

# Caring

Headlines

November 3, 2011

## Celebrating the life and career of Judy Newell, RN

MGH  
*pays tribute  
to one of  
the greats*

*See  
remembrance  
on page 4*

Nursing director, Judy Newell, RN, against the backdrop of the undersea fantasy world that adorns the halls of the Ellison 17 and 18 pediatric units.

# Gregg Meyer, MD, senior VP for Quality & Safety updates PCS leadership on care re-design

What we've learned from these experiences is that there's no short-cut, no simple, easy solution for managing healthcare costs. The answer lies in working smarter and more efficiently.

On October 12, 2011, at an expanded meeting of Patient Care Services leadership, we were fortunate to hear from senior vice president for Quality & Safety, Gregg Meyer, MD, who spoke to us about the important work taking place around care re-design. Gregg's presentation provided valuable context for the Partners-wide and MGH-specific efforts to cut costs and improve care, and I'd like to share some of the salient points with you.

With a series of graphs and charts, Gregg showed how healthcare costs have risen sharply over the past 50 years with no real correlation between higher spending and positive patient outcomes. Our friends at *The Boston Globe* remind us that Massachusetts health-insurance premiums are the highest in the country (as of 2009). And there exists an interesting conundrum in that—from the federal government's perspective, Medicare costs are unsustainably high to the extent that they threaten to bankrupt the system; while from health care's perspective, payment rates from the government are inadequate and threaten the viability of hospitals across the country. Sadly, both assessments are accurate.

Gregg reminded us of past efforts at MGH to contain costs: Operations Improvement in the late '90s, which focused on reducing utilization and line-item



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

costs; and more recently, Clinical Performance Management, which focused primarily on reducing lengths of stay. He re-visited the long list of payment methods, each hailed at one time or another as 'the way to go': fee-for-service; capitation; episodes of care; public utility, etc.

What we've learned from these experiences is that there's no short-cut, no simple, easy solution for managing healthcare costs. The answer lies in working smarter and more efficiently. And that means enlisting every employee at every level to embrace and support a new way of doing business.

One of Gregg's slides focused on things we should continue doing, things we should stop doing, and things we should start doing. I want to share the things we should *start* to do:

- Make this initiative sustainable
- Keep the people who are doing the work as informed and involved as possible

*continued on next page*

Our commitment to our patients and families has always been our greatest asset, and that commitment is only strengthened in challenging times. I look forward to working with all of you as we strive to make MGH a stronger, smarter, more efficient organization.

- Make care-improvement part of normal operations, not just a phase
- Develop clinicians to lead improvement and provide formal training for that development
- Make this initiative a priority for everyone not just high-level committee members
- Be up front (transparent) about what will happen with cost savings

As you may recall, several condition-specific re-design teams were created to explore new, more efficient approaches to care-delivery. The first five teams (Colon Cancer, Coronary Disease, Diabetes, Stroke, and Primary Care) were formed by Partners last year and include representatives from across the Partners network. Five more teams were created in April to focus on MGH-specific care improvements (Vaginal Delivery, Total Joint Replacement, Endovascular Procedures, Lung Cancer, and Transplantation).

These care-re-design teams engaged in something called, 'value-stream mapping,' a visual exercise that helps facilitate identification of non-value-added work and opportunities to standardize or streamline processes. Each team is at a different stage in their progress, but many have already set new goals and begun to test some of the recommendations identified in their value-stream analyses.

Any discussion about care re-design involves every person in Patient Care Services—clinicians and support staff alike. Which is why I think Gregg's final slide might have been one of the most important. How can we help? What can we do to support this work? Gregg suggests the following:

- Keep abreast of changes in the marketplace
- Support the implementation of Partners care re-design initiatives
- Help generate ideas
- Identify opportunities to eliminate waste
- Get involved with care re-design teams
- Let your expertise and experience inform best practices
- Learn about process-improvement and seek out opportunities to incorporate it into your practice
- Attend a care re-design meeting

We truly are at the dawn of a new age. I thank Gregg for his insightful look at the issues surrounding care re-design, and I have no doubt that we'll succeed in this important work. Our commitment to our patients and families has always been our greatest asset, and that commitment is only strengthened in challenging times. I look forward to working with all of you as we strive to make MGH a stronger, smarter, more efficient organization.

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# Judy Newell, RN

*A legacy of leadership, kindness, and devotion to others*

—by Susan Sabia, editor, *Caring Headlines*

In the course of her distinguished career, Newell helped shape the culture, environment, and soul of this institution through her committee work, her leadership of patient care units, and her unflinching desire to do the right thing no matter how difficult or uncomfortable.

“Hello, my darling.” Judy Newell’s trademark greeting. “Hello, my darling,” she would say as if you were the one person she was hoping to see; as if your mere presence had brought that smile to her face; as if nothing else mattered but talking to you. Judy Newell, RN, pediatric nursing director and veteran nurse leader, passed away, October 7, 2011, surrounded by family and friends. She had been a fixture at the hospital for more than four decades, having come to MGH as a staff nurse in 1969.

In the course of her distinguished career, Newell helped shape the culture, environment, and soul of this institution through her committee work, her leadership of patient care units, and her unflinching desire to do the right thing no matter how difficult or uncomfortable. From her earliest days as a staff nurse on Vincent 2, she was a natural mentor and coach; she was an expert clinician, team player, and team-builder. She made leading by example look easy.

