing care to older adults and their families
- retain both senior and junior nurses

This innovative program caught the attention of nursing leaders across the country, including Brenda Cleary, RN, director of the Center to Champion Nursing in America, who convened a special committee to accelerate national dissemination of the program. The Center to Champion Nursing in America is a joint initiative of AARP, the AARP Foundation, and the Robert Wood Johnson Foundation dedicated to ensuring that the country is producing highly skilled nurses who can provide accessible, affordable, quality health care, now and in the future. And since older adults account for about 50% of all hospitalized patients, it makes sense to share this program with as many nurses as possible.

In an effort to package the RN Residency Program in a way that would lend itself to duplication by other hospitals, the name was changed to AgeWISE, and some small changes were made to the curriculum to make it more accessible to a wider audience. To kick off expansion of the program, the MGH AgeWISE team (comprised of Barbara Blakeney, RN; Ed Coakley, RN; Constance Dahlin, RN; Deborah D'Avolio, RN; Dorothy Jones, RN; and Marion Rideout, RN, under the leadership of Susan Lee, RN) organized a four-day summit, held here in Boston, November 9–12, 2010.

With support from the Center to Champion Nursing in America, the AgeWISE team invited nurses from academic medical centers across the country to apply. Only applicants from Magnet-designated, NICHE-certified hospitals were considered. Ultimately, 36 nurses from six hospitals were invited to participate:

- NYU Langone Medical Center in New York City
- The University of Rochester Medical Center's Strong Memorial Hospital in Rochester, New York
- University Hospitals Case Medical Center in Cleveland, Ohio
- St. Joseph's Regional Medical Center in Paterson, New Jersey
- Sanford University of South Dakota Medical Center in Sioux Falls, South Dakota
- Nebraska Methodist Hospital in Omaha, Nebraska

Throughout the summit, participants received 'train-the-trainer' education on numerous geropalliative topics and heard presentations by MGH faculty and guest lecturers.

continued on next page

Early on, Brenda Cleary provided context by asking some provocative questions, such as: "What happens when all the registered nurses over the age of fifty retire from the workforce? What will that do to the quality and safety of patient care? Will that loss of knowledge be devastating to organizational performance and productivity?" She reminded us that AgeWISE is in alignment with the recent IOM recommendation to implement nurse residency programs and the Initiative on the Future of Nursing that advises state boards of nursing, accrediting bodies, government and healthcare organizations to support nurses' completion of residency programs following completion of pre-licensure or advanced-practice degree programs or when transitioning to new clinical practice areas.

Other speakers were equally impressive. Muriel Gillick, MD, professor of Ambulatory Care and Prevention at Harvard Medical School/Harvard Pilgrim Health Care, spoke about, "The Denial of Aging." Ellen Robinson, RN, clinical nurse specialist in Ethics, talked about, "Decision-Making in the Sunset of Life." Angelika Zollfrank, MDiv, supervisor of Clinical Pastoral Education, spoke about "Spiritual Distress among Elders." Noted researcher, Angelo Volandes, MD, shared information on the use of video aides to assist in end-of-life decision-making.

Participants left the program with the tools and information they'll need to implement AgeWISE programs in their own institutions. Over the next two years, each site will offer two, six-month residency programs as they receive on-going training from the MGH AgeWISE team through video- and telephone-conferencing and on-site visits.

At this critical time in the evolution of health care, AgeWISE is a unique and important program. It honors the embedded wisdom of senior nurses while drawing attention to the unique knowledge necessary to care for the complex needs of older adults. For more information about AgeWISE, contact Susan Lee, RN, AgeWISE project director, at 4-3534.

Images from the AgeWISE summit (clockwise from top left): 1) Brenda Cleary, RN, director, Center to Champion Nursing in America, Lynda Brandt, RN, project specialist, and Marion Rideout, RN, program coordinator; 2) Barbara Blakeney, RN, innovation specialist, and Ed Coakley, RN, director emeritus; 3) Susan Lee, RN, project director; 4) Muriel Gillick, MD, professor of Ambulatory Care and Prevention at Harvard Medical School/Harvard Pilgrim Health Care; 5) Constance Dahlin, RN, palliative care nurse practitioner; and 6) group shot of attendees.

(Group photo provided by staff)

Patient & Family Advisory Councils: partnering for an even better future

—submitted by Teri M. Fryer of the MGH Heart Center Patient & Family Advisory Council

"Nothing is more important than the safety and quality of care provided to our patients." That was the message delivered by MGH president, Peter Slavin, MD, at the second annual Patient & Family Advisory Councils Networking Dinner hosted by the MGH Heart Center's Patient & Family Advisory Council (PFAC) November 2, 2010. Slavin, senior vice president for Patient Care, Jeanette Ives Erickson, RN, and 44 members of PFACs (representing the Heart Center, the Cancer Center, and MassGeneral Hospital *for* Children) talked about respect for patients and families and the need to hear their voices if we are to improve health care in the 21st century. Slavin spoke about advancing patient-centered care by listening to patients and families and incorporating their point of view. He acknowledged the vital role PFACs play in making recommendations about policies and procedures and the role of technology in improving communication between patients and providers.

Members of Patient & Family Advisory Councils network with MGH leaders, including associate chief nurses, Deb Burke, RN (top right), Theresa Gallivan, RN (lower right), and senior vice president for Patient Care, Jeanette Ives Erickson, RN, and MGH president, Peter Salvin, MD (lower left).

Ives Erickson emphasized that health care is as much about wellness as it is about managing illness. Promoting good health and disease-prevention not only enhances quality of life but helps reduce hospital costs. She recognized the important contributions of PFACs in developing meaningful educational materials, raising awareness about culturally competent care, and altering our physical environment to be more welcoming to individuals with disabilities.

