Caring Headlines
April 21, 2011

Volunteer Recognition Week

In the Maxwell and Eleanor Blum Patient & Family Learning Center, volunteer, Maria Olivier (in pink jacket) assists patient in finding health information.

Celebrating the service of the more than 1,200 volunteers who support patients, families, and staff throughout the MGH community

(see story on page 6)

MASSACHUSETTS GENERAL HOSPITAL 1811 - 2011

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Care re-design driven by quality and safety

thanks to wisdom, commitment, and insight of MGH clinicians

On Friday, April 8, 2011, we were privileged to have Maryann Fralic, RN, professor at Johns Hopkins University School of Nursing, speak as part of our Bicentennial Nursing Grand Rounds series. I was struck by how much of what she said relates to the work we're doing around care re-design and patient-affordability. I thought three of Fralic's observations were especially relevant:

1) It doesn't make any difference how high-quality patient care is if no one can afford to pay for it. When it comes to cost and quality, *neither* is more or less important
2) Flexibility and resilience will ultimately determine who succeeds in health care

And my favorite:

3) The future is not optional. Everyone will attend. If *we* don't develop new practice models, someone else will do it for us

The future is not optional. Everyone will attend. If we don't develop new practice models, someone else will do it for us

As you know, Partners launched a number of strategic initiatives last year in an effort to position MGH and the other Partners affiliates to meet the challenges of rising healthcare costs and a struggling national economy. These initiatives revolve primarily around care re-design, patient affordability, employee health benefits, and a re-energized Partners reputation and communication strategy. We recently reached a significant milestone in this work with the delivery of the first round of recommendations.

Care re-design teams with multi-disciplinary representation from institutions throughout the Partners network focused on finding new, more efficient ways to deliver care. They concentrated initially on five patient populations, selected for their prevalence across all Partners institutions: colon cancer; coronary disease (acute myocardial infarction and coronary artery bypass graft surgery); diabetes; stroke; and primary care.

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

Some common themes emerged as these teams began to examine existing systems. Many of their recommendations speak to a need for better scheduling and improved navigational assistance for patients and clinicians. One idea that's been suggested is the implementation of a 'nurse navigator' role. Terry McDonnell, RN, an MGH representative on the Colon Cancer Team, reports, "A cornerstone of our team's recommendation is the introduction of the nurse navigator role, modeled after the access nurse role currently used in the Cancer Center. This individual is responsible for triaging patients from diagnosis through pre-surgical work-up to follow-up care based on each patient's individual pathology and genetic risks. We use this role to coordinate multi-disciplinary care in the Cancer Center, and it's been very successful."

continued on next page

Earlier this month, five new MGH care re-design teams were announced. These teams will focus on total joint replacement, vaginal birth deliveries, endovascular procedures, lung cancer, and organ and tissue transplantation. They have been asked to deliver their recommendations by fall.

Physical therapist, Kristin Parlman, PT, who sits on the Stroke Team, says, "Our group is highly motivated, not just to cut costs, but to look critically at current practice and implement changes to improve care. We're looking at what we can do to ensure successful discharge and transition back into the home; to develop systems that take into account the 'whole picture,' the patient, support system, community resources, and follow-up care."

Chelby Cierpial, RN, shares that the AMI (Acute Myocardial Infarction) Team is focusing on, "standardizing care wherever possible, minimizing the number of patient hand-offs from team to team, and ensuring appropriate support and follow-up after discharge."

I'm thrilled to see that recommendations are geared toward optimizing quality and safety while reducing adverse clinical events and preventing unnecessary readmissions.

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All of the care re-design teams came together recently for a retreat to synchronize expectations, share data, and begin to manage their work more cohesively.

Patient affordability teams were asked to evaluate opportunities to reduce costs (across Partners) in emergency services, perioperative services, inpatient services, and a number of other direct-patient-care areas. Standardization was a common theme in these groups, including recommendations for consistency of products and supplies throughout Partners and a standardized approach to the acquisition of new technology.

The Employee Health Benefit Team recommends continued focus on ways to reduce pharmaceutical spending, better manage high-risk, high-cost patients, and help employees and their families improve and maintain good health. This team is also looking at ways to increase capacity for mental-health and primary-care services.

The Reputation and Communication Team focused on publicizing and reinforcing Partners' commitment to quality care through public education and multi-media advertising. The new Partners website (connectwithpartners.org) was created as a forum for sharing our thoughts and perspectives on current healthcare issues in Massachusetts.

Going forward, we will remain true to our mission and guiding principles, keeping patients and families at the forefront of our decision-making. I want to thank all PCS employees for your continued and unwavering commitment to our patients, our hospital, and our promise to strive for Excellence Every Day.

Update

I'm pleased to announce that associate chief nurse, Debbie Burke, RN, who has held interim responsibility for the Cancer Center since January, has accepted this expanded role on a permanent basis effective immediately.

