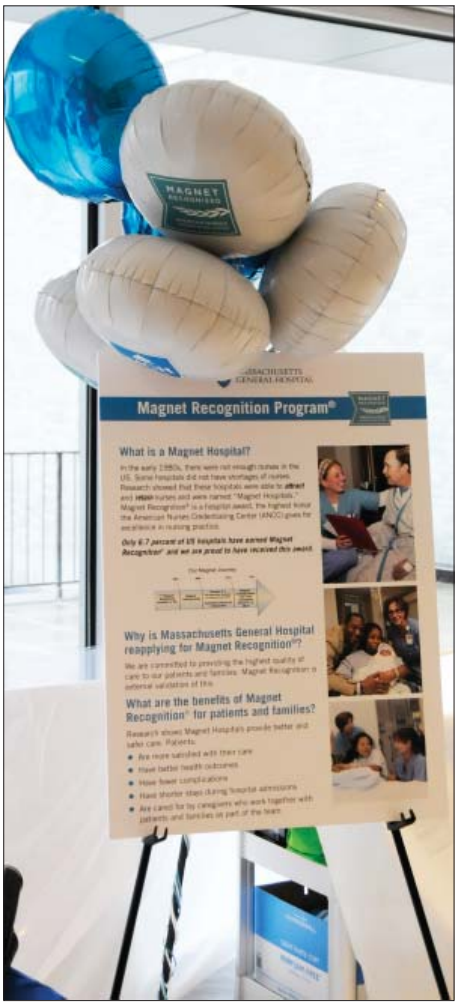
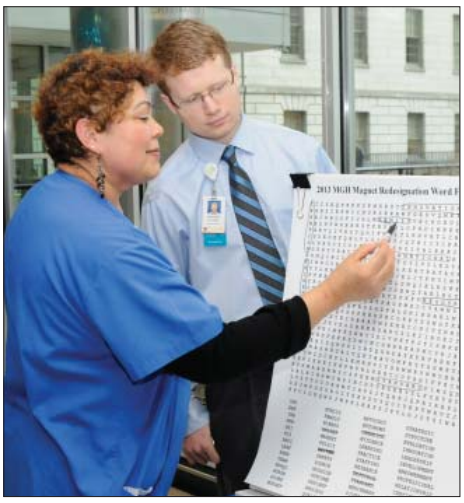
Headlines Caring
March 7, 2013

Magnet site visit

March 4–7, 2013





Linda Akuamoah-Boateng (top center); Tara Tehan, RN (top right), and Christopher Wilterdink (bottom center), staff Magnet educational booth in the Main Lobby.

Magnet Core and Education Teams package Excellence Every Day and take it 'on the road'

(See page 13)

The newsletter for **Patient Care Services**
Massachusetts General Hospital

Jeanette Ives Erickson

Partners *e*Care

Preliminary validation sessions: a key milestone in journey toward unified information system

Just last week, we reached the preliminary validation phase. Subject-matter experts and other key stakeholders came together for three days of deliberations that included a demonstration of Partners eCare in action.

As most of you are aware, we're well on our way to creating a unified, Partners-wide, health-information system, called Partners *e*Care. While it may not be apparent as we go about the business of caring for patients, I can assure you that much work is going on behind the scenes to bring us closer to our goal—having one integrated system that will allow us to share and access health information throughout the Partners network and ultimately improve care for our patients. Representatives from all Partners hospitals are involved in this work; many of our MGH colleagues have been asked to play long-term roles in the design and implementation process.

You may recall that we're looking at a five-year implementation plan that would see Partners *e*Care up and running at all Partners sites by mid-2017. In order for that to happen, a number of key milestones have been identified, each one tied to a very precise time line. Just last week, we reached one of those milestones—the preliminary validation phase.

Subject-matter experts and other key stakeholders came together for three days of deliberations that included a demonstration of Partners *e*Care in action. They had an opportunity to provide input, ask questions, voice concerns, and make decisions that will ultimately drive the design and functionality of our system. There were conversations about workflow, operations, quality and safety, and how to incorporate the highest priorities of all entities into one unified system. And believe me, our shared commitment to excellence and doing right by our patients was well represented during this phase.

