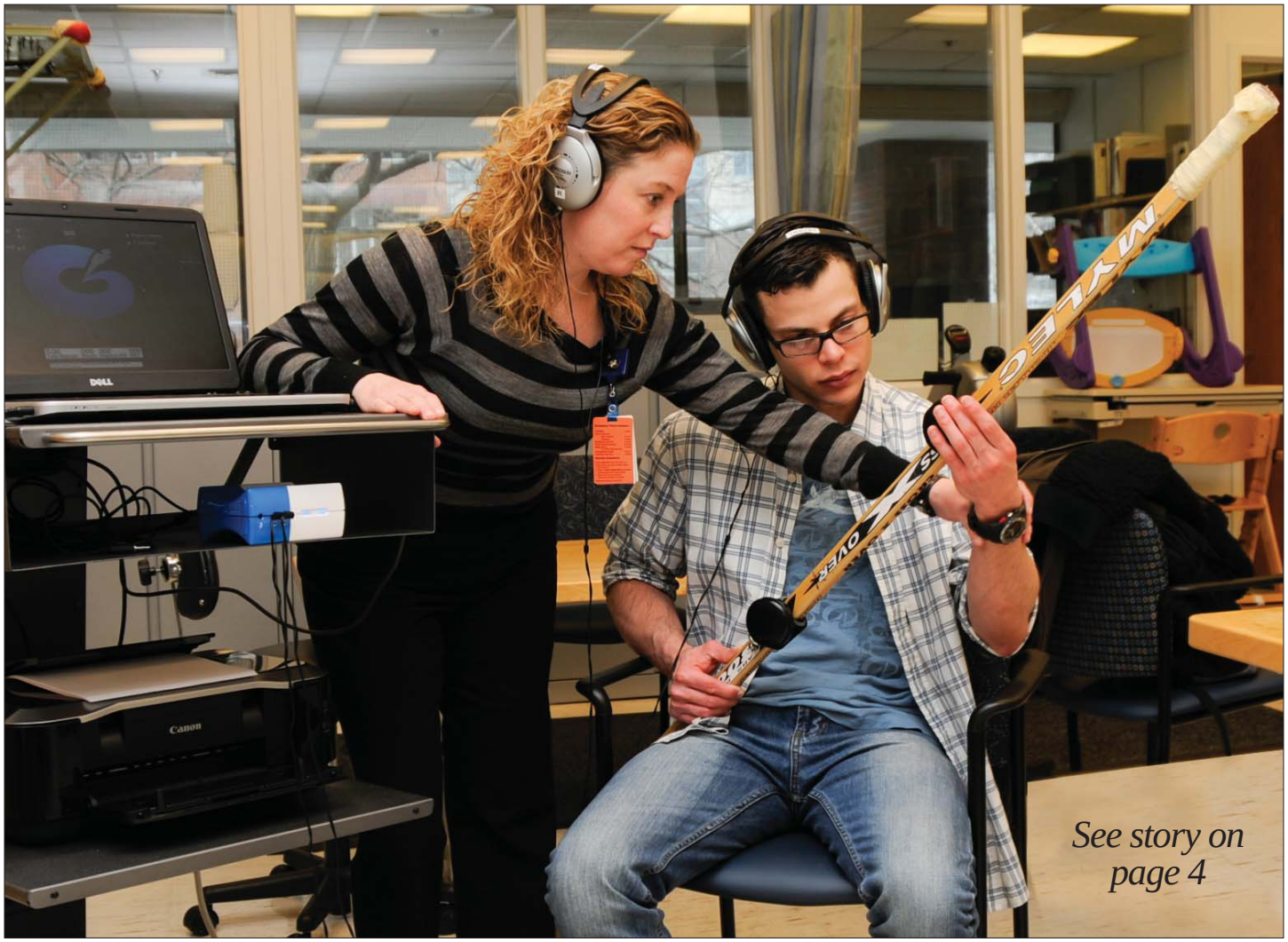
Caring Headlines
April 3, 2014

April is Occupational Therapy Month



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Occupational therapist, Julie MacLean, OTR/L, works with patient, Jeffrey Fernandini, using an interactive metronome to improve the finger movement needed to play the guitar.