In this Issue

Social work presentations spotlight best practice

—by Barb Luby, LICSW

Throughout the month of March, in honor of National Social Work Month, the Social Services Department presented a series of lectures and discussions highlighting the important work of clinical social workers throughout MGH. Following is a summary of presentations held during National Social Work Month.

Elizabeth Speakman, LICSW, with assistance from Claudine Riley, LICSW, presented, "Mindfulness in the Healthcare Setting," which focused on the clinical effectiveness of mindfulness meditation, strategies to address common barriers to meditation in inpatient and outpatient settings, and opportunities for clinicians to increase awareness by "doing nothing."

In their presentation, "Living with Uncertainty: Strategies for the Client and Clinician," social workers, Julie Berrett-Abebe, LICSW; Mary Susan Convery, LICSW; Corinne Holbrook, LICSW; and Jocelyn Walls, LICSW, offered a range of interventions designed to help patients and caregivers cope with the myriad psychosocial issues encountered by patients facing chronic and potentially fatal illness.

"Prenatal, Birth and Attachment Therapy: Pioneering Approaches," presented by Mimi Nelson Oliver, LICSW, highlighted the physical, mental, and emotional effects of early attachment and bonding between child and primary caregiver, all of which can carry through to adulthood.

In their presentation, "Preparing Patients and Families for End of Life," Marilyn Wise, LICSW, and Mary Zwirner, LICSW, used the ethical gold-standard question, "What does human dignity demand?" to look at the role of social workers in supporting and empowering patients and families facing end-of-life decisions.

Lourdes Barros, LICSW, closed out the month with her presentation, "The Cultural Formulation Model." Using a case involving a complex relationship between a Brazilian and Cape Verdean, Barros illustrated how cultural considerations influence comprehensive care.

For more information about services offered by MGH social workers, please call 6-2643.

(Top right photo by Paul Batista)

MGH social workers present (clockwise from top left): Elizabeth Speakman, LICSW; Mimi Nelson Oliver, LICSW; Lourdes Barros, LICSW; Marilyn Wise, LICSW; Mary Zwirner, LICSW; Corinne Holbrook, LICSW; Jocelyn Walls, LICSW; Julie Berrett-Abebe, LICSW (seated); and Mary Susan Convery, LICSW.

CLCDN: expanding opportunities for diverse nurses throughout Partners

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

For the past 15 years, there has been growing evidence that greater racial and ethnic diversity among healthcare providers is an effective means of decreasing healthcare disparities among diverse patient populations. Efforts have been made at MGH, Partners HealthCare, and within the city of Boston, to increase the number of educational opportunities available to diverse students wishing to pursue careers in health care. The Clinical Leadership Collaborative for Diversity in Nursing (CLCDN), a collaborative initiative between MGH; UMass, Boston; and other Partners institutions, has been highly successful in this area.

The goal of the CLCDN is to increase the number of minority nurses (American Indian, native Alaskan, Asian, black or African American, Hispanic or Latino, Hawaiian, or Pacific Islander) employed within Partners. In addition to scholarship support, the CLCDN aims to ease the transition from student to nurse through capstone experiences, mentoring, and employment opportunities. Nurse mentors play a key role in the program. In formal and informal sessions, CLCDN mentors and students identify ways to achieve academic excellence, develop clinical and leadership skills, and manage the racial, ethnic, and cultural issues that may arise.

The CLCDN was implemented in 2007 with 18 nursing students. Since then, more than 59 UMass nursing students have matriculated through the program. Of the 37 who have graduated, 32 are currently employed at PHS institutions.

Originally designed to support students at the baccalaureate level, a new CLCDN initiative is being implemented that will provide opportunities for diverse nurses already employed at a PHS institutions who would like to pursue a master's or doctoral degree. Led by Gaurdia Banister, RN, executive director of The Institute for Patient Care, and Marion Winfrey, associate dean, this initiative will help position nurses for managerial and advanced practice roles through scholarship support, educational offerings, and mentoring. Seven nurses have already been selected to receive scholarships, and another round of applications is scheduled for the summer.

The CLCDN seeks to enhance workforce diversity in an effort to better meet the needs of patients and families and support the nursing leaders of the future.

For more information about the CLCDN, call Gaurdia Banister at 4-1266.

(L-r): CLCDN mentors: Linda Redd, RN; Ted Hester, RN; Sheridan St. Jour, RN; Gaurdia Banister, RN, and Decima Prescott, RN.