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

No topic was too big or too small. Following are *some* of the issues and concerns that were brought up for consideration:

- documentation that doesn't require patients to be asked the same information over and over
- ensuring we understand the patient's expectations, fears, needs, concerns, and goals
- integrating all disciplines into the plan of care
- having the ability to automatically retrieve information already stored in the system
- being able to 'see' the patient, mind, body, and spirit

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An underlying theme of the validation sessions (and indeed, this entire process) is the need to standardize clinical and administrative data in a way that will be meaningful and effective for all Partners entities. Again, we're not talking about standardizing the *delivery of care*—we're talking about standardizing the way we collect and input data.

- reducing duplication wherever possible
- ensuring we still know the patient's story as documentation becomes more standardized
- creating a common language among/between all Partners hospitals
- ensuring system captures the dynamic needs of patients at all stages of their hospitalization—patients' needs are different on day one than they are on day four
- ensuring patients and families are involved in the plan of care
- weighing the pros and cons of SBAR being the standardized handoff communication tool
- capturing patient and family education; from acknowledgement to participation to goal-setting
- maintaining the integrity of medication-reconciliation

The clinical knowledge, attention to detail, and passion that was brought to the table by all participants was nothing short of inspirational. All parties were focused on the patient, the quality of care, and the unique contributions of each discipline.

An underlying theme of the validation sessions (and indeed, this entire process) is the need to standardize clinical and administrative data in a way that will be meaningful and effective for all Partners entities. Again, we're not talking about standardizing the *delivery of care*—we're talking about standardizing the way we collect and input data. We want to be able to meet the needs of each institution while minimizing the number of variables involved in capturing patient information.

We know from our work on Innovation Units that standardizing certain processes (our 15 interventions) can help make care more efficient, effective, and affordable. That same kind of standardization will be key in designing and implementing a unified system for all Partners entities.

Following last week's validation sessions, we enter a period of re-engineering where subject-matter experts will continue to work closely with system designers to overcome obstacles and incorporate feedback captured in the preliminary validation process. All this brings us closer to the next phase of implementation, which is the resolution and final validation of all the choices we're painstakingly zeroing in on.

There is much work still to be done, and I'll continue to update you as we approach future milestones. For now, I just want you to know that we're fully engaged in this multi-site, multi-disciplinary, multi-pronged effort to improve quality, cost, and service through the creation of a unified health information system, called Partners *e*Care.

Stay tuned.

In this Issue

Oral History Project looks at the early days of MGH nursing

—by Mary Larkin, RN, chair of the NAA's Oral History Project

Marion Bates, class of 1934, is the oldest living active member of the MGH Nurses' Alumnae Association (NAA). She is 100 years old. Recently, Mary Larkin, RN, class of 1976 and chair of the NAA's Oral History Project, met with Bates. What follows are excerpts of that interview, partly in Bates' own words and partly in Larkin's.

Marion Bates was born in Trenton, New Jersey, October 12, 1912 (before the first World War, when fire trucks were still drawn by horses). She later re-located to Milton, Massachusetts. Bates' older sister was a nurse, and Bates herself assisted in caring for her mother during an illness. Her mothers' physician recognized her skill, compassion, and intelligence and suggested she pursue a career in nursing.

Bates entered nursing school in 1931 and lived in the Thayer Building (the nurse's dormitory and classroom). She recalls, "Because I was a 'probie' [new student], I was moved to 90 Charles Street (a brownstone used as a student-nurse dormitory). At four months, we were capped with blue uniforms and cuffs, then we got our 'checks' (the MGH student-nurse uniform made of black and white checked material). Once we were capped, we moved to the Walcott House so we'd be closer to the hospital and

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At four months, we were capped with blue uniforms and cuffs, then we got our 'checks' (the MGH student-nurse uniform made of black and white checked material).

I worked as a staff nurse in the Baker Building, which was new at the time. Staff nurses were paid $68 per month if you lived at the hospital, $90 if you lived off campus.

could be assigned to night duty in Bulfinch. I remember we all used the same gown in the isolation unit, folded a certain way, hung on a hook by the room, and we only touched the inside of it. You really had to rely on everyone to be careful and follow procedures because we just had the one gown and no antibiotics.

"I was on night duty my first year on Ward 4, the Bulfinch Research Ward, run by Dr. Fuller Albright, later called the Metabolic Unit. I was the only nurse, and I had never stayed up all night before."

Bates worked nights and went to class during the day. She remembers how difficult it was to stay awake for lectures, even in the uncomfortable seats of the Ether Dome. For a short time, she worked as a scrub nurse at the Massachusetts Eye and Ear Infirmary, where, she says, "I watched a senior nursing student and did what she did. That's how we learned.