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

Jeanette Ives Erickson

Fixed nurse-patient staffing ratios

When it comes to patient safety, one size definitely does not *fit all*

I want to be very clear—I oppose any legislation that imposes fixed nurse-patient ratios and replaces nursing judgement and expertise with an arbitrary number set by policy-makers who have no immediate knowledge of the clinical situation.

As nurses, our primary focus is keeping patients safe. We advocate for the safety of patients every day with every action we take. We do so with knowledge gained through higher education, skills developed in clinical practice, and critical thinking that's sharpened every time we step into a patient's room. More than a career, nursing is a personal calling. So when something threatens to impinge on our ability to keep patients safe, we must take our advocacy from the bedside to the public forum in defense of what we know is right.

I'm referring, of course, to the conversation that's taking place in newspapers, hospitals, and state houses across the country—the debate about fixed nurse-patient ratios and whether they're good for patient care. Here in Massachusetts, that means Senate Bill 557 and House Bill 1008, which seek (among other things) to establish a fixed ratio of patients per nurse at healthcare facilities throughout the Commonwealth.

As chief nurse at one of the most respected hospitals in the world, as the highest ranking nurse at the first Magnet hospital in Massachusetts, and as a lifelong advocate for patients' rights and patient safety, I want to be very clear—I oppose any legislation that imposes fixed nurse-patient ratios, replacing nursing judgement and expertise with an arbitrary number set by policy-makers who have no immediate knowledge of the clinical situation.

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

Nursing instincts, intuition, and experience are not interchangeable from one nurse to another. The depth and breadth of experience of a new-graduate nurse is far different from that of a seasoned veteran, as it would be for any professional in any industry. Attempting to ensure high-quality care by looking solely at the *number* of nurses providing that care is like saying you want five surgeons to perform your open-heart surgery having no idea whether any of them has any experience with cardiac surgery. It's not only absurd, it's reckless.

Senate Bill 557 and House Bill 1008 were brought before the Joint Committee on Health Care Financing, on Monday, March 24, 2014, where nurses, healthcare professionals, and others had an opportunity to speak in support or opposition to the bills. I'm proud to say that three MGH nurses testified before the committee. With their permission, I'd like to share some of what they said.

Staff nurse, Meg Soriano, RN, a member of our Central Resource Team and 15-year veteran of

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MGH, began by educating committee members about the intricacies of responding to a code call or any acute bedside emergency. She told the committee, "There's no way to predict what's going to be required of me when I walk through the door to start my shift. I could hold a man's hand as he takes his last breath; I could take a patient with congestive heart failure for a CAT scan; I could perform chest compressions during a two-hour code call; or I could do all of those things... Meeting the needs of patients in real time requires flexibility and clinical judgment. I ask you to please leave the decisions of nurse staffing where they belong—with nurses."

Staff nurse, Sabianca Delva, RN, provided the perspective of a relatively new medical-surgical nurse. She told the committee, "When I came out of orientation, the resource nurse ensured that my patient assignment was balanced with less complex patients so I wouldn't get overwhelmed. A more seasoned nurse could handle a heavier patient load, but taking into account years of patient-care experience safeguards the quality of care." She spoke about the impressive response of the Boston healthcare community following last year's Marathon bombings. "Our hospital was able to accommodate the sudden influx of patients in part due to the flexible nature of our practice environment and our ability to match resources to patients' needs. We didn't need legislation to guide our practice; we made those important staffing decisions... This legislation takes autonomy away from nurses and expunges the critical conversation between administrators and staff necessary to provide appropriate care."

Associate chief nurse, Kevin Whitney, RN, spoke eloquently and brought the voice of administrative experience. He told the committee, "Individual patient needs vary hospital to hospital, unit to unit, hour to hour... At MGH, nurse staffing is patient-centered, nurse-directed, and adjusted as needed to meet patient needs. We empower nurses, we give them the freedom to employ flexible staffing strategies in real time. We cannot and should not replace professional nursing judgment and clinical decision-making with government-imposed limits that mandate rigid, unrealistic, and impractical staffing ratios. We should focus on care-delivery and nursing practice based on evidence and quality outcomes."