Volunteer Recognition Week

celebrating a record milestone

—by Milton Calderon, project specialist

March 28, 2011, marked the beginning of Volunteer Recognition Week, a time when MGH honors the invaluable service of the (currently) more than 1,200 volunteers who help support patients, families, and staff throughout the hospital. This year, the Volunteer Department hosted a number of activities in an effort to give volunteers and supervisors more opportunities to take part in the celebration. At one event, museum director, Peter Johnson, gave volunteers a preview of the Paul S. Russell, MD, Museum of Medical History and Innovation. An ice cream social and evening reception in the Thier Conference Room gave volunteers a chance to meet and mingle. And at a special 'breakfast of champions,' volunteers heard remarks from MGH president, Peter Slavin, MD; Cathy Minehan, chairman of the MGH Board of Trustees; and Marianne Ditomassi, RN, executive director of Patient Care Services Operations. Volunteer champions are those volunteers who model exemplary service and assist in training new volunteers.

Below (l-r): volunteers, Jenna Davis, Caesar Nuzzolo, Bianca Ornaf, and Brendan O'Brian.

(Photo by Michelle Rose)

The evening reception, complete with violin and piano music, gave many volunteers a chance to meet some of their peers for the first time. The reception culminated with a raffle of the new book, *Something in the Ether: a Bicentennial History of Massachusetts General Hospital*, by Webster and Martha Bull.

Director of Volunteer Services, Paul Bartush; volunteer coordinator, Meghan Fitzgibbons; and project specialist, Milton Calderon, attended the reception to personally thank volunteers for their selfless service. Said Bartush in his remarks, "Throughout the history of MGH, we have benefited from the service of community members willing to step forward to offer a helping hand. As we look toward the future, we are assured that with the support of our dedicated volunteers, we will continue to deliver exceptional patient- and family-centered care."

In 2010, MGH volunteers contributed a record 101,000 hours in support of patients, families, and visitors. The MGH community applauds them for achieving this momentous milestone. We are grateful to these committed individuals who enhance the patient and family experience with their presence.

For more information about volunteer opportunities at MGH, call 6-8540.

Teachback/showback: effective patient-education tool

—by Vita Norton, RN; Anna Pandolfo; Silvianne Ngueya, RN; and Kathryn Best Manzo, RN

As medical care becomes increasingly complex, the need for patients to be 'health-literate' is greater than ever. Studies show that the majority of medical information given to patients is either forgotten or retained incorrectly. One of the best ways to ensure effective communication between healthcare provider and patient is the teach-back/show-back method.

The teach-back/show-back method lets clinicians assess how well a patient understands the information being presented. In the teach-back phase, a patient is given instructions then asked to repeat them back in their own words. In the show-back phase, the patient is taught a new skill then asked to demonstrate it for the care provider. If the patient is unable to explain or demonstrate the skill correctly, the information can be re-taught using a different approach.

When providing patients with information, it's important to go slowly, use simple words that have only one meaning, and focus on no more than five main points. Stress what they *need to know* not what would be *nice to know*.

Patients shouldn't perceive teach-back as a test. They should understand it's a way to confirm that the provider has explained important information and concepts effectively. Try to create a safe, non-threatening atmosphere. For instance, you might say, "Many patients find it confusing to take this medication, so I want to make sure I take the time to explain it correctly."

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Asking Yes/No questions such as, "Do you understand?" doesn't provide a true sense of a patient's understanding. Asking a patient to repeat something in their own words lets you know they 'get it.' Open-ended questions also work well. Try, "Tell me what would you do if..." or "How would you know if..."

When using the show-back method, if the patient cannot demonstrate the task or recall the information, try a different approach.

Every patient is unique with a unique learning style. Assessing learning needs at admission is critical to the teach-back/show-back method and the effect it can have on the hospital experience. It's best to begin patient-education at admission and continue throughout hospitalization rather than overwhelm a patient at discharge.

By putting these teaching techniques into practice, the patient is not a passive listener with communication flowing only from provider to patient. The teach-back/show-back method creates opportunities for dialogue. It helps engage patients and better prepare them to participate and make decisions about their own health. The teach-back/show-back method also gives providers a chance to identify obstacles that might interfere with compliance.

Teach-back and show-back are just two examples of how we can improve communication. As health care continues to evolve, it will be essential to ensure effective, two-way communication between healthcare providers and patients.

For more information on the teach back/show-back method, call Judy Gullage, RN, at 6-1409, or any member of the Patient Education Committee.

New graduate nurse navigates the nuances of end-of-life care

My preceptor, Richard, and I received report on our patient, Ms. M, a recent admission who had stage IV cervical cancer. The cancer had recently metastasized to her lungs and bones, and her prognosis was poor.

My name is Kaitlyn Kariger, and I am a new graduate nurse practicing in critical care. I have worked in the Medical Intensive Care Unit for three months. Half-way through my six-month orientation on the unit, I started to take on full patient assignments. Every morning between 7:00 and 9:00am felt like a marathon—there was so much to do. I try to do everything in a timely fashion, especially since I don't like seeing those red pills on my EMAR screen (red pills are icons that appear on the Electronic Medication Administration Record to indicate a medication is overdue).