A champion of diversity, Newell worked tirelessly to enrich the MGH environment for patients, families, and staff of diverse backgrounds. Her words were backed by action; her philosophy rooted in kindness and inclusion. In a special diversity issue of *Caring Headlines* in November of 1997, Newell wrote:

“It is essential that an atmosphere exist in which patients and caregivers can learn cultural differences from one another. There’s no blueprint for change in creating such an environment.... In building a team of clinically competent caregivers, a nurse manager supports the process of change. Real change will be slow, frustrating, exhilarating, invigorating, and ultimately the path to improving the patient and caregiver experience.... What we know now is just the tip of the iceberg. Plunging below the surface will open up a world of possibilities. We must be courageous in stepping to the forefront on the issue of diversity... For patients, families, and caregivers, we must ‘do the right thing’ to



Judy Newell, circa 1947



Newell, student nurse of the year, Lowell General Hospital School of Nursing, class of 1966



In 2001, Newell receives the prestigious Vincent Club Award of Distinction for Outstanding Contributions in Women’s Health



## Remembrance (continued)

Newell was respected for her clinical leadership and open mind, but she was adored for her great warmth, generosity of spirit, and sense of humor. We will think of her often and miss her gentle guidance.

ensure the best environment in which to receive care and practice our professions.”

Newell’s brother, Wayne, is manager of Volunteer Services and himself a veteran of MGH. Said Wayne Newell, “All Judy’s awards and the work she did to advance diversity and family-centered care grew from her respect for everyone she encountered. What meant the most to Judy was her work with staff—nurses and support staff alike—empowering and encouraging them. Giving them the confidence to try for more... and to succeed. Respect for the individual was at the core of who Judy was. I can’t go a hundred feet in this hospital without someone coming up to me and telling me how much Judy meant to them, how she supported and inspired them. That was her real joy. That was her gift.”

A true patron of the arts, Newell loved literature, movies, music, art, and theater. Ellison 17 staff nurse, Melissa Catone, RN, recalls, “My fondest memory of Judy occurred when the *Lion King* came to town. The morning tickets went on sale, I went to the box office at the crack of dawn fully believing I’d be able to get tickets and still make it to work on time. Needless to say, that didn’t happen. I was very late getting to work, and Judy called me into her office. All she said was, ‘I can’t really be mad at you. I drove by the theater this morning planning to do the same thing myself. I saw you waiting outside the box office and laughed wondering if you’d let me cut in line.’”

In the weeks and months leading up to Newell’s death, members of the MGH community far and near

reached out to their ailing colleague. Newell’s sister, Amy Laurencio (also a nurse), recalls the outpouring of love and concern. “Judy received so much mail, she literally had shopping bags full of cards and letters—from her staff, from friends, from colleagues she hadn’t heard from in years. Every note was a tribute to Judy’s friendship, support, and kindness, and she read every one of them.” Laurencio shares one of the many notes Newell received:

*Dear Judy,*

*I don’t know where to start... How can I ever truly express my gratitude for everything you’ve done for me, both professionally and personally? You’re an amazing person, and I am blessed to have known you. I hope you know what a profound impact you’ve had on countless people in this world. I’m thinking of you and sending peace, love, and comfort. I will carry you in my heart always.*

*Much love...*

Newell was respected for her clinical leadership and open mind, but she was adored for her great warmth, generosity of spirit, and sense of humor. We will think of her often and miss her gentle guidance. But her kindness and wisdom will live on through the compassionate care we provide and the respect and consideration we show to our patients, families, and one another every day.

Thank-you, my darling.



In 2002, she receives a surprise Family-Centered Care Award from senior vice president for Patient Care, Jeanette Ives Erickson, RN



In 2008, she’s named an honorary member of ‘roll call,’ a Southern tradition where non-African Americans who support the African American community are recognized. (Shown here with Firdosh Pathan, RPh, and Kathie Myers, RN)



In 2011, Newell attends the dedication ceremony to re-name the Ellison 18 playroom in her honor. (Shown here with Ron Kleinman, MD, and Debbie Burke, RN)

"A true colleague, Judy knew how to work with everyone in a kind and positive manner. Her presence will be felt for a long time at MGH."

—Dawn Tenney, RN,  
associate chief nurse

"Judy was my first and best nurse mentor. Her dedication and magnanimity to MGH were unparalleled."

—Marie Elena Gioiella, LICSW,  
director, Social Services

"Words are inadequate.

Judy was kind, understanding, and able to see the best in all of us.

Judy was selfless.

Judy had a passion for fairness.

Judy was always there to help someone else; especially those less fortunate.

Judy brought the essence of family-centered care to life.

Judy loved being a nurse. She loved her staff—every one of them.

And everyone loved Judy."

—Debbie Burke, RN  
associate chief nurse

"Judy was a consummate nursing leader. She cared deeply for patients and inspired her staff to care for them with dignity and respect. We are grateful for her contributions to MGH, and we will miss her dearly."

Peter Slavin, MD,  
president of MGH

"Judy was a wonderful human being and an outstanding nurse. Her spirit will fill the halls of MGH for many years to come. Rest in peace, my friend."

—Marilyn Bernard, RN, staff nurse

"Judy was an extraordinary nurse leader and an incredible role model. She made certain that all patients were treated with dignity and compassion. But I'll miss her most as a dear friend."

—Isaac Schiff, MD, chief,  
Obstetrics & Gynecology

"When I think of Judy I think of love—for patients and families, for MGH, for family and friends. She leaves a legacy as an exemplary nurse leader, colleague, and friend, reminding us all to be more joyful and kind to one another."

—Theresa Gallivan, RN,  
associate chief nurse

"Judy gave me my first nursing job, and I've been on Ellison 18 ever since (ten years). I don't think I would have stayed as long as I have if it weren't for her. Judy championed my volunteer missions. I was able to spend seven months in Cambodia because of her.

I will truly miss her."

Vira Kou, RN, staff nurse, Ellison 18

"Judy always had a bias for yes. She'd work out the details later to make it happen even if the issue was problematic. I miss our morning tea, talking about music and restaurants, and her exuberance for life. I miss her very much."

—Kate Stakes, RN, clinical nurse specialist,  
Ellison 17

"I'm grateful for Judy's warm welcome when I started at MGH, and I'm grateful for her support, wisdom, and collaboration over the past eight years. When the going got tough, Judy was someone I would seek out for support. I valued her perspective and her sense of humor. I could count on her to listen well, share a wise story, and always have a basket of chocolate at the ready. I miss her, and I give thanks for her well-lived life. I will remember Judy for helping people achieve more than they dreamed possible."