I thank Meg, Sabianca, and Kevin for their courage and advocacy. A similar initiative (House Bill 3843) may appear on the November ballot as a voter referendum. While I hope the residents of Massachusetts grasp the finer points of this issue, there's no substitute for the voice of a nurse. I urge you to share your practice and add your voice to the conversation; contact your representatives; educate your family and friends. Whether it's advocating for patient safety at the bedside or earning the public's trust at the State House, our allegiance is first, last, and always, to our patients.

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In this Issue

April is Occupational Therapy Month

—submitted by the Occupational Therapy Department

April is Occupational Therapy Month. This year the MGH department of Occupational Therapy (OT) chose to highlight how both inpatient and outpatient therapists bring 'generalist' skills to patient care. The vignettes on the following pages illustrate the powerful perspectives that emerge when therapists care for a wide variety of patients. Inpatient therapists rotate to different units, fostering clinical reasoning and a deep understanding of occupational-therapy practice across multiple patient populations. Outpatient therapists, though highly specialized, draw on a broad base of knowledge acquired through years of experience. Both approaches are invaluable in terms of providing holistic care to patients and families. As health care continues to evolve to meet ever changing patient needs, occupational therapy generalists are well positioned to meet the diverse needs of the patients we serve. The American Occupational Therapy Association will celebrate its centennial anniversary in 2017. Its vision for the next century is that, "Occupational Therapy will be a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs."

MGH occupational therapists

Sarah McKinnon, OTR/L, has worked as an occupational therapist at MGH for almost two years.

Sarah McKinnon, OTR/L
occupational therapist

On September 30, 2013, I had the opportunity to go to Capitol Hill in Washington, DC, for Hill Day to discuss key legislative issues affecting occupational therapy and the overall state of health care. Organized by the American Occupational Therapy Association (AOTA), Hill Day is an opportunity to educate legislators about the role occupational therapy plays in improving the health of individuals and society, as well as our meaningful and effective efforts to improve the healthcare system.

Representing AOTA and Massachusetts occupational therapists, I urged Congress to pass the Medicare Access to Rehabilitation Services Act. I was able to discuss the role of occupational therapy in meeting the needs of people with mental-health and substance-abuse disorders; I weighed in on a bill to improve, coordinate, and enhance rehabilitation research; and I encouraged funding for special education.

My practice over the past five years, has allowed me to build a foundation of skills to meet the rehabilitation needs of the adult population with various neurological, orthopedic, and chronic diagnoses. The combination of my professional experiences and knowledge about the role of occupational therapy across a variety of populations allows me to advocate for occupational therapy with populations that I don't see often, such as outpatient, mental health, and pediatric patients.

The ability to 'generalize' has helped me to be a confident advocate and a well-rounded therapist in the diverse, acute-care setting at MGH.

Julie MacLean, OTR/L, senior occupational therapist has worked at MGH for six years.

Julie MacLean, OTR/L
senior occupational therapist

As the only outpatient occupational therapist working with patients with neurological conditions, I consider myself a specialist. But as I reflect over my practice, I realize I've gained wisdom and knowledge from situations that have caused me to think outside of neurology and build on my general OT skills.

This year, I was introduced to the interactive metronome (IM), a computerized, game-like program that provides feedback at milli-second intervals allowing users to improve their timing. Timing, known in neurology as cognitive processing, can become disrupted following an injury to the brain. When I learned that the IM could be used in conjunction with functional activities, I began to see how I could use the program with my patients. To be an effective OT, you need many 'tools' in your treatment bag. The metronome addresses the neurological underpinning of symptoms, such as impaired problem-solving, attention, concentration, and coordination.

One patient recently came to me with impaired function due to deficits in coordination following a head injury. He wanted to be able to play his guitar again, but was unable to despite having had therapy in the past. This clinical challenge drove me to explore the use of the metronome. We began by focusing on the timing of his large arm movements. He saw striking improvement in his timing and accuracy. We're now using the metronome to work on the individual finger movement needed to play the guitar.