"Our textbook, *Procedures in Nursing*, was written by Annabella McCrae, an 1895 graduate of the Boston Training School for Nurses. She was our instructor of Nursing Arts. She had a commanding presence that inspired excellence."

Bates recalls that open wards had a head nurse, and a senior student-nurse was in charge when the head nurse was off. The senior student in charge was given a ½-inch black band for her cap to indicate she was in charge. All other staff were students.

"We had a great deal of responsibility" says Bates, "and we took it very seriously. On night duty, two graduate-nurse supervisors were in charge of all the nurses at MGH, and the rest of the staff were students. We took doctors' orders, made treatment sheets, supervised all the other students on the floor, and essentially ran the wards.

"I was one of the first new grads to be hired as a 'staff nurse' working alongside students. The idea of employing graduates on wards started with the graduating class of 1933 to provide supervision when the head nurse was off duty. There was one graduate nurse per floor or ward, and we supervised the students. Sally Johnson, RN, the director of Nursing, gave me my diploma in 1934. I worked as a staff nurse in the Baker Building, which was new at the time. Staff nurses were paid $68 per month if you lived at the hospital, $90 if you lived off campus.

"I worked in private duty for a while, which is like the ICU today. We would care for one patient who was very ill, and the assignments lasted anywhere from a few days to a few months. I loved caring for these patients; we got to know them and their families very well.

"Then in the early 1940s, World War II came, and I was asked to be a supervisor. We were very short-staffed during the war, so we did whatever had to be done; from admissions to sweeping the floor."

Look for the second installment of this chapter of The Oral History Project in the next issue of *Caring Headlines*.

Opposite page: Marion Bates, RN, with chair of the Oral History Project, Mary Larkin, RN.

At left: Bates (right) with her sister, circa 1930s.

Effective, innovative clinical nutrition care

—by clinical dietitians, Katherine Hebel, RD, and Erin Gillis, RD

March 1, 2013, marked the first day of National Nutrition Month, a campaign created by the Academy of Nutrition and Dietetics to promote greater understanding of healthy eating. It's also a time to celebrate the contributions and expertise of registered dietitians and the important work they do to foster public health.

At MGH, dietitians develop care plans with the multi-disciplinary team, provide patient- and family-centered care, and initiate projects both within Nutrition & Food Services and in collaboration with other disciplines to ensure best nutrition practices.

When Innovation Units were launched, having the ability to participate in inter-disciplinary rounds and review the care plan with the team gave us an opportunity to coordinate care much more efficiently.

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Below: members of Clinical Inpatient Nutrition Team

Standing (l-r): Sandy Klemmer, RD; Laurie Manzo, RD; Maika Escandon, RD; Renee Reynolds, RD; Kara Beasley, RD; Meaghan Alexander, RD; Ellen di Bonaventura, RD; Erin Gillis, RD; Caroline Breen, RD; and Donna Belcher, RD.
Seated: Sharon Darak, RD; Molly Cleary, RD; Caitlin MacKay, RD; Meg Baker, RD; Jill Israelite, RD; and Tara Nelson, RD.

Rounding with the team allows us to identify barriers to good nutrition earlier in a patient's admission and work with the patient and the team to overcome those obstacles.

Dietitians prioritize early enteral nutrition support to help improve patient outcomes. Providing enteral nutrition support within the first 24–72 hours of hyper-metabolic insult can help maintain gut integrity, modulate stress and the systemic immune response, and attenuate disease severity. In order to meet this standard among high-risk populations, dietitians have worked with unit-based teams to enhance admission templates. The Cardiac ICU now has an option for starting low-dose (trophic) feeds for critically ill patients unable to take food by mouth as soon as a feeding tube is placed. The Medical ICU admission template now includes a nutrition consult, and the Surgical ICU has its own enteral nutrition order set. These changes enable patients to receive nutrition faster. And dietitians, Caitlin MacKay, RD, Erin Gillis, RD, and Sharon Darak, RD, play an important role the new Enteral Advocacy Tasked Interdisciplinary Team (EAT-IT), responsible for optimizing nutrition in the SICU.

Meghan Klauer, RD, collaborated on research to optimize nutrition and growth in the Neonatal ICU, including a weekly review of growth during interdisciplinary rounds, accelerated parenteral nutrition, increased amino-acid content in pre-made parenteral solutions, early initiation of enteral nutrition, and a revised enteral feeding protocol. These interventions contributed to positive outcomes, and the data was presented as a poster at the annual Perspectives in Pediatrics Symposium last month.