—Ann Haywood-Baxter,  
pediatric chaplain

Judy Newell, RN





"I miss her... I really, really miss her."

—Brenda Miller, RN,  
nursing director, NICU

"Judy's calm and welcoming presence was a fixture on the inpatient unit. I always felt safely grounded when I saw her in her corner, open to all comers, dispensing wisdom, humor, and comfort. Her gracious spirit will continue to live among us."

Pat O'Malley, RN, director emeritus,  
Pediatric Emergency Services

"I turned to Judy often for her wisdom and guidance. She was part of the fabric of MGH for more than forty years. I miss her already. Our thoughts and prayers go out to her family and all who loved her."

—Jeanette Ives Erickson, RN,  
senior vice president for Patient Care

A few days before Jude passed, we were chatting about life and death and the mysteries of the Universe.

I asked her to try to communicate with me from the 'other side.' (If anyone could... it would be Jude.) She was weak. But a smile spilled across her face.

'Look for me in rainbows,' she said.

"That's where I'll be."

—Susan Sabia, *Caring Headlines*

"I had the deepest respect and affection for Judy and the principles she espoused—a balanced life and a bias for yes.

I was thrilled she was able to see the Ellison 18 playroom dedicated in her name. That we even have a playroom and so many other amenities for children and families is a testament to her vision and perseverance."

—Ron Kleinman, MD,  
chief of Pediatrics

"Had it not been for Judy, I would not have accepted the position of director of Diversity sixteen years ago. I had gone from staff nurse to fledgling chair of the brand new department of Nursing Diversity Committee, and Judy mentored and coached me. She taught me how to lead a group, to create and manage a strategic plan. When the director role was created, Judy came to me on my unit to tell me I should interview for the job. To which I immediately said, "No." I didn't think I had the skill or leadership 'chops' to do it. Judy wouldn't take No for an answer. She coached me through my worries, and I finally decided to take the leap. She was there through every step of my journey. The PCS Diversity Committee, diversity events, speaking up in support of our work, philosophical conversations in her office—all part of what she gave to me. She never wavered. Judy Newell changed my life."

—Deborah Washington, RN,  
director, PCS Diversity Program

"I think of Judy every day and hope to emulate her loving, caring leadership. She made us a kinder, smarter, more caring leadership team that strives to exceed the expectations of our staff, patients, and families."

Adele Keeley, RN,  
nursing director, Bigelow 7

"When I think of Judy, I instantly think of her warm, heartfelt smile. I think of integrity, kindness, friendship, and always having time to listen... and now in the silence, I remember her graceful courage."

—Patricia Cignetti, RN,  
former Nurse Partners nurse

"Judy had a knack for celebrating everyone's unique talents. I know staff will honor her memory through exceptional practice and family-centered care."

Mary Lou Kelleher, RN,  
pediatric clinical nurse specialist

"I was a new grad in the mid-80s still waiting to hear if I'd passed the boards (before boards were computerized). I was so afraid I had failed and thought sure I was going to hurt someone. But Judy gave me confidence. She was warm, and funny, and gracious. She was the 'head nurse' but I still remember her helping me make a patient's bed one morning. She was the consummate nurse."

—Mimi Bartholomay, RN, clinical nurse specialist

"I will remember Judy for her kindness, easy-going manner, compassion for others, and infectious laugh. As a nursing leader, she was always approachable and interested in her staff, both personally and professionally. She will be missed by colleagues and patients alike."

—Rande Rubenstein, RN,  
former Nurse Partners nurse

"I was lucky to have worked side-by-side with Judy for the past fifteen years. We huddled together many times to resolve patient-care issues, and I always came away with a positive vibe. I admired Judy's poise, leadership style, soft touch, and direct and sincere approach to improving the patient experience. Our patients and their families and all members of the MGH/C team are better today because of Judy."

—Howard Weinstein, MD

"I was only a teenager when Judy took me under her wing. She became a mentor to me, teaching me, sharing her knowledge, encouraging me to be the best I could be. She always listened and provided comfort when times were tough. She never gave up on me and was always proud of my accomplishments. She was a compassionate, intelligent, committed nursing director, and she will forever be in my heart."

—Georgette Young, RN  
staff nurse, Ellison 17

"Judy believed everyone on her staff had special abilities, even if they didn't recognize it in themselves. When she asked me to co-chair the Diversity Committee, I thought she had lost her mind—I didn't think I had any leadership skills. But she was like a mother who gets joy from seeing her children grow. She was so proud of me when I led my first meeting. She made me see that I had more potential than I thought. When we walked the hallways together, she was as proud to introduce me to 'Tom the janitor' as she was to Peter Slavin. She was kind and gracious, and I will miss her dearly."

—Carly Jean-Francois, RN, staff nurse

# Nurse Residency Program

*Another nursing milestone. Another reason to celebrate*

—by R. Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development

**T**he Nurse Residency Program, developed by the Norman Knight Nursing Center for Clinical & Professional Development, is a new, faculty-guided, 960-hour training

On September 27, 2011, a standing-room-only crowd in O'Keeffe Auditorium saw history made as 49 nurse residents accepted certificates of completion marking their graduation from the ground-breaking Nurse Residency Program. Senior vice president for

*continued on next page*

Clockwise from top left: Kelli McLoughlin, RN; Jeanette Ives Erickson, RN; Gaurdia Banister, RN; Lauren Harvey, RN, with Mary Ellin Smith, RN; Nicole Toomey, RN, with Kevin Whitney, RN; and Kelly Mullane, RN, with Barbara Cashavelly, RN.

model, established to help new graduate nurses make the transition from student to staff nurse. The Program links recently licensed nurses to the knowledge and expertise of experienced nurse-residency faculty to provide a pathway for becoming a caring, thoughtful, competent nurse.