The greatest reward for me is finding ways to help patients improve functionally in the activities that are important to them. Being an effective occupational therapist means being a generalist even in an area of specialization.

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Christina Jelenik, OTR/L, has worked as an occupational therapist at MGH for almost two years.

Christina Jelenik, OTR/L
occupational therapist

Throughout my career as an occupational therapist, I've had the opportunity to work with many different patient populations in many different settings. These experiences contributed to my becoming a well-rounded 'generalist.' As a result of my experience working at an acute rehabilitation facility and working as a float therapist throughout MGH, I'm well versed in behavior-management, neurologic recovery, assistive technology, sensory integration, and orthopedic surgery. I currently work in the Neuroscience ICU where I'm able to draw on all these experiences to better assist patients throughout their recovery.

I recently worked with a young woman who had sustained significant brain injury as a result of a severe accident. She was restless, impulsive, unsteady on her feet, and had multiple musculoskeletal injuries. Her restlessness and impulsivity were limiting her ability to engage in structured tasks and putting her at high risk for falling. Drawing on my prior experience with brain-injured patients, I was able to use a multi-sensory approach to give her an outlet for her excess energy and a way to relieve her anxiety. At the end of my evaluation, the patient was able to sit in her chair for several minutes without restraints and self-initiate some calming techniques. For a young brain injured patient, that was a huge success.

Every individual is different and complex in their own way. As a clinician, being able to draw on a variety of patient experiences makes me a better therapist and gives patients a greater chance to achieve positive outcomes.

Christopher Kreutzer, OTR/L, has worked as an occupational therapist at MGH for 18 months.

Christopher Kreutzer, OTR/L
occupational therapist

I've always strived to be well rounded in all aspects of my life. When I recently began a career in occupational therapy, I sought an employer that would provide opportunities for multi-faceted growth. One of the major attractions to MGH were their nine-month rotations with different patient populations. My second rotation was on the Cardiac Service. I wasn't sure what to expect, but I was pleased to find that it not only facilitated a broadening of my skills, but reinforced the importance of a wide range of experiences in my professional career. I've found that while cardiac diagnoses are very specific and require a great deal of specialization to manage, they can cause, and be caused by, many other medical complications.

As an occupational therapist, I take an holistic approach, looking beyond the cardiac limitations to functional performance. This has frequently required me to rely on skills I learned on other units and in other settings. For example, I've drawn on my experiences with orthopedic patients when working with individuals with upper-extremity fractures resulting from a fainting episode caused by a cardiac complication. I've had to draw on my neurological experience while working with patients who suffer a CVA, or stroke, due to septic emboli originating from endocarditis (inflammation of the heart).

Still in my first few years of practice, I find that the diverse skill set my patients sometimes require occasionally exceeds my current capability. At those times, I'm fortunate to be able to reach out to my more experienced colleagues for guidance. It is through this guidance and working with a diverse patient population that demands a diverse skill set that allows me to develop clinically and better serve my patients, now and in the future.

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Allison Pinsince, OTR/L, has worked as an occupational therapist at MGH for five years.

Allison Pinsince, OTR/L
occupational therapist

When people ask where I work, it's always an interesting answer because occupational therapists at MGH are always rotating. People comment on how difficult it must be to get used to different units, different staff, and different patient populations. But I think this is one of the most interesting and valuable parts of our role here—it allows us to get to know a variety of diagnoses and patient populations and broaden our skills as occupational therapists.

Transitioning from a rotation on the Burn/Plastic Surgery Unit to Neurology felt like an abrupt move from one patient population to another. But I quickly found that many of the skills I'd developed on the Burn Unit working with patients and families who had experienced devastating, life-altering events very much carried over to Neurology. Although the nature of the therapy may change, the support for patients and families, and the education about the role of occupational therapy is very much the same.

I've found that difficult conversations and questions posed by patients and families are often similar and easier to manage because of my experience on the Burn Unit. I've also found that I'm better equipped to 'read' where a patient or family member is in the acceptance process and can more easily meet them there.

Every time I rotate, I'm able to take clinical and professional skills with me to the next rotation, continually broadening my experience.