My preceptor, Richard, and I received report on our patient, Ms. M, a recent admission who had stage IV cervical cancer. The cancer had recently metastasized to her lungs and bones, and her prognosis was poor. She was admitted to the Medical ICU due to increased work of breathing, and she had been intubated.

After hearing report, I went see Ms. M and told her the plan for the morning. She wasn't able to respond because she'd been sedated. Looking at Ms. M, I couldn't help but feel sad; she was only 12 years older than me, and looked so young lying there in the bed. I met her very supportive, but anxious, parents and siblings.

Kaitlyn Kariger, RN, staff nurse, Blake 7 Medical ICU

I explained that I was there to do my assessment, get Ms. M's medications, re-position her, and round with the Medical Team. Then Ms. M and I were scheduled to go to Interventional Radiology for an adjustment to her nephrostomy tube, then hopefully, her breathing tube could be removed.

When it was time to go to Interventional Radiology, I gathered up all the equipment I would need: a defibrillator, a travel monitor, and, as I had learned from Richard, my 'goodie bag.' The goodie bag contains everything I might need in the event something

continued on next page

goes wrong during transport. We went to Interventional Radiology, and fortunately, Ms. M's procedure was uneventful.

Upon arriving back in the MICU, I explained to Ms. M's family what to expect when they removed her endotracheal tube. I told them that many patients experience a dry mouth afterwards, and I explained that Ms. M might be groggy for some time. After all their questions were answered, I gathered all the necessary equipment, including oxygen-tubing, humidified face mask, and a Yankauer suction, and asked Ernie, the respiratory therapist, to assist me.

Once in the room with Ms. M, I explained the procedure to her and prepared her for how she might feel afterward. I assured her I would stay with her the whole time. Ernie removed the endotracheal tube, and I coached Ms. M to take some deep breaths. She did well breathing with just a humidified face mask.

I asked Ms. M if she was able to speak.

She answered, "Yes I can. Thank-you for saving my life."

I was surprised those were her first words.

I said, "Thank-you. The whole medical team has been working to get you better."

Ms. M reached up to hug me and started to cry. As I leaned over and hugged her back, I didn't know what to say.

As her sobs subsided, she said, "I know I'm not better. I know I'm going to die, and I know it's going to happen soon. I don't want to die."

I hadn't prepared myself for anything like this. I didn't have a goodie bag to help me with this conversation. I always try to be prepared for everything—as a new graduate, it's one of the most important things. But for this statement, I had never learned a response.

I looked Ms. M in the eye and thought about what I would want to hear if I were the one lying in bed with stage IV cervical cancer.

I told her, "You're better in the sense that you don't require a ventilator, or medications for your blood pressure. But you're right, your cancer is not any better. I'm so sorry. This shouldn't happen to anyone. What can I do for you? How can I make you feel better today?"

Ms. M responded, "I guess I'm ready to have 'the talk.' Being in the ICU has been scary. And I have questions about my options for the future."

Ms. M and I spent the next few hours talking about everything: her past career, how she lived in the next town over from me, how she worried about her Chihuahua and who would care for him when she was gone. She made it clear that although it would be hard, she wanted to have everything in order before she died.

The oncologist came to speak with her later in the day. It was clear that Ms. M's time in the MICU had changed her perspective on her medical condition and her wishes for the future.

My nursing practice changed that day. I realized the importance of seeing the forest for the trees. I know it's impossible to be prepared for every situation, especially in nursing where there is so much variability, and every patient is different. But being able to be honest, having those difficult conversations, and taking the time to be present for patients is what's important—even if it sometimes means a red pill on EMAR.

About a month later, I ran into Ms. M' sister at Coffee Central. She told me that Ms. M was close to death; the family thought it could be as soon as that night. I gave her a hug and asked about Ms. M's Chihuahua. She told me Ms. M's nieces were going to take care of the dog. I smiled through my tears. I felt at peace that Ms. M had been able to express some of her last wishes, and that I had been her nurse when she needed someone to listen and care.

My nursing practice changed that day. I realized the importance of seeing the forest for the trees. I know it's impossible to be prepared for every situation... But being able to be honest, having those difficult conversations, and taking the time to be present for patients is what's important.

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

Three months into her practice, Kaitlyn was faced with a situation that gives many experienced nurses pause. Talking openly and honestly about a patient's impending death can be a delicate challenge. Kaitlyn put herself in Ms. M's situation and let herself be guided by empathy. She sat with Ms. M and candidly answered her questions. I have no doubt that Kaitlyn's compassion and honesty played a part in Ms. M's ability to begin the process of acceptance, knowing she would be cared for with dignity and respect.

Thank-you, Kaitlyn.

A look at the newly re-designed collaborative governance

On May 15, 1997, Jeanette Ives Erickson, RN, senior vice president for Patient Care, informed the original members of collaborative governance that their work was about to change. She described how their participation in collaborative governance would give them an opportunity to interact with diverse teams of clinicians and support staff, with colleagues from different disciplines, and with professionals who want to create a better place for patients, families and employees.