Pediatric dietitians give inservice presentations to educate the team about total parenteral nutrition (TPN) in the Pediatric and Neonatal ICUs. In other areas, such as the Burn Unit, MICU, and SICU, dietitians provide education on nutrition for these specialized patient populations. Caroline Breen, RD, teaches a class on malnutrition and pressure ulcers through the Knight Nursing Center.

Dietitians are involved in many initiatives designed to help patients progress toward a safe and timely discharge, often working to optimize nutrition beyond the inpatient stay. Renee Reynolds, RD, dietitian for the Lunder 9 Oncology Unit, is collaborating with attending nurses on a project to ameliorate the cycle of constipation, nausea, and other side effects of chemotherapy that can delay discharge. As part of the GIFTS project, Meghan Baker, RD, is working to optimize nutrition for elderly patients admitted with fragility fractures to minimize the time these patients spend NPO (nothing by mouth) in the perioperative period. Ellen di Bonaventura, RD, is part of the hospital-wide effort to reduce re-admission among heart-failure patients.

Says Donna Belcher, RD, assistant director of Clinical Nutrition, "Medical nutrition therapy plays a vital role in improving outcomes, lowering costs, and decreasing length of stay. MGH dietitians constantly work to provide the highest quality, evidence-based nutrition care for all patients."

In addition to a bachelor's degree, supervised practice, and a registration examination, most MGH dietitians have completed a master's degree program, and more than half of the inpatient nutrition staff have earned advanced certification.

For more information about the service provided by MGH registered dietitians, call 6-2520.

Below: clinical dietitian, Erin Gillis, RD (second from right), participates in inter-disciplinary rounds on the Blake 12 Innovation Unit.

Surgical/trauma nursing

it's more than treating physical injury

My name is Brenda Pignone, and I am a staff nurse on White 7. When I decided to accept a position on a Surgical/Trauma unit 18 years ago, I knew I'd be caring for patients in serious, life-changing situations. Many are able to return to 'normal' lives. Others, like Ms. A, suffer such severe trauma, their day-to-day lives will be anything but normal.

Brenda Pignone, RN, staff nurse, White 7

Ms. A was a 50-year-old woman who'd been in a high-speed motor-vehicle accident... She was a paraplegic and would be required to wear a spinal brace (to maintain alignment) for up to twelve weeks.

Ms. A was a 50-year-old woman who'd been in a high-speed motor-vehicle accident while driving in another state. She suffered severe spinal-cord injury, traumatic brain injury, small subdural hematoma, and a fracture of a finger on her right hand. She was stabilized at a nearby hospital then transferred to the Surgical ICU at MGH. Two days after being admitted, she was taken to surgery for a T-1 laminectomy (a procedure to remove a portion of the vertebral bone) and open reduction of her spinal fracture. Ms. A was a paraplegic and would be required to wear a spinal brace (to maintain alignment) for up to 12 weeks. She was transferred to White 7 when her condition stabilized. Her finger had been splinted, and her subdural hematoma was resolving. On her second day on the unit, she had an emergent tracheostomy and placement of a feeding tube secondary to her spinal cord injury.

I began caring for Ms. A the day after her tracheostomy. I knew, after reading her nursing assessment and plan of care, that she was going to need an experienced nurse. In report, I learned that Ms. A had had a difficult night with nightmares about the accident. She had required a great deal of emotional support and physical care due to her injuries. Upon entering her room, I went to the head of the bed and leaned over so she could make eye contact with me. Her brace limited her ability to move her head. I immediately saw the fear and anxiety in her eyes. I introduced myself and told her I'd be her nurse for the next 12 hours. After traumatic brain injury, many patients need constant reminders of the plan of care. I assessed her physical needs. Her vital signs were stable; her lungs sounded clear; her trach was secure; her position was comfortable; her brace was properly fitted; IV lines, feeding tube, and Foley catheter checked, secured, and dated; her Morse Fall Scale and Braden Scores were recorded; and her pain was under control. I was able to make these assessments while continuing to provide emotional support to Ms. A.

After meeting with the surgical team during morning rounds, I spent time with Ms. A and her husband discussing Ms. A's physical and emotional issues and helping staff manage the situation. Both

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Trauma releases chemicals that increase anxiety, distort our ability to make decisions, and create fear... I assured Ms. A, as I do all my patients, that these reactions are the normal response to stress. Validating these responses is vital to the emotional and physical well-being of patients long after their hospital stay is over.