Stephanie Smith OTR/L, senior cccupational therapist has worked at MGH for six years.

Stephanie Smith, OTR/L
senior occupational therapist

One Saturday nearly six years ago, I anxiously met with my co-workers to divvy up the work for my first weekend here at MGH. As a new graduate with limited experience, working a minimally staffed weekend shift felt intimidating. I wondered how I could be of help to my more experienced colleagues.

In the years since, I've sought opportunities to expand and generalize my skills. The Occupational Therapy Department has encouraged me to think beyond the boundaries of rotations, populations, and diagnoses; to approach each patient as a unique individual with distinct needs that will call upon some combination my skills as a therapist. I never realized how important 'being a generalist' was until a recent Sunday when we received a consult for a 13-month-old baby boy with a complex medical history including significant oxygen-deprived brain injury. My experience with pediatrics was limited. But I felt if I drew on my rotations on Neurology and Psychiatry, I could take the consult.

Once I met this remarkable young boy and his parents, I found myself drawing on skills I'd learned throughout my time at MGH. My neurological background allowed me to identify barriers to the child's ability to engage his environment in a meaningful, age-appropriate way. The most prominent of these was the tone and spasticity of his arms. Using my experience from Psychiatry, I was able to provide calming sensory input and fully stretch his arms. I used my splinting skills from Orthopedics to fabricate a set of small splints allowing the boy's hands to rest in a more functional and comfortable position.

On Monday, when the primary pediatric therapist returned, I went to see the child with her, giving me another opportunity to further my knowledge. These are the opportunities that being an occupational therapy generalist provides—opportunities that allow us to better ourselves so we can better the lives of the patients we serve, no matter what day of the week.

On any given day

a look at the practice of MGH social workers

—by By Laura S. Metz, LICSW

Every day, hundreds of patients from all over the world pass through our doors seeking world-class medical care. At MGH, we know patients are more than the sum of their diagnoses and symptoms; they're individuals with personal challenges, triumphs, goals, and emotions. Recognizing these unique traits is as important to healing as medical interventions and medication. It was in that spirit in 1905 that MGH established the first Social Service Department, recognizing the impact psychosocial stressors have on health and wellness. Since that time, social workers have become integral members of the healthcare team, from the Emergency Department to inpatient medical and surgical floors to outpatient mental health. This work started more than a century ago, and social workers' commitment to blend the art of human service with the science of medicine remains strong today.

Founding director, Ida Cannon, leads the Social Service Department in this undated photo.

(Photo provided by Social Service Department)

March marks National Social Work Month, and at MGH it is a time to honor this institution's history of excellence in serving patients, families, and communities near and far. It is the month when we pay tribute to clinical social workers who provide compassionate care to patients of all ages in nearly every practice area. Social workers utilize clinical skills along with their own warmth and humor to provide tangible and intangible support. Every day, social workers have the privilege of glimpsing the strength and challenges of patients and families amid a vast array of circumstances.

On any given day, MGH social workers collaborate with inter-disciplinary colleagues to address the medical and social care of patients and families. By assessing patients' needs and acting as their advocates, social workers provide the team with a unique perspective on their strengths and challenges. Social workers in the Cancer Center meet with patients throughout treatment to discuss the impact of a cancer diagnosis, how to balance the physical and emotional demands of treatment with work and family responsibilities, and how to manage feelings at the end of treatment.

Social workers connect patients with community resources. One oncology social worker, reflecting on

Every day, social workers provide a calm and empathetic presence for patients and families facing stressful and challenging situations. Social workers guide and advocate for patients struggling to navigate a complex healthcare system as they validate their fears, anxiety, grief, anger, and loss.

her weekly support group for women with breast cancer, notes, "Patients' individual diagnoses and treatments may differ, but what brings them together is living with cancer and seeking a place to find support, understanding, validation, and ideas for coping." This same social worker uses mindfulness and writing exercises to help patients develop coping strategies. She consults the Social Service oncology resource specialist to educate patients about community resources and benefits. On this particular day, the resource specialist helps an elderly patient who lives in the suburbs coordinate transportation; without it, he wouldn't have been able to get to the hospital for his radiation treatment.