MGH Nursing is once again at the forefront of nursing-education models with the implementation of the Nurse Residency Program.

Patient Care, Jeanette Ives Erickson, RN, congratulated nurse residents for completing the rigorous curriculum and asked each one to reflect on how they had grown and evolved over the past six months.

Oncology nurse resident, Lauren Harvey, RN, and ICU nurse resident, Kelli McLoughlin, RN, shared clinical narratives chronicling their care of patients who were particularly meaningful to them. Harvey described the power of the nurse-patient relationship with her story about the simple act of assisting a patient in brushing his teeth. McLoughlin told of a devastating patient outcome in which she was able to comfort the family as they coped with their loss. Professional development manager, Mary Ellin Smith,

RN, engaged each in a dialogue about their experiences, helping them unbundle the key lessons in their passage from nurse resident to staff nurse.

Associate chief nurses, Kevin Whitney, RN, and Theresa Gallivan, RN, acknowledged the nursing directors, clinical nurse specialists, and nurse partners who made the Nurse Residency Program not only possible but successful beyond expectation.

MGH Nursing is once again at the forefront of nursing-education models with the implementation of the Nurse Residency Program. For more information, contact Gino Chisari, RN, director of The Norman Knight Nursing Center for Clinical & Professional Development, at 3-6530.



MGH nurse residents, class of 2011

# New nurse resident learns truth of old adage: “Never assume”

**M**y name is Laurie Carlson, and I just completed my nurse residency (see article on page 8). During my precepted residency experience, I took care of many

patients who impacted me in different ways, both good and bad. Mr. S is one patient who touched me deeply. I cared for Mr. S during my rotation in the Respiratory Acute Care Unit (RACU). He had been trached and was in the RACU after a long hospitalization for many other medical issues. His most recent problem was abdominal distension due to a problem with his pancreas that seemed to be baffling the medical team.

When I got my assignments for the morning, I was told that Mr. S was, “a grumpy man who hadn’t been sleeping well.” So I chose to see him first. When I walked into his room, I saw a man slouched down in his bed looking absolutely miserable. I introduced myself, and he looked at me rather disinterestedly. He pointed to the television and gestured for me to turn up the volume. Mr. S had a PMV (Passy-Muir Valve, a small attachment to the tracheostomy tube that aids swallowing and speaking), but according to his respiratory therapist, he didn’t use it because it caused his oxygen saturation to drop. Throughout the day, I found it

When I got my assignments for the morning, I was told that Mr. S was, “a grumpy man who hadn’t been sleeping well.” So I chose to see him first.



Laurie Carlson, RN, new graduate nurse resident

difficult to understand a lot of what Mr. S was trying to say and wished I could hear him speak just once.

Mr. S had a lot of secretions draining from his nasogastric tube. He also had a lot of respiratory secretions that required frequent suctioning to keep his oxygen saturation at a safe level. I had seen the respiratory therapist suction him a few times that morning, and every time it seemed to absolutely terrify Mr. S. He would grimace and look as if he were going to cry whenever someone approached him with a suction catheter.

I went through the day completing all my tasks, and when I came in the next day, I was happy to see that Mr. S was assigned to me again. When I went into his room, he looked at me with the same disinterested expression. He began pointing to things, trying to tell me what he wanted done.

*continued on next page*

I asked the respiratory therapist if we could try the PMV for just a short time because I felt as though Mr. S wanted to speak—to tell me what he needed. She was agreeable. We tried it, and Mr. S did surprisingly well. We left it on for most of the day.

As the day went on, Mr. S seemed to grow more fond of me. He would even throw me a weak wave when I passed his room in the hallway. That afternoon, I helped Mr. S get washed up. I used some of the information on his Get to Know Me poster to fuel our conversation. We talked about his family, his grandchildren, and how he felt so discouraged about his illness.

About an hour or so after I helped Mr. S wash up, I was at the nurses' station writing my notes when I heard the monitor alarm go off. It was Mr. S. Fortunately, Mr. S's doctor was sitting only a few feet away from me, and we both hurried to his room.

Mr. S was in rapid atrial fibrillation. He was given Lopressor, and his rhythm returned to normal. I stayed with Mr. S for quite a while. Later, when I had to go check on another patient, I stood and told Mr. S, "I'll be right back. I just have to go see another patient."

Mr. S began to tear up. I pulled a chair up next to him and held his hand. I asked what was wrong, and he just stared at me.

"Are you scared?" I said.

He nodded, and I could see the fear in his eyes.

"What will happen if I stop breathing or something happens to me?" he asked.

"What do you mean?"

"How will you know if something is happening to me?"

I thought this was a strange question for someone who'd been in the hospital as often as Mr. S. I had assumed he knew we were monitoring him from the nurses' station.

I explained that everything we could see on the monitor in his room, we could also see at the nurses' station. I assured him that an alarm would go off alerting us if there was any problem. He seemed relieved and said he was glad to have that information. He had been afraid to go to sleep since being admitted because he thought no one would know if he stopped breathing.

I was completely heartbroken for Mr. S upon hearing this statement. Here he was, so ill he needed his rest, and he was too worried to go to sleep thinking no one would come to his rescue if he wasn't awake to call for help. He seemed relieved when I told him we were keeping a close eye on him, and he slept soundly for the rest of my shift.

This was an important lesson for me. Sometimes, the little bits of information we assume patients know—they don't know at all. I was glad I was able to ease Mr. S's mind and help him relax and get the rest he needed.

When I came back the next day, Mr. S was on my assignment list again. When I walked into his room to check on him, he had his PMV on and greeted me with a big smile.

"Hi Laurie!" he beamed. "Are you getting sick of me yet?"