Almost 14 years later, Ives Erickson's prediction is a reality—collaborative governance has become an integral part of Patient Care Services and the MGH culture. Thanks to those original committee members and leaders and all those who followed, we have compiled an impressive list of accomplishments:

Almost 14 years later, Ives Erickson's prediction is a reality—collaborative governance has become an integral part of Patient Care Services and the MGH culture.

The Diversity Committee

- Created and organized annual HAVEN (Helping Abuse and Violence End Now) gift-giving program
- Coordinated annual Black History Month Pinning Ceremony
- Sponsored educational programs on healthcare disparities and culturally competent care

The Ethics in Clinical Practice Committee

- Raised awareness around advance care planning among staff, patients, families, and the community
- Educated MGH community about ethics through case studies, journal articles, and local and national presentations
- Collaborated with other collaborative governance committees on educational programs for the MGH community

The Nursing Practice Committee

- Updated and revised many policies and procedures
- Collaborated with the Electronic Medication Administration Record (EMAR) and Acute Care Documentation (ACD) workgroups
- Collaborated with Materials Management on product reviews

The Nursing Research Committee

- Developed the *Did You Know* evidence-based poster series
- Developed the Nursing Research Journal Club, which brings journal authors together to share and discuss their research with clinicians
- Coordinated annual Nursing Research Day and Expo

The Patient Education Committee

- Collaborated with the Quality Committee to implement "Ask Me 3" and "Teach Back" patient-empowerment programs
- Surveyed PCS clinicians to evaluate their patient-education practice and implemented interventions to address relevant issues
- Educated MGH clinicians, staff, and the public on issues of health literacy through educational conferences and resources written in plain language

The Quality Committee

- Reviewed cases for reportability to the Board of Registration in Medicine
- Provided leadership preparing for Joint Commission visits and responding to CMS (Centers for Medicare and Medicaid Services) visit

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Champions embrace new collaborative governance model

While it might seem like semantics, the word champion better reflects the evolution of committee members into the empowered communicators, content experts, and leaders they have become.

One exciting aspect of re-designing collaborative governance has been the integration of the champion model into the committee structure. What this means is that if you participate in collaborative governance, you're now considered a champion. While it might seem like semantics, the word champion better reflects the evolution of committee members into the empowered communicators, content experts, and leaders they have become.

Over the years, the champion role has been closely associated with Excellence Every Day and Magnet recognition (and re-designation). Effective immediately, those champions and the work associated with Excellence Every Day and Magnet are now part of collaborative governance. This new approach ensures an environment of quality, safety, and regulatory compliance in an organization that supports professional nursing practice, autonomy, and superior patient outcomes.

Claire Paras, RN, staff nurse on Phillips House 22 served as an Excellence Every Day champion. When asked what being a champion meant to her, Paras spoke of being a liaison between her peers and the Excellence Every Day program. "Communication was critical to the success of the program. It's what allows all our quality efforts to succeed."

Identifying the best way to communicate also ensures success. Along with unit leadership, Paras offered weekly quizzes and Jeopardy games with prizes and group discussion of important topics.

Joanne Parhiala, RN, staff nurse on the Blake 11 Psychiatric Unit, served as a Magnet champion. Parhiala agrees that communication is critical to the success of Magnet recognition. "Being able to frame the forces of magnetism in the context of our unit allowed us all to communicate in the same language."

Collaborative governance champions, Joanne Parhiala, RN (left), and Claire Paras, RN

Parhiala personalized posters with pictures of staff engaged in activities related to quality and safety; she held a variety of informational forums. "You have to know what works on your unit," she says. "One communication style doesn't fit all."

Paras is now a champion on the Skin Care Subcommittee, and Parhiala is a champion on the Restraint Usage Subcommittee, both offshoots of the new Practice & Quality Committee.

Says Paras, "The new collaborative governance structure makes sense. It promotes a more cohesive, inclusive, and complete foundation by which to communicate quality and safety issues."

Parhiala cautions us not to forget the lessons learned from the Magnet experience. "Communication, information, and clearly identified outcomes are key."

With the experience, talent, and enthusiasm all the collaborative governance champions bring to the table, the new committee structure promises to be a powerhouse of communication, commitment, and team work.

For more information on the re-designed collaborative governance, call Mary Ellin Smith, RN, at 4-5801.

the committees

The Diversity Committee

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.

(L-r): Anabela Nunes, co-chair; Judy Newell, RN, advisor; Robyn Stroud, recorder; Maureen Schnider, RN, coach; and Michelle Andrews, co-chair

The Ethics in Clinical Practice Committee

The Ethics in Clinical Practice 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.