Ms. A and her husband spoke about how important it was for her to be able to touch her surroundings and her caregivers — it helped remind her of where she was and reassured her she was safe. Ms. A shared that because she could no longer feel her legs, her sense of touch was vital to her sense of 'who she was at that moment.'

Ms. A was a professional French horn player. She needed to feel that she could still use her arms, so she'd constantly move her arms seeking things to touch. I quickly arranged a meeting with Ms. A, her husband, the nurse practitioner, the social worker, and the psychiatric clinical nurse specialist. With this new information, I felt it was important for Ms. A to have a sitter, a patient care associate who could sit by her bed at night. When Ms. A reached out, the sitter could remind her that she was at MGH, that she'd had an accident, give her the date and time, and assure her that she was safe.

My colleagues and nurse manager supported the plan, and it was a tremendous help to Ms. A. Over the next few nights, her anxiety diminished, she felt more comfortable having a sitter, and she was able to sleep better during the night. Her need to use the call bell decreased as she developed trust with the sitters, knowing they'd call a nurse if necessary. And with hourly rounds, both the patient and the sitter knew that someone would check in on a regular basis.

Ms. A spent many weeks on White 7 recovering from her spinal-cord injury. Because of the complexity of her care, I spent a great deal of time with her performing skin care, maintaining adequate pain relief, helping her learn to eat again, and performing chest physical therapy and respiratory toilet. After a few weeks, Ms. A was able to come out of the brace and transfer to a wheelchair that she soon learned to roll by herself.

I helped initiate many consults for Ms. A, including Psychiatry to help with her anxiety and post traumatic stress syndrome; Pain Management to be sure she was appropriately weaned from narcotics; Physical and Occupational Therapy, Social Service, and Case Management so she could transition smoothly into rehabilitation with no change in her plan of care.

Ms. A had an incredible family that was very supportive. She was married with three children. One daughter was a senior in college and extremely supportive. She called every day and spent evenings with her mother at the hospital. Mr. A and I discussed how important it was for Ms. A's friends to visit. Visitors helped her relax. We created a list of visitors so I could remind Ms. A who'd be visiting her and for how long. I encouraged the evening staff (with Ms. A's permission) to involve the daughter in her mom's care and show her what she'd need to know to help care for her mother at home. Both Ms. A and her daughter found this beneficial as we talked about what Ms. A's 'new normal' was going to be. Her daughter told me that after graduating, her goal was to design a new spinal brace that was simpler to use and more comfortable for patients.

The day Ms. A was transferred to a rehabilitation facility, I spoke at length to the rehab nurse about the plan we had put in place to help Ms. A with her anxiety. I was fortunate to be able to visit her at rehab and see she was progressing well.

Ms. A inspired me with her courage and strength. I care for trauma patients every day, and I always incorporate my experience and expertise in critical-incident stress-management into my care. I knew it was important for Ms. A to understand how trauma affects the body, both physically and emotionally. Trauma releases chemicals that increase anxiety, distort our ability to make decisions, and create fear. I try to help trauma patients minimize the effects of stress by encouraging them to keep a journal, get plenty of sleep, maintain proper nutrition, surround themselves with family and friends, and seek professional help when needed. I assured Ms. A, as I do all my patients, that these reactions are the normal response to stress. Validating these responses is vital to the emotional and physical well-being of patients long after their hospital stay is over.

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

How do you rebuild a life? Slowly, and with a lot of guidance, support, and understanding. Brenda's expert knowledge and interventions allowed Ms. A and her family to be able to imagine the next chapter of their lives. It would have been easy to focus on Ms. A's extensive physical injuries, but Brenda gave equal attention to her mental and emotional needs. As Brenda pointed out, trauma triggers a number of responses, and she was right there to guide Ms. A and her family through them with skill and compassion.

Thank-you, Brenda.