While oncology social workers meet individually with patients and families and facilitate group sessions, on inpatient units social workers collaborate with the inter-disciplinary team to identify patients in need of social work intervention. At 8:00am, obstetric social workers discuss consults with their nursing colleagues. On this particular day, one social worker meets with a patient to assess risk factors for post-partum depression prior to discharge; then offers support to two women who've suffered miscarriages. While on another unit the obstetric social worker meets with an investigator from the Department of Children and Families to discuss potential state custody for a newborn experiencing withdrawal symptoms.

Social workers work on Medical, Surgical, Cardiac, Neurology, and intensive care units, facilitating family meetings; discussing patients' diagnoses and goals of care; educating patients and families about coping skills to manage medical treatments; providing resources to children facing the loss of a parent; assisting patients from other countries to navigate the medical landscape, assessing patients' ability to care for themselves in the community; and coordinating in-home services.

Starting at 11:00am, one social worker sits in on back-to-back family meetings discussing arrangements for homemaker services, assisting in completing a healthcare proxy, and addressing other administrative tasks that many patients and families find daunting.

By 2:00pm, the social worker is in an ICU talking with the husband of a patient who will not survive despite extensive medical intervention. She joins the medical team in imparting the news; helps him identify next steps, and supports him as he begins to come to terms with the loss.

On a medical unit, a patient's mother speaks with a social worker about continuing aggressive treatment for her daughter. They discuss the daughter's quality of life and weigh the difficult options.

Across the hospital in the HIV clinic, a social worker is paged about a patient unable to fill a prescription due to insurance issues; a doctor introduces the social worker to a patient struggling with a new HIV diagnosis and an active substance addiction.

A social worker in the outpatient mental health practice meets a new patient who's been referred for therapy. The patient has never met with a therapist before; the social worker eases into a discussion about goals of treatment while quickly building a rapport and helping the patient feel comfortable with the idea of therapy.

On the Transplant Unit, social workers have time to build a rapport with patients awaiting transplant. They assess support systems, housing, and financial situations.

On the inpatient Psychiatric Unit, social workers provide psycho-education regarding symptom-management, put patients in touch with psychiatric providers in the community, and address concerns about discharge.

At MGH, social-work coverage doesn't stop at 5:00pm; social workers provide evening coverage in the Emergency Department and are on call throughout the night. On one such night, a social worker is called in at 2:00am to meet with a mother concerned for the safety of her young son. The social worker talks with the medical team to gather information, meets with the mother to conduct a safety assessment, and provides emotional support.

Every day, social workers provide a calm and empathetic presence for patients and families facing stressful and challenging situations. Social workers guide and advocate for patients struggling to navigate a complex healthcare system as they validate their fears, anxiety, grief, anger, and loss.

One social worker describes it this way: "Empathy—the ability to connect with, understand, and share the feelings of another person—is an intrinsic part of the work we do as clinical social workers. I'm continually struck by the power of the human connection and the idea that, as much as I seek to guide and provide resources to people, I'm humbled by their process. I learn a great deal from them as they come to terms with some of the most difficult experiences of their lives."

For more information about the services offered by MGH social workers, call 617-726-5807.

Anxiety-management helps patient manage physical impairments

'John' was a 69-year-old man with a history of hepatitis C, stage IV non-small-cell lung cancer, and epilepsy. He presented with possible pneumonia and urinary tract infection. He had an unsteady gait and looked much older than 69.

My name is Christine Carifio, and I am an occupational therapist. I first met 'John' on the Ellison 16 Medical Unit. He was a 69-year-old man with a history of hepatitis C, stage IV non-small-cell lung cancer, and epilepsy. He presented with possible pneumonia and urinary tract infection. He had an unsteady gait and looked much older than 69.

John was sitting up in bed eating breakfast with his wife, Judy, at his bedside. The first thing I noticed was the physical shaking as he attempted to feed himself. His entire body shook, making the eating process very challenging, but he was determined to try to feed himself with no assistance—despite spilling food and an obvious inability to control his tremors. John shared with me that he wasn't sure of the origin of the tremors, but he knew they got worse with increased anxiety. During my evaluation, John did appear anxious, frazzled, and overwhelmed.