(Back row, l-r): Sharon Brackett, RN, coach; Berney Graham, LICSW, co-chair; Cynthia LaSala, RN, advisor; (front row): Robyn Stroud, recorder; Connie Wilson, RN, co-chair

the committees

The Informatics Committee

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. Meets the second and fourth Thursday of the month, 1:00–2:30pm, Yawkey 7-980.

(L-r): Abby MacDonald, LICSW, co-chair; Michelle Stuler, RN, co-chair; Ann McDermott, RN, coach; and Eleanor Delaney, recorder. (Sally Millar, RN, advisor, not pictured)

The Patient Education Committee

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.

(L-r): Judy Gullage, RN, co-chair; Sally Hooper, LICSW, coach; Waveney Cole, recorder; Kate Russo, OTR/L, co-chair; and Brian French, RN, advisor

the committees

The Research & Evidence-Based Practice Committee

The Research & Evidence-Based Practice 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.

(L-r): Mary Larkin, RN, coach; Diane Carroll, RN, advisor; Kate Whalen, RN, co-chair; Kate Fillo, RN, co-chair; and Linda Lyster, recorder

The Policies, Products & Procedures Sub-Committee

The Policies, Products & Procedures Sub-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.

(Back row, l-r): Waveney Cole, recorder; Tom Lynch, RN, co-chair; (front row): Maureen Beaulieu, RN, co-chair; Barbara Cashavelly, RN, coach; and Joanne Empoliti, RN, advisor

the committees

The Skin Care Sub-Committee

The Skin Care Sub-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.

(Back row, l-r): Denise Lauria, RN, co-chair; Ginger Capasso, RN, advisor; (front row): Jill Pedro, RN, coach; Shirley Rizzotto, recorder; and Jacqui Collins, RN, co-chair

The Restraint Usage Sub-Committee

The Restraint Usage Sub-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.

(L-r): Jennifer Repper-Delisi, RN, coach/advisor; Nghi Thuc Huynh, recorder; Catherine Mackinaw, RN, co-chair; and Meaghan Rudolph, RN, co-chair

the committees

The Pain-Management Sub-Committee

The Pain-Management Sub-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.

(L-r): Michael Murphy, RN, co-chair; Paul Arnstein, RN, coach/advisor; Jennifer Carr, RN, co-chair; and Wendy Adams, recorder

The Fall-Prevention Sub-Committee

The Fall-Prevention Sub-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.

(L-r): Bridget Lyons, RN, co-chair; Deborah D'Avolio, RN, advisor/acting coach; Helen O'Carroll, recorder; and Christina Connors, RN, co-chair. (Monica Staples, RN, coach, not pictured)

(Thanks to the MGH Photo Lab for many of the collaborative governance photos in this issue of *Caring Headlines*)

Collaborative governance continues to place the authority, responsibility, and accountability for patient care with practicing clinicians, integrating clinical staff into the formal decision-making of Patient Care Services.

- Worked with colleagues and unit-based leadership to create an environment of quality and safety

Staff Nurse Advisory Committee

- Provided input on recruitment and retention efforts
- Served as a liaison between senior nursing leadership and clinicians regarding day-to-day clinical issues, quality of work-life, and helped plan for regulatory and Magnet site visits

The work of these committees has been transformative. So why re-design collaborative governance? The answer lies in the changing healthcare environment and its focus on informatics, healthcare reform, and meeting the needs of our patients. If we are to continue to provide the best possible care to patients and families, the work of our collaborative governance committees must be aligned with our current reality and with Patient Care Services' strategic goals.

The re-designed collaborative governance structure merges the Nursing Practice and Quality committees to form the Quality and Practice Oversight Committee, comprised of five sub-committees:

- Fall-Prevention
- Pain-Management
- Policies, Products & Procedures
- Restraint Usage
- Skin Care

A new Informatics Committee has been created, and the Nursing Research Committee is now inter-disciplinary and has been re-named the Research & Evidence-Based Practice Committee.

The philosophy and work of the Excellence Every Day and Magnet champions will be incorporated into the work of every collaborative governance committee. Every collaborative governance member is now a collaborative governance champion.

Other than the shift to the champion model, the Diversity, Ethics in Clinical Practice, Patient Education, and Staff Advisory committees were not affected by the re-design.