Excellence in Action

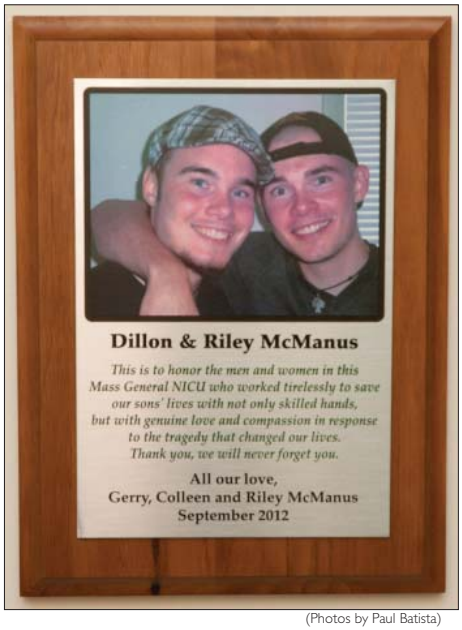
Recognizing exemplary, inter-disciplinary care in the Lunder 6 Neuro ICU

On Wednesday, February 13, 2013, MGH president, Peter Slavin, MD; senior vice president for Patient Care, Jeanette Ives Erickson, RN; members of the Neuro ICU team; and the McManus family came together on Lunder 6 for the presentation of an Excellence in Action Award. Nursing director, Tara Tehan, RN, describes the events that led to this well-deserved recognition.

"Last fall," says Tehan, "we cared for 20-year-old twin brothers, Riley and Dillon McManus, who'd been involved in a motor vehicle accident. Every member of the inter-disciplinary team worked tirelessly to support this family. When it became clear that Dillon wasn't going to survive, the family requested the two brothers be brought to the same unit so the family could be together one last time. When Dillon passed away, Riley was moved to another room so his parents wouldn't have to be in the room where Dillon had died in order to spend time with Riley. This family was supported through the loss of their loved one and through the difficult process of organ donation. Unit staff, the medical team, social workers, and chaplains all played a crucial part in caring for this family."

Said Mr. McManus, "We are so grateful for the care our sons received. The sense of humanity on this unit was like an extension of our own family. We wanted you to have this plaque so future patients and families will know the kind of care they can expect, and maybe it will help soothe their minds and make their paths a little easier."

Neuroscience ICU team with senior vice president for Patient Care, Jeanette Ives Erickson, RN (left); MGH president, Peter Slavin, MD (second from right); and members of the McManus family. At right: the plaque given by the McManus family to honor efforts of staff.



(Photos by Paul Batista)

Remembering friend and colleague, James Silvia, RN

The MGH community mourns the loss of James 'Jim' Silvia, RN, who passed away here at the hospital, November 12, 2012, surrounded by family, friends, and colleagues. Silvia began working at MGH in 1985, and during his career held many positions in the peri-operative setting, including staff nurse, resource nurse, and orthopedic team leader. A mentor to many, he touched the lives of countless patients, family members, and colleagues from all disciplines.

Says Alan Goostray, RN, clinical coordinator of the OR and longtime friend of Silvia, "Jim's grounding manner, calm disposition, organizational skills, and ability to prioritize made him a cut above the rest."

Dawn Tenney, RN, associate chief nurse, knew Silvia well. Says Tenney, "Jim was as devoted to MGH and our patients as he was to his own family. The hospital was his second home, and because of that, he treated everyone with the utmost care and respect. He was a professional at all times, often putting our needs above his own. He was as committed to his colleagues as they were to him, always there for each other in times of joy, sorrow, and healing. His example of teamwork, collaboration, and true concern for his co-workers will be remembered in the OR for many years to come."

Peter Dunn, MD, executive medical director of Perioperative Services, recalls, "Jim exemplified the best of MGH in everything he did. He excelled as a leader in the operating rooms, always facing challenging situations with a calm demeanor and friendly smile that put everyone else at ease. He will surely be missed."

James Silvia, RN,
peri-operative nurse

Another co-worker recalls, "When Jimmy was at the Gray desk, you knew you were going to have a good day."

Peri-Operative Services and the MGH Chaplaincy are coordinating a memorial celebration to honor Silvia's life and contributions, April 4, 2013, at 7:00am at the Shriners Hospital for Children. A breakfast reception will follow in the East Garden Dining Room at MGH.

For more information, call the MGH Chaplaincy at 6-2220.

Peri-Operative Services and the MGH Chaplaincy are coordinating a memorial celebration to honor Silvia's life and contributions, April 4, 2013, at 7:00am at the Shriners Hospital for Children.