I explained the role of occupational therapists to John and how we try to help individuals regain the means and ability to perform everyday activities. But given what I had learned in my chart review, the

Christine Carifio, OTR/L
occupational therapist

time I'd spent on the Psychiatric Unit, and my observations of his apparent anxiety, I decided to add that occupational therapists also facilitate coping strategies. This could help John manage his anxiety so he'd have a better opportunity to participate more fully in his daily roles and routines.

After explaining the idea of managing anxiety versus strictly helping with physical impairments, both John and his wife's interest were piqued. Both agreed that, "That's something we're really interested in."

After my initial evaluation, John's wife followed me out of the room with many questions about his anxiety. She told me she believed anxiety was the root of his poor function. She shared that they had recently moved out of a home where John had lived for 30 years and how the event had triggered ex-

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treme anxiety. Prior to this hospital admission, John had been a fairly independent man. He was retired and independent with basic activities of daily living. He did receive assistance from her for most IADLs, and she reported that he had started drinking more in an effort to ease the anxiety.

My 'mental-health brain' perked up. What she was describing were the sort of questions I asked patients on the Psychiatric Unit. I wanted to help John and his wife not only with his physical disabilities, but also from a mental-health perspective. I consulted his chart to ensure that Psychiatry was following John. I found that they were prescribing several medications for anxiety and agitation, as needed.

During my next session with John, I began by introducing relaxation strategies in hopes that after trying them, he'd calm down enough to be able to participate in more activities of daily living. John demonstrated insight into his anxiety and seemed interested in hearing about sensory strategies, deep breathing, and other relaxation techniques. I gave him a ball to squeeze, which he immediately clung to. And I had him practice deep-breathing exercises while supine in bed. After completing just a few relaxation exercises, it was amazing how much more we were able to accomplish.

The shaking was still significant but John was motivated for therapy. We were able to do edge-of-bed activities and lower-body dressing with assistance. I noticed that when John performed upper-extremity exercises, his shakiness decreased dramatically—which again brought me back to my time on the Psychiatric Unit and reminded me how repetitive-movement activities can be calming. And here I was seeing it in action on a medical unit.

I left John with a number of sensory objects and explained how he could use each of them and what they would do for him with the hope that he would carry these strategies over when I left. After our session, I looked back at the most recent psychiatry follow-up note in John's chart and one suggestion was, "Consider occupational therapy for sensory strategies." It looked like we were all on the same page.

The combination of medications to manage his anxiety, relaxation and coping strategies prior to activity, and participation in meaningful activities was working. According to John's nurse and chart, the plan was for John to be discharged to a rehabilitation facility the next day with outpatient psychiatric follow-up.

Several days later, I met John for our second session. The first words out of his mouth were, "I was hoping you'd come back. I broke my squeeze ball!"

Again, I noticed an improvement with John's function after participating in relaxation strategies. And he reported that he enjoyed the candy I had provided (for oral stimulation) and wanted more. When I asked why he liked the candy, he said, "It helps me focus."

During this session, we were able to complete full-body bathing and dressing at the bedside and toileting with RW to commode—again progressing more than we had in the prior session and with me providing less assistance. The combination of medications to manage his anxiety, relaxation and coping strategies prior to activity, and participation in meaningful activities was working.

According to John's nurse and chart, the plan was for John to be discharged to a rehabilitation facility the next day with outpatient psychiatric follow-up.

Since then, I've learned that John is doing well at rehab, walking with a walker and, "doing better than when he came in." I felt that my experience with both mental health and physical disabilities served John's needs appropriately and effectively during his time on the medical unit. I hope to continue to employ sensory and coping strategies for improved function and participation in meaningful activities whenever the opportunity arises.

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

Christine quickly recognized that John's symptoms had a strong psychological component, so she developed a holistic plan to encompass all his symptoms, not just the physical. By partnering with John and his wife, they entered into a trusting, supportive relationship. This empowered Christine to draw on her experience and creativity and explore alternative strategies to meet John's needs. I'm sure these coping strategies could be put to good use on many units throughout the hospital.