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

There's a certain lightness that comes with being a new clinician. They're more apt to ask questions and see possibilities. That's exactly what Laurie did when she asked about the PMV so that Mr. S could speak to her. Like so many others, she had assumed that Mr. S understood how monitors work. But when he said he was scared, Laurie asked, "Why?" And that gave her the opportunity to understand his anxiety and ease his fears. What a lovely story by a new clinician.

Thank-you, Laurie.

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*The Nurse Residency Program is a new, faculty-guided, 960-hour training model that was established to help new graduate nurses make the transition from student to staff nurse. The Program links recently licensed nurses to the knowledge and expertise of an experienced nurse-residency faculty to provide a pathway for becoming a caring, thoughtful, competent nurse. The Nurse Residency was developed by the Norman Knight Nursing Center for Clinical & Professional Development. For more information, call 6-3111.*



# Collaborative Governance welcomes Michael Bleich, RN

—by Mary Ellin Smith, RN, professional development manager

**I**n a year packed with bicentennial celebrations, September 13, 2011, marked another important milestone. Patient Care Services' Collaborative Governance Program celebrated its 14th anniversary with a visit from Michael Bleich, RN, vice provost for Inter-Professional Education & Development and Carol A.

Lindeman distinguished professor at Oregon Health and Science University. Bleich spoke about the complexity and nuances of clinicians' commitment to work together as a team on behalf of patients.

Bleich met with members of the inter-disciplinary planning committee that helped create the Dedicated

Education Unit. They shared a rich discussion about the challenges and rewards of having a unit where nursing, physical therapy, and speech-language pathology students can learn together in a practice environment similar to the one they'll be entering upon graduating.

In a riveting conversation with an inter-disciplinary group of clinicians, Bleich listened as they described their care of a young woman treated for self-inflicted burns. Logan Monahan, OTR/L, Lisa Montalbano, PT, Mary McKinley, RN, Jennifer Mello, SLP, and Robert Scannell, RRT, told how they had worked together to meet the needs of this critically injured patient. In his commentary, Bleich noted that each discipline had brought a different lens to the care of the patient, but they had worked together in a way that each voice was heard and respected.

Later in the day at the annual collaborative governance celebration, Gaurdia Banister, RN, executive director for The Institute for Patient Care, highlighted the work of collaborative governance champions in educating, influencing, and communicating the work of the various committees. Banister thanked retiring committee leaders:

- Maureen Beaulieu, RN, co-chair, Nursing Practice
- Ann Daniels, LICSW, Collaborative Governance Re-Design Task Force
- Joanne Empoliti, RN, coach, Nursing Practice
- Mary Larkin, RN, coach, Research & Evidence-Based Practice
- Denise Lauria, RN, co-chair, Quality
- Carol Camooso Markus, RN, coach, Quality
- Judy Newell, RN, advisor, Diversity
- Keith Perleberg, RN, advisor, Quality
- Judith Sinsheimer, LICSW, co-chair, Quality

Bleich described inter-disciplinary collaboration as a process that fosters innovation and advanced problem-solving. It requires mutual respect, different but complementary competencies, and an equal balance of power. He congratulated MGH clinicians for promoting and living inter-disciplinary collaboration.



(Photo by Joe Ferraro)

# SMART

*a new collaborative resource  
to ensure a safe environment for patients,  
families, and staff*

—by Jennifer Goba, Police & Security

The SMART team operates in two ways. First, the team meets quarterly to review and discuss relevant incidents and trends; and second by providing an immediate response to emerging situations

The Strategic Management Assessment and Response Team (SMART) is a new group developed by Police, Security & Outside Services to provide a multi-disciplinary response to complex workplace violence and conflict situations. SMART

is comprised of members from Police & Security, Human Resources, Risk Management, Occupational Health, Employee Assistance, Psychiatry, the Office of Patient Advocacy, and Nursing Administration (with consultation from ad hoc members as needed).

The SMART team operates in two ways. First, the team meets quarterly to review and discuss relevant incidents and trends involving disruptive, inappropriate, threatening, or violent behavior. These incidents may encompass criminal or ethical situations, staff unrest, fear, threats of violence, or a history of past criminal behavior. Incidents may involve patients, visitors, or employees. Quarterly meetings are an attempt to be proactive

in preventing workplace violence by assisting managers and supervisors to develop the tools and awareness necessary to recognize and resolve incidents before they escalate into something more serious.

The other facet of the SMART team is providing an immediate response to emerging situations. Directors, managers, and administrators can contact any member of the SMART team to request a consulta-

tion. After receiving a request, the SMART team member will determine the level of response necessary and activate the team accordingly.

SMART can be activated during business hours, by contacting Police & Security investigative manager, Jennifer Goba, at 6-1474; or after hours, by contacting the Police & Security manager on duty at 6-2121.

Please note, SMART is intended to be used in re-

sponse to evolving situations that require a multi-disciplinary assessment, not situations that can be resolved by one responder or department.

For more information about the SMART team, call 6-1474.



# The value of verbal report and its effect on cost and re-admission

—submitted by Tessa Goldsmith, SLP-CCC, on behalf of the  
Research Evidence-Based Practice Committee

Effective communication among health-care providers is critical. Medical errors can result from mis-perceptions, false assumptions, and misunderstandings when patients are transferred from one care environment to another, increasing both length of stay and costs.

Stakes are even higher in patients with prolonged respiratory failure and complex co-morbidities. In 2005, the multi-disciplinary team in the Respiratory Acute Care Unit (RACU) noted a 21% re-admission rate 72 hours after discharge to rehabilitation facilities, and on September 12, 2011, the REBPC Journal Club learned about the strategy they used to address hand-off communication. Dean Hess, RRT; Susan Gavaghan, RN; Mary O'Malley, RN; and Ulrich Schmidt, MD, represented their co-authors in describing the study that was published in *Chest*, 2010.