Purim at MGH

a Jewish holiday observed with passion, pageantry, and plenty of play-acting

—by Rabbi Benjamin Lanckton

On February 22, 2013, the MGH Chaplaincy hosted the seventh annual observance of Purim, the Jewish holiday commemorating the salvation of the Jews from Haman's plot to, "destroy, kill, and annihilate" them in ancient Persia. The main focus of Purim is the reading of the Scroll of Esther, known as the Megillah, or 'scroll' in Hebrew. It is the custom to dress in costume, often as characters from the story, and as the story is read aloud of how Queen Esther and her uncle, Mordecai, defeated Haman's plot to kill the Jews, every mention of Haman's name is met with boos and raucous noisemakers.

Purim, observed annually one month before Passover, is a time to be charitable to the needy, send gifts of food to friends, and celebrate with a festive meal to rejoice in the Purim spirit. Hamantaschen (literally "Haman's pockets—triangular-shaped pastry with poppy, prune, or other sweet filling) are often part of this feast.

For more information about Purim or any of the other services offered by the MGH Chaplaincy, call 6-2220.







Group photo: Chaplaincy director, John Polk, DMin (left), with those who participated in the reading of the Megillah. Individual shots (clockwise from top left): Rabbi Ben Lanckton; Esther Israel, MD; Kathryn Beauchamp, RN; Deb Washington, RN; Devora Baronofsky, RN; and Jonathan Peled, MD.

The Magnet Road Show

Magnet Team packages Excellence Every Day and takes it to patient care units

In anticipation of the Magnet site visit, March 4–7, 2013, members of the Magnet Team recently took a Magnet 'Road Show' to patient care units to answer questions, let staff see the written evidence submitted in support of our application for re-designation, and familiarize new staff with the Magnet site-visit process. Information about Magnet and the site visit are available on the revised Magnet portal (http://www.mghpcs.org/PCS/Magnet/index.asp).

Says Magnet Team member, Mary Jane Costa, RN, "It feels like staff are ready and eager to showcase their practice. They're looking forward to the site visit as an opportunity to talk about the great work we do."

At right: Magnet Team members, Mary Jane Costa, RN (left), and Judy Carr, RN, with staff on Ellison 10. Below: Magnet Team members, Christopher Wilterdink and Tara Tehan, RN, with staff on White 11. The Magnet Road Show visited inpatient units, February 13–14, 2013.

Diversity, community-engagement, and Excellence Every Day

Question: It seems that involvement with the community has become a new focus of our diversity program. Is that intentional?

Jeanette: I'm glad you noticed. We've been making a concerted effort to invite community members and organizations to participate in our educational offerings and to partner with community-based groups to build relationships outside the walls of MGH. One example is a soon-to-be-launched program called, "Relaxing with Gospel Music," where patients, families, and visitors will be invited to relax and de-stress while listening to gospel music. The second annual Stand Against Racism event, co-sponsored by the PCS Diversity Program and The Diversity Committee of the Emergency Department, is scheduled for April 26, 2013. And to commemorate the 50th anniversary of the March on Washington, we'll be holding our own "walk the talk" event. Stay tuned for details.

Question: Is culturally competent care still a focus?

Jeanette: Absolutely. Soon, we'll be adding a new section to our diversity website—cultural profiles to provide information about patient populations specific to our diverse local communities. To check it out, go to the Excellence Every Day portal page (http://www.mghpcs.org/pcs/eed) and click on the Diversity link.

Question: I'm a minority employee looking for a minority mentor. Can you suggest anyone?

Jeanette: Group mentoring is available to minority employees. Contact Deb Washington, RN, director of Diversity, for details.

Question: I'm hearing a lot about a 'great wave' of people who will be newly insured with healthcare reform. Do we know anything about these newly insured people?

Jeanette: There could be as many as 32 million people entering the healthcare system under the new legislation. Some sources say many of the newly insured will have limited familiarity with the health care system, chronic health conditions, minimal knowledge about preventive and elective care, and concerns about the value of the care they receive. We should be mindful of these factors as we welcome these new patients and families into our service community.

Question: One of my co-workers is on a collaborative-governance committee and really enjoys it. I was thinking of joining the Diversity Committee. How would I go about that?

Jeanette: The Diversity committee is a great group that works hard to create a welcoming, inclusive, and culturally sensitive environment for patients and staff. If you'd like to become part of it or any collaborative governance committee, you should seek the approval of your unit or departmental leadership then e-mail PCSCollaoborativegovernance@Partners.org for an application.