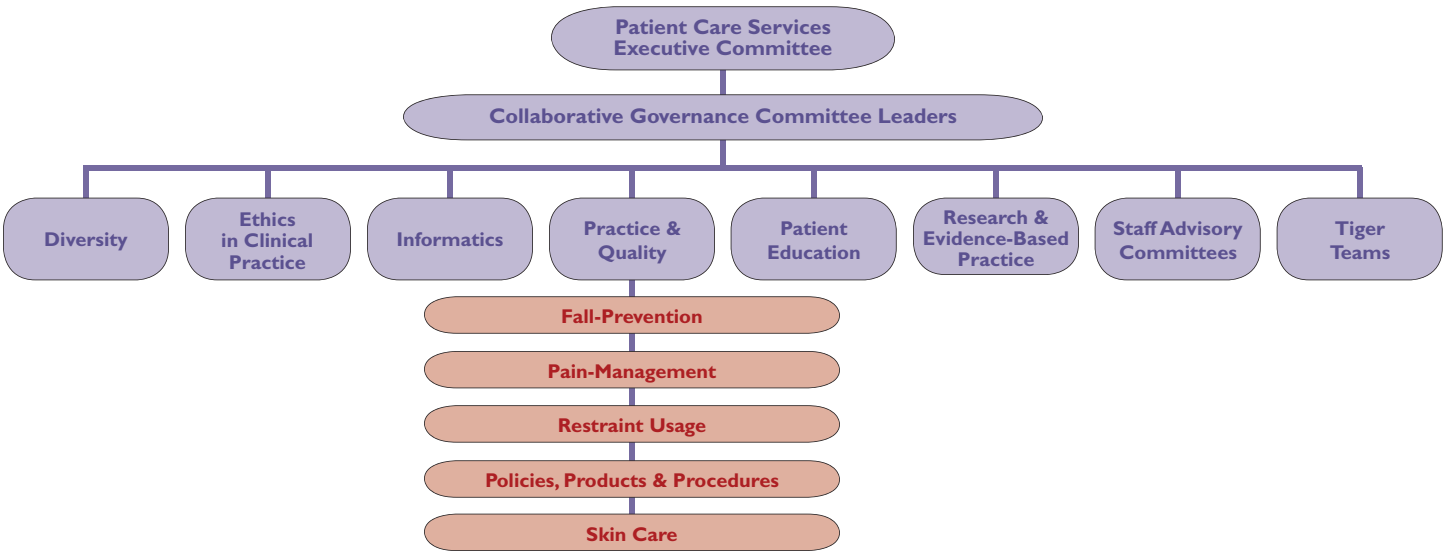
While much has changed, much remains the same. Collaborative governance continues to place the authority, responsibility, and accountability for patient care with clinicians, integrating clinical staff into the formal decision-making of Patient Care Services.

And with the new structure comes a new look. The logo for the re-designed collaborative governance was unveiled recently (see below). Look for it on future communications related to collaborative governance.

Collaborative Governance

For more information about any of the collaborative governance committees, call Mary Ellin Smith, RN, at 4-5801.

Re-Designed Collaborative Governance Structure



Hourly safety rounds have positive impact on patient-satisfaction

A standardized approach to hourly rounding is essential. Consistency helps builds trust with patients and families and allows us to accurately measure the impact of safety rounds on nursing sensitive indicators such as falls, pressure ulcers, and patient-satisfaction.

Question: Do all units at MGH employ hourly safety rounds?

Jeanette: According to a survey of nursing directors in February, 2011, 100% of inpatient units and the Emergency Department use some form of safety rounds (compared to 49% in June of 2010).

Question: Why are safety rounds so important?

Jeanette: Evidence shows that hourly rounds—rounds that are focused and predictable—help prevent falls and pressure ulcers, manage pain, and increase patient-satisfaction. Patients and families are less anxious knowing their needs will be met as nurses, patient care associates, and other clinicians check on them at regular intervals.

Question: What are the seven Ps?

Jeanette: The 7 Ps stand for: Presence, that sense of being there, honoring the patient's individual response to illness, and gaining trust; Person, introducing yourself and your role; Plan, reviewing the care plan; and Priorities, making sure you know the patient's wishes. These are all part of the initial daily encounter. In subsequent encounters (every hour or two), staff should offer assistance with Personal hygiene (going to the bathroom), Positioning, and assessing for Pain.

Question: Do hourly safety rounds apply to critical care units?

Jeanette: If critically ill patients are unresponsive, the 7 Ps can be used to assure family members about continuity and attentiveness of care.

Question: Are hourly safety rounds scripted?

Jeanette: Some believe that using a scripted approach when rounding is too impersonal and sounds rehearsed. The important thing is to make sure you touch on each of the seven Ps using your own language and style of communication. Patients should know what to expect from hourly safety rounds, such as knowing they'll be asked about their comfort and level of pain at regular intervals.

Question: Are we doing anything to ensure consistency around hourly rounding?

Jeanette: A standardized approach to hourly rounding is essential. Consistency helps builds trust with patients and families and allows us to accurately measure the impact of safety rounds on nursing sensitive indicators such as falls, pressure ulcers, and patient-satisfaction. In the coming weeks, the PCS Office of Quality & Safety will be distributing toolkits to assist staff in achieving consistency in their hourly rounding.

As we move forward, we'll call upon our clinical experts in falls, pressure-ulcer prevention, and pain-management to help us refine our approach in these areas of the seven Ps.

For more information on hourly safety rounds, call the PCS Office of Quality and Safety at 3-0140.