Prior to 2005, written reports by RACU physicians, nurse practitioners, nurses, and respiratory therapists

were provided to receiving facilities without verification that the information had been received. The research team hypothesized that the 72-hour re-admission rate could be reduced by supplementing written discharge reports with discipline-to-discipline telephone calls. In this observational, retrospective study, researchers compared demographic factors of an historical control group with those of the experimental group. They looked at re-admission to MGH within 72 hours and total costs (using the TSI methodology, which estimates true resource use not costs or reimbursement data).

The no-verbal-report group was comprised of 151 subjects while the verbal-report group was comprised of 211 subjects. There were no changes to admission or discharge policies, and the nature of the hand-off was not specified. Results showed no significant difference in re-admission rates by demographic variables. However, there was a 60% less chance of re-admission if the hand-off included a verbal report, and the cost savings per patient was \$184,000 per 100 discharges. The authors emphasized that the two-way communication between clinicians focused on the important details of patient care that may be difficult to communicate in writing alone. In an editorial that appeared in the same journal, Murphy and Dunn underscored the, “sad irony that communication errors are probably the number one current cause of patient harm” and urged clinicians, “to do better.”

The next meeting of the Research Evidence-Based Practice Committee Journal Club is scheduled for November 9, 2011, 4:00–5:00pm, in the Blake 10 Conference Room. Kate Gregory, RN, will present her research on, “Clinical Predictors of Necrotizing Enterocolitis in Premature Infants.”

Dean Hess, RRT (right), and colleagues present their research on improving hand-offs of respiratory-care patients at a recent meeting of the REBPC Journal Club.



(Photo by Paul Batista)



# Changes in code-red (fire) drill procedure

—by Stephanie Cooper, senior operations manager

**H**ospital fires can be caused by any number of things: stoves, faulty equipment, careless smoking, improper trash disposal, broken electrical devices. That's why fire safety is such a high priority at MGH and why every quarter Patient Care Services conducts fire drills on patient care units.

Recently, to make fire drills more effective, changes have been made to our code-red (fire) drill procedure.

Fire safety is a mandatory part of new-employee orientation and annual required training in HealthStream. What's changing is what employees are expected to do in the event of a drill or an actual fire. Effective immediately:

- drills will take place at the same time as fire-alarm testing, which means everyone is expected to respond when a fire alarm sounds. Sounding alarms during fire drills is a requirement of the Joint Commission (except at night when a flashing light is used)
- whenever a building fire alarm sounds, employees should respond as if it's a real event and proceed according to their unit's fire plan
- employees should know what their responsibility is and be familiar with their unit's fire plan
- units not hearing the evacuation signal should account for all patients and stand by
- the drill coordinator will assess the unit's response according to the RACE fire plan:

**R = Rescue.** Provide prompt assistance to persons in immediate danger and re-locate them to the extent necessary to stay safe. If there is a fire in a patient room, move the patient(s) out of the area. Reassure and inform patients and visitors about what is happening and coach them through the appropriate response. Patients and visitors should remain in patient rooms unless evacuation is ordered.

**A = Alarm.** Upon discovering smoke or flames or hearing the building fire alarm, staff should loudly announce, "Code red," and the location of the fire. In a code-red *drill*, locate pull stations but don't activate them unless instructed to do so. Know alarm signals and their meanings. Simulate calling 6-3333, the back-up code-red call.

**C = Contain.** Contain the fire by closing doors and windows. Close doors to patients' rooms and reassure patients and families. Know the location of fire doors and make sure they're closed.

Move oxygen tanks away from fire. Know the location of oxygen shut-off valves. Move paper recycling bins, linen carts, and other flammable materials away from fire.

**E = Extinguish/ Evacuate.** If safe to do so, get an appropriate fire extinguisher and

bring it to the location of the fire. Clear corridors of equipment and describe appropriate means of egress:

- Identify fire doors
- Know how to operate any special locking devices
- Know how to coordinate the move of many patients
- Know where the evacuation toolkit is and how and when to use it
- Know your unit's evacuation plan

Night shift fire drills are conducted using strobe lights rather than audible alarms. During drills coordinated with fire-alarm tests, employees may be instructed to activate a fire-alarm pull station. Do so only if instructed by the drill coordinator. In the event of a drill or an actual fire, the resource nurse is the incident commander and directs staff.

For more information about the revised fire drill procedure, contact either of your unit's operations managers.

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Effective immediately, whenever a building fire alarm

sounds, employees should respond as if it's a real event and proceed according to their unit's fire plan.

# Professional Achievements

## Perry publishes

Donna Perry, RN, professional development coordinator, wrote the book review, "Global Health and Human Rights: Legal and Philosophical Perspectives," in the *Journal of Human Rights*, September 2011, quarterly issue.

## O'Toole publishes

Jean O'Toole, PT, physical therapist, authored the article, "Commentary on Predictive Factors of Response to Decongestive Therapy in Patients with Breast-Cancer-Related Lymphedema," in *Breast Diseases: The Year Book Quarterly*, 2011.

## Team publishes

Melissa Skolny, Cynthia Miller, Jean O'Toole, PT, and Alphonse Taghian, MD, authored the article, "Breast Cancer-Related Lymphedema: Modern Methodology of Assessment and Management," in *Breast Diseases: The Year Book Quarterly*, 2011.

## Nurses publish

Kelly Trecartin, RN, staff nurse, and Diane Carroll, RN, nurse researcher, authored, "Nursing Interventions for Family Members Waiting During Cardiac Procedures," in *Clinical Nursing Research*, in August, 2011.

## Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, presented, "Trimorbidity: Assessing and Treating Patients with the Complex Care Issues of Pain, Addiction and Psychiatric Illness," at the International Nurses Society of Addictions, in Tucson, September 7, 2011.