Announcements

Blum Center Events

National Health Observance Series:
"Understanding Your Kidneys"
Thursday, March 14, 2013
12:00–1:00pm
speaker: Laurie Biel, RN

Shared Decision Making:
Colon Cancer Screening
Thursday, March 21th
12:00–1:00pm
speaker: Daniel Chung, MD

Harp Music
Wednesday, March 27th
12:00–12:35, 12:40–1:00pm
Harpist: Becky Wertz

Programs are free and open to MGH staff and patients.
No registration required.
All sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

ACLS Classes

Certification:

(Two-day program
Day one: lecture and review
Day two: stations and testing)

Day one:
April 8, 2013
8:00am–3:00pm
O'Keeffe Auditorium

Day two:
April 22nd
8:00am–1:00pm
Their Conference Room

Re-certification (one-day class):
March 13th
5:30–10:30pm
Founders 130 Conference Room

For information, contact Jeff Chambers at acls@partners.org

Classes are subject to change; check website for current dates and locations.

To register, go to: http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf.

"Did You Know?"

It's easier than you think to author a DYK poster

The PCS Research and Evidence-Based Practice Committee is seeking clinicians from all disciplines to author "Did You Know" (DYK) posters. Distributed throughout the MGH community, DYK posters are a great way to share clinical expertise.

If you have a topic you'd like to share, or if you'd like to learn more about the process of creating a DYK poster, contact Carolyn Bleiler at cbleiler@partners.org.

Save the Date

Connell Visiting Scholar

Angela Barron McBride, RN, international nurse leader and Connell visiting scholar is coming to MGH to work with staff, leaders, and Connell scholars to advance the nursing research agenda.

McBride will present, "Orchestrating a Career for Nursing Leadership," to the MGH community.

April 5, 2013
9:30am
O'Keeffe Auditorium

Internationally renown for her scholarship on leadership-development and career-planning, McBride is currently chair of a Nursing Advisory Board for the Robert Wood Johnson Foundation.

For more information, call 3-0431.

Memorial celebration for James Silvia, RN

A memorial celebration to honor the life of James Silvia, RN, will be held:

April 4, 2013
7:00am
Shriners Hospital for Children
51 Blossom Street

A breakfast reception will follow in the East Garden Dining Room at MGH

Senior HealthWISE events

All events are free for seniors 60 and older

"Medication Safety in the Older Population"
Thursday, March 7, 2013
11:00am–12:00pm
Haber Conference Room
Speakers: pharmacists Joanne Doyle Petrongolo, RPh, and Laura Carr, RPh

Hypertension Screenings:
Monday, March 25th
1:30–2:30pm
West End Library
151 Cambridge St.
Free blood pressure checks with wellness nurse, Diane Connor, RN.

Special Presentation from the Museum of Fine Arts
Guest educator, Nicole M. Claris, will explore the Impressionist period in France, Northern Europe, and the US.
Thursday, March 28th
10:00–11:00am
Haber Conference Room

Special Event

Boston Conservatory Cabaret will perform songs from favorite Broadway musicals
Monday, April 8th
2:30–3:30pm
Thier Conference Room

(RSVP is required
call: 617-724-6756)

For more information, call 4-6756.

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senior vice president for Patient Care

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Distribution
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Submissions
All stories should be submitted to: ssabia@partners.org
For more information, call: 617-724-1746

Next Publication
March 21, 2013

Inpatient HCAHPS Results

2010–2012 final results

Measure	*2010*	*2011*	*2012*
Nurse Communication Composite	78.8	79.4	81.0
Doctor Communication Composite	80.4	81.9	81.6
Room Clean	71.4	69.8	72.9
Quiet at Night	45.9	45.2	48.5
Cleanliness/Quiet Composite	58.7	57.5	60.7
Staff Responsiveness Composite	63.1	63.6	64.9
Pain Management Composite	70.7	71.5	71.9
Communication About Meds Composite	62.0	62.7	64.0
Discharge Information Composite	89.8	89.8	91.2
Overall Rating	78.4	79.1	80.1
Likelihood to Recommend	89.3	89.4	90.5

The 2012 results are in. MGH performed well overall on patient-experience metrics, with an average increase of 1.6 points per indicator over 2011 scores. Three indicators increased by more than 3 points. And MGH met all its targets for the year. HCAHPS scores reflect the diligence and commitment of every member of the team. Well done!

Data complete through 12/31/12
All results reflect Top-Box (or 'Always' response) percentages
Pull date: 2/18/13

Caring Headlines
March 7, 2013

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Bigelow 10 Nursing Office,
MGH, 55 Fruit Street
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