Announcements

Pediatric Grand Rounds

April 26, 2011
12:00 noon
O'Keeffe Auditorium

Pediatric Family Advisory Council will present.
For information, call 6-3964.

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.

MGH Chaplaincy Easter/Passover Services

All services held in the MGH Chapel

Friday, April 22, 2011
11:00–11:45am
Passover/Shabbat Service
Regular Shabbat service with Passover songs

12:00–3:00pm
Good Friday Service
Music, reflections, readings and prayers based on the "Seven Last Words"

Saturday, April 23rd
There will be no 4:00pm Mass

Sunday, April 24th
12:15pm
Ecumenical Easter Service

4:00pm
Easter Sunday
Roman Catholic Mass

For more information, call 6-2226.

Neuroscience Nurse Week

May 15–21, 2011, is National Neuroscience Nurse Week. MGH neuroscience nurses will staff a stroke-education table in the Main Corridor on May 17th.

For information, call 6-5298.

Clinical Pastoral Education fellowships for healthcare providers

The Schwartz Center is offering fellowships for the fall, 2011, MGH Clinical Pastoral Education Program for Healthcare Providers

Group sessions meet Mondays from 8:30am–5:00pm with additional hours for the clinical component.

The program begins September 6th and runs through December 20th. Applications will be accepted after May 1st.

For more information call 4-3227.

AMMP scholarships

Applications available on-line

As of October, 2010, previous scholarship awardees re-applying for an AMMP scholarship are no longer required to submit a five-page essay. A two-page update of your educational journey since receiving the last award is sufficient.

Starting in the fall of 2011, the MGH Institute of Health Professions (IHP) will partner with the AMMP Scholarship Program to offer a three-credit scholarship. Awardees are required to volunteer a minimum of 20 hours at the IHP.

This scholarship is available to applicants with an interest in Nursing, Physical Therapy, and Speech-Language Pathology.

For more information, call 4-4424.

An Ounce of Prevention

a women's health fair

MGH and the department of Obstetrics & Gynecology are celebrating National Women's Health Week by sponsoring An Ounce of Prevention, a day-long health fair with opportunities to learn how to stay healthy throughout the life cycle. Providers will be on hand to answer questions. Door prizes will be raffled off.

May 11, 2011
8:00am–4:00pm
Under the Bullfinch tent

For information, call 3-5420.

Senior HealthWISE events

Lecture Series:
"Glaucoma"
Thursday, April 21, 2011
11:00am–12:00pm
Haber Conference Room
Speaker: Tom Hsu, MD, Ophthalmic Consultants of Boston

Book Club:
The King's Best Highway
by Eric Jaffe
Thursday, April 21, 2011
3:00–4:00pm
West End Library
151 Cambridge Street
Light refreshments provided.

Hypertension Screenings:
Monday, April 25, 2011
1:30–2:30pm
West End Library
151 Cambridge St.
Free blood pressure screening with wellness nurse, Diane Connor, RN, who will answer questions and provide information about healthy blood pressure.

Senior HealthWISE events are free for seniors 60 and over
For information or to RSVP, call 617-724-6756.

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Next Publication
May 5, 2011

Sixth annual Medical Nursing Visiting Scholar Program

Nurses as compassionate caregivers

—by Kathryn E. Hall, RN, nursing director

On Tuesday, March 8, 2011, the sixth annual Visiting Scholar Program, sponsored by Medical Nursing and The Norman Knight Nursing Center for Clinical & Professional Development, featured visiting scholar Colleen Person, RN, a consultant with Creative Health Care Management. Person's work focuses on relationship-based care.

The day began with a rich and insightful roundtable discussion where medical nurses, Priscilla McCormack, RN, Nora Sheehan, RN, and Suzanne Murphy, RN, shared clinical narratives exemplifying compassionate care-giving. The session was facilitated by Person and Kathy Hall, RN, nursing director of the Clinical Research Center.

Associate chief nurse, Theresa Gallivan, RN, welcomed participants to the first address, "Celebrating Caring Relationships: the Essence of Professional Practice." Person reviewed the three central relationships of our professional lives: "our relationship with self, colleagues, and patients and families, and how they affect our practice."

During lunch, participants took part in mindful meditation and break-out sessions focusing on self-care, such as Reiki, Therapeutic Touch, hypnotherapy, aromatherapy, and blessings. Nurses were thrilled to have an opportunity to experience these complementary therapies and their relaxing effects.

The keynote address, introduced by nursing director, Colleen Gonzalez, RN, was entitled, "Creating and Sustaining Cultures of Excellence." Person's warm presentation style, strong nursing identity, and passion for nursing emanated throughout the day.

For more information on the Medical Nursing Visiting Scholar Program, call 6-3295.

(Photo by Michelle Rose)

Visiting medical nursing scholar, Colleen Person, RN

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