Arnstein also presented, "Demystifying the Joint Commission Requirements," at the 21st annual meeting of the American Society for Pain Management Nursing, also in Tucson, September 8th; "Assessment of Persistent Pain in Older Adults," at the Division of Geriatric Medicine at the University of Michigan Medical School in Ann Arbor, Michigan, September 22nd; and "Laws and Policies Affecting People with Pain," at Tufts University, in Medford, September 29th.

## Zhang certified

Jing Zhang, RN, became certified in Infusion Therapy by the Infusion Nurses Society, in September, 2011.

## Curley presents

Suzanne Curley, OTR/L, occupational therapist, presented, "Professionalism," at Tufts University in Medford, September 26, 2011.

## Lapointe certified

Gail Lapointe, RN, became certified in Case Management by the American Case Management Association, in September, 2011.

## Arnstein appointed

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, was appointed a member of the Education Advisory Committee of the American Pain Society, on September 14, 2011.

## Hultman appointed

Todd Hultman, RN, nurse practitioner, Palliative Care Service, was appointed a member of the Review Committee of the American Board of Internal Medicine, in Philadelphia, September 19, 2011.

## Callahan presents

Janet Callahan, PT, physical therapist, presented, "Dystonia and Exercise," at the Dystonia Support Group in Providence, Rhode Island, September 10, 2011.

## Burke presents

Debbie Burke, RN, associate chief nurse, presented, "Professional Practice Model"; "Roles of Inpatient Nurses"; "Staff Perception Survey"; and "Nurse Staffing Based on Patient Acuity," at the 2011 International Symposium on Pediatric Nursing, in Seoul, Korea, September 22-23, 2011.

## Phillips presents

Katherine Phillips, PT, physical therapist, presented, "Scapular Dyskinesis," at the 23rd annual meeting of the American Society of Hand Therapists in Nashville, September 23, 2011.

## Russo presents

Katherine Russo, OTR/L, occupational therapist, presented, "Evaluation of the Hand and Upper Extremity," at Tufts University in Medford, September 20, 2011.

## Capasso presents

Virginia Capasso, RN, clinical nurse specialist, presented, "Pressure Ulcers," in "Essentials of Geriatrics" course for second-year medical students at the School of Osteopathic Medicine at the University of New England in Biddeford, Maine, September 28, 2011.

## Bolton presents poster

Rachel Bolton, RN, Radiation Oncology, presented her poster, "Show Me How: Peer Mentoring Among Children Receiving Radiation Therapy," at the 2011 Annual Conference of the Association of Pediatric Hematology/Oncology Nurses on September 6, 2011.

## Arnstein publishes

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, and Ellen Robinson, RN, clinical nurse specialist, Ethics, authored the article, "Is Palliative Sedation Right for your Patient?" in *Nursing* 2011.

## Miller presents

Brenda Miller, RN, nursing director, PICU, presented, "Quality and Safety" and "Setting Global Standards: Pain and Procedural Sedation and Coordinated Care in the Ambulatory Setting," at the 2011 International Symposium on Pediatric Nursing in Seoul, Korea, September 22-23, 2011.

## Bolton and Mannix publish

Rachel Bolton, RN, staff nurse, Radiation Oncology, and Catherine Mannix, RN, nursing director, Radiation Oncology, authored the chapter, "Radiation Therapy," in *Nursing Care of Children and Adolescents with Cancer and Blood Disorders*.

## O'Toole presents poster

Jean O'Toole, PT, physical therapist, presented her poster, "Cording in the Presence of Breast-Cancer-Related Lymphedema: a Prospective Study on Natural History," at the 23rd congress of Lymphology, International Society of Lymphedema, in Malmo, Sweden, September 19-23, 2011.

## O'Toole presents

Jean O'Toole, PT, physical therapist, presented, "The Incidence of Lymphedema Related to Breast Cancer that Resolves without Intervention," at the congress of Lymphology, International Society of Lymphedema, in Malmo, Sweden, September 19-23, 2011.

## Clinical Recognition Program

The following clinicians were recognized between July 1 and October 1, 2011

### Advanced clinicians:

- Arthur Edmonds, RN, Thoracic Surgery
- Kristin Moriarity-Puggi, RN, Cardiac Step-Down Unit
- Tara Logan, RN, Cardiac Surgical ICU
- Katharine Teele, PT, Physical Therapy
- Heidi Cheerman, PT, Physical Therapy
- Lin Wu, RN, General Medicine
- Karen Ratto, RN, Pediatric ICU
- Julie Cronin, RN, Gynecology
- Colleen Kehoe, RN, Vascular Surgery

### Clinical scholars:

- Elizabeth Cole, PT, Physical Therapy
- Rosanne Karp, RN, Case Management
- Brenda Pignone, RN, Surgery/Trauma

# Plan ahead for Nursing Research Expo

—submitted by the Nursing Research Expo Committee

**A**re you working on a research project? Have you ever thought about submitting an abstract for the annual Nursing Research Expo? If you said “Yes” to either of those questions, read on.

The Nursing Research Expo is held each year during Nurse Recognition Week in May. The Expo showcases the work of MGH nurse researchers and culminates in an interactive poster session that brings nurse researchers together in one location for a stimulating exchange of ideas and information.

The event is an opportunity for the MGH community to learn about the many studies underway throughout the hospital and for researchers like you to disseminate their findings.

Submitting an abstract can

be intimidating, which is why the Nursing Research Expo Planning Committee wants to help. With the proper guidance and resources, the process for submitting an abstract is actually quite manageable, even rewarding. The committee is offering an abstract writing class presented by Carolyn Paul, associate director of the Treadwell Library. The class will help researchers

organize their thoughts in preparation for creating an abstract. The new Yvonne L. Munn Center for Nursing Research website ([www.mghpcs.org/munn](http://www.mghpcs.org/munn)) provides details about the three categories of submission: original research, evidence-based practice, and performance-improvement, along with examples and requirements for each.