One question concerned the recent healthcare reform bill and the impact it's likely to have on MGH. Slavin explained that healthcare costs are expected to soar as Baby Boomers enter their senior years, observing that the 85+ age group accounts for the greatest expenditures in health care. Containing those costs represents a challenge that must be addressed with 'safe, cost-effective care.' Ives Erickson added that home care, shorter hospital stays, and preventative programs will become even more important.

Other topics of conversation included access to diagnostic testing, palliative care, experimental research, and treatment protocols for heart patients. It was obvious that there are many opportunities for collaboration among patients, families, and staff.

The interactive nature of PFACs whereby everyone teaches and everyone learns has rendered measurable outcomes for MGH patients and families. Said Ives Erickson, "MGH would not be the world-class hospital it is without the valuable input of patients and families." It was a sentiment shared by everyone in attendance.

Announcements

New hours for Back-up Childcare Center

The MGH Back-Up Childcare Center offers occasional and temporary care for children of MGH employees and patients, aged 9 months–12 years.

Hours of operation have changed; the Center is now open from 6:30am-5:45pm daily.

For more information or registration form, visit: www.partners.org/childcare.

Bridge construction affects MGH

The Craigie Bridge near the Museum of Science will undergo construction from November 6, 2010, through April 24, 2011. Employees, patients, and visitors are encouraged to take public transportation when traveling to and from the hospital.

For the latest in traffic changes, access the Department of Transportation website at www.mass.gov/massdot/charlesriverbridges.

Collaborative Governance

Applications are now being accepted for collaborative governance. Collaborative Governance integrates multi-disciplinary clinical staff into the formal decision-making structure of Patient Care Services. To learn more about how to join a collaborative governance committee (Diversity, Ethics, Informatics, Patient Education, Practice, Quality, or Research) contact Mary Ellin Smith, RN, at 4-5801.

Are you Gluten-intolerant?

One out of every 120 Americans is gluten intolerant, which is why patient services coordinator, Elaine Budnik-Caira has created a website to help inform the public and the MGH comminunity about this growing problem.

For more information, visit: www.gfhomecooking.com

Call for Abstracts

Nursing Research Expo May, 2011

Submit your abstract to display a poster during the 2011 Nursing Research Expo

Categories:

Original Research
Research Utilization
Performance Improvement

For more information contact Laura Naismith, RN, or Teresa Vanderboom, RN, or Nursing Research Committee at: mghnursingresearchcommittee@partners.org.

Abstracts must be received by January 31, 2011.

Eldercare monthly discussion group

Join facilitators, Janet T. Loughlin, LICSW, Partners EAP, and Barbara Moscowitz, LICSW, geriatric social worker for the Eldercare monthly discussion group, sponsored by the Employee Assistance Program.

Next session:
December 14, 2010
12:00–1:00pm
Doerr Conference Room
Yawkey 10-650

Old friends and new members are welcome
Feel free to bring a lunch
For more information, call 6-6976 or visit www.eap.partners.org.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday, 7:30am – 5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday, Thursday, 7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

Volunteers needed for research study

Funded by MGH and the Robert Wood Johnson Foundation, a study on nursing and clinical decision-making is seeking volunteers.

Participants must have:

- a BSN or advanced degree
- at least two years of clinical experience
- full-time employment at MGH
- basic computer skills
- English as a first language

Study will use board games and videos to explore decision-making.
Time commitment: one hour
Location: Founders Classrooms

For more information, contact: KariHeistad6@gmail.com or visit: http://www.entertainingdiversity.com/ClinicalDecisionMaking.

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Next Publication
December 16, 2010

Safe patient handling contributes to healthier workforce

Question: I understand one of the PCS strategic goals is related to reducing staff injuries. Can you tell me more about that?

Jeanette: The health and well-being of staff is critically important to our mission. That's why the installation of ceiling lifts throughout the hospital is an organizational priority, and we've made significant progress with this initiative. Installation will be completed by the end of the year.

Question: Have ceiling lifts been well received by staff?

Jeanette: Installation of the lifts was the first step, followed by extensive training. We held our annual Safe Patient Handling Fair, now called Workstrong, to promote the use of ceiling lifts and other safe-patient handling devices. We're trying to increase utilization, gain insight, and share best practices as we continue to raise awareness about the importance of safe patient-handling techniques.

Question: What are some of the strategies you're using to do this?

Jeanette: The focus of the Safe Patient Handling Committee has shifted from ensuring staff understand how to *use* the equipment to ensuring they realize the long-term effects that manual patient handling can have on their health and well-being.

Question: There must be evidence that supports the use of assistive equipment.

Jeanette: Absolutely. We often think of work-related injuries as isolated events. But evidence shows that repeated manual lifting of patients and equipment can result in cumulative trauma to the musculoskeletal system. In the United States last year, more than 71,000 nurses suffered back injuries—and those are just the injuries that can be traced to work-related events. 48% of nurses complain of chronic back pain, but only 35% report work-related injuries. A recent survey of our own nursing workforce revealed that 40% of those who responded had to reduce or alter their work schedule because of injury or physical pain. An equal percentage reported that pain and/or physical limitations required them to miss work altogether. The same survey tells us that only 25% of respondents use lifts 'always' or 'often' to move or re-position patients.

Question: That's very telling. What do you think we can do to increase utilization?

Jeanette: We have begun to focus on a few patient care units in the hope of making safe patient-handling practices routine. Ultimately, it will require the full engagement and participation of leadership and staff. Behavioral change can be challenging. Hopefully, when staff understand the health benefits associated with safe patient handling, they will be quick to adopt these new practices.

For more information, contact your nursing director or supervisor.

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