Thank-you, Christine.

Creating a more compassionate healthcare system

Learning from patients and families

—by Robin Lipkis Orlando, RN; Rick Evans; and Lin-Ti Chang, RN

On Tuesday, February 25, 2014, nearly 80 patients, family members, and staff from six Patient and Family Advisory Councils, the Council on Disability Awareness, and the Schwartz Center came together to dialogue about ways to create a more compassionate healthcare system. The event was hosted by Jeanette Ives Erickson, RN, senior vice president for Patient Care, and Beth Lown, MD, medical director of the Schwartz Center.

Based at MGH, the Schwartz Center is a national non-profit organization dedicated to strengthening the relationship between patients and healthcare providers and preserving the human connection in health care. It was founded by Kenneth B. Schwartz shortly before he died of lung cancer in September of 1995. In an article printed in *The Boston Globe Magazine* in July of that year, Schwartz wrote, "For as skilled and knowledgeable as my caregivers are, what matters most is that they have empathized with me in a way that gives me hope and makes me feel like a human being, not just an illness."

That sentiment was echoed many times throughout the evening by patients and family members.

Powerful stories were shared about the experience of receiving compassionate care at MGH. Attendees told of clinicians who took the time to sit and listen; who responded to distress with a warm touch; who went above and beyond to create connections within and outside the hospital; who encouraged and supported families to be present during emergent situations; who knew how to make them smile; who respected patients' wishes; who provided information in a sensitive and timely manner; who knew when to bend the rules; who recognized the unique cultural needs of patients and families; who were able to see what was needed even when you couldn't; who individualized care to meet the needs of every patient; and who repeatedly assured patients, "We're in this together."

In addition to sharing personal stories, attendees offered recommendations on how to foster an environment of compassionate care. Recommendations were based on the seven commitments put forth by the Schwartz Center as part of a national 'call to action' on compassion in health care.

Recommendations included:

- Commitment #1 to compassionate health care leadership
  Recommendations:
  - Everyone serves a leadership role in the eyes of the patient
  - Leaders rise above daily operations and remain focused, attentive, and in control
- Commitment #2 to teach compassion
  Recommendations:
  - Learn from patients and families; they are the best teachers
  - Develop a template of guidelines for compassion
- Commitment #3 to value and reward compassion
  Recommendations:
  - Find ways to recognize compassion with accolades, rewards, or money
  - Form support groups to help caregivers process events
- Commitment #4 to support caregivers

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Photos clockwise from top left: members of the Cancer Center PFAC: (l-r) Lisa Dooling, Sally Hooper, Lynne Graziano-Morin, and Paula Gilman Bayles; Beth Lown, MD, medical director of the Schwartz Center; Jeanette Ives Erickson, RN, senior vice president for Patient Care; and Patient and Family Advisory Council members deliberate over recommendations for compassionate health care.

Patient-Family Advisory Councils (continued)

Recommendations:
- Provide training in interpersonal relations
- Promote teamwork

- Commitment #5 to involve, educate, and learn from patients and families

Recommendations:
- Invite PFAC members to be part of clinical teams
- Learn best ways for patients and families to learn, including patients and families with disabilities

- Commitment #6 to build compassion into the fabric of health care

Recommendations:
- Make compassion part of the first encounter, including phone contact, registration, and front-desk interactions
- Develop a system for hand-overs that reinforces continuity of care

- Commitment #7 to deepen our understanding of compassion

Recommendations:
- Conduct research to measure the impact of compassion and patient-centered care
- Provide empathy training

To learn more, go to: www.committocompassion.org.

For information about the Schwartz Center, go to: www.theschwartzcenter.org

For information about Patient and Family Advisory Councils, e-mail PCSCPFAC@partners.org.

(Photos by Walter Reeves)

Simchat Purim

the joy of Purim

—by Rabbi Ben Lanckton

On Monday, March17, 2014, the MGH Chaplaincy hosted its seventh annual Purim celebration in the MGH Chapel. Purim is