Nurse scientist, Jeffrey Adams, RN, and nurse practitioner, Teresa Vanderboom, RN, of the Nursing Research Expo Planning Committee, are available for consult as you assess whether your study is ready to be submitted as an abstract. And unit-based clinical nurse specialists and doctorally prepared nurses are also a resource.

Once an abstract is accepted, guidance will be provided as to the process for creating a poster. Displaying a poster during Nursing Research Day is a valuable opportunity for researchers to describe their work and engage in discussion about lessons learned and challenges encountered. During the interactive poster session, posters are judged by an impartial panel, and prizes are awarded for best poster in pre-specified categories. To qualify for a prize, researchers must be able to engage in meaningful discussion about their research with the judges.

## Timeline:

December 5, 2011	Abstract writing class 12:00–1:00pm Blake 8 Conference Room
January 31, 2012	Abstract submission deadline
March, 2012	Poster production
May, 2012	Poster presentation during Nurse Recognition Week

For more information, contact Linda Lyster, Yvonne L. Munn Center for Nursing Research, at 3-0431.

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# Beacon: the new on-line patient-discharge and escort request system

Beacon simplifies the process for requesting volunteer support for patient discharge and escort; eliminates the need to staff the discharge/escort telephone line; and eliminates the possibility of missed calls.

*Question:* Is there a new way to request volunteer assistance with inpatient discharges?

*Jeanette:* Yes. The Volunteer Department has implemented an on-line patient-discharge and escort request system, called Beacon, eliminating the need to call the volunteer discharge/escort line (6-2283). Beacon simplifies the process for requesting volunteer support for patient discharge and escort; eliminates the need to staff the discharge/escort telephone line; and eliminates the possibility of missed calls.

*Question:* How does Beacon work?

*Jeanette:* There are two sides of the Beacon process: one is the user page where staff enter requests, the other is the administration page where volunteers respond to requests. Here's how it works:

- 1) Staff enter information directly into Beacon, including the patient's medical record number and the locations where the patient is to be picked up and dropped off (a list of locations is provided to prevent requests for areas not allowed)
- 2) The request is received and a volunteer is assigned
- 3) A request summary is printed
- 4) The volunteer goes to the pick-up location
- 5) The volunteer transports patient to desired location

*Question:* How do I access Beacon?

*Jeanette:* Beacon is being rolled out to inpatient and outpatient areas simultaneously. Units and practices will be given the URL address for Beacon as their areas are brought on-line. Operations managers and practice managers will serve as point people to bring training to staff.

The next phase of Beacon will feature accessibility to the program via Partners Applications in the Start-Up menu.

*Question:* When will Beacon be available throughout the whole hospital?

*Jeanette:* Beacon will be completely rolled out by the end of December, 2011. At that time, the volunteer discharge/escort line (6-2283) will be disconnected.

*Question:* Can we request bariatric wheelchair transport through Beacon?

*Jeanette:* Only requests for transport via standard-sized wheelchair can be made through Beacon. Requests for transport via bariatric wheelchairs or stretchers and all requests for wheelchairs should still be made through Material Management at 6-2255.

For more information about Beacon, please contact Wayne Newell, manager, Volunteer Department, at 4-1753.

# Announcements

## 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?

Visit the new MGH/MGPO intranet site:

<http://priorities.massgeneral.org>.

## New disability indicator in PATCOM

Effective November 1, 2011, the patient registration process under Admitting & Registration Services will include a disability indicator. Including information about a patient's permanent disability in our registration system, will help staff be more proactive in meeting special needs.

To begin, disability information will be used for inpatient and surgical visits only. The disability indicator will be rolled out to ambulatory practices early next year.

For more information, call Zary Amirhosseni at 3-7148.

## First annual Robert Leffert, MD, Memorial Lecture

Living Well in the Face of Serious Illness  
"Connecting with Patients: Where Art Meets Science" presented by Anthony Back, MD, professor, Oncology Division  
University of Washington School of Medicine

sponsored by  
MGH Palliative Care Services

Tuesday, November 29, 2011  
Light refreshments 4:45pm  
Program 5:00–6:00pm  
O'Keefe Auditorium

For more information,  
call 4-9197

## American Assembly for Men in Nursing Seeking members for new chapter

The American Assembly for Men in Nursing (AAMN) is seeking members to launch a New England chapter. AAMN is a national organization that provides a framework for nurses to meet, discuss, and influence factors that affect men in nursing. The AAMN offers scholarships, continuing education programs, and advocates for research and education for the recruitment and retention of men in nursing.

Membership is open to all nurses, male and female. For more information on joining the New England chapter, e-mail Gerald Browne, RN, or visit [aamn.org](http://aamn.org).

## Clinical Recognition Program

The Clinical Recognition Review Board and Steering Committee are happy to announce a new initiative by which clinicians applying for recognition at the advanced clinician and clinical scholar levels can submit their portfolio for a preview prior to formal submission. This voluntary, anonymous process gives clinicians an opportunity to receive feedback on their portfolios from former review board members.

Reviewers will provide feedback on specific areas identified by clinicians, leadership, and review board members based on past experience.

For more information, e-mail questions or portfolios to  
MGH PCS Clin Rec  
(in the Partners directory).

## Journal Club Research and Evidence-Based Practice Committee

'Clinical Predictors of Necrotizing Enterocolitis in Premature Infants,' presented by  
Kate Gregory, RN

Wednesday, November 9, 2011  
4:00–5:00pm  
NICU Conference Room  
Blake 10

Contact hours: 1  
All are welcome.

For more information,  
call 6-2763

## 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>.

## 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

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

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For more information, call:  
617-724-1746

### Next Publication

November 17, 2011

# Blake 4 goes all 'Mad Hatter' to support colleague



Staff of Blake 4 Endoscopy don scrub hats in show of solidarity for colleague, Sandy Hession, RN (seated, center), affectionately known on the unit as 'Flo' (as in Florence Nightingale). Hession recently completed treatment for cancer and continued to work through much of her treatment.

**Caring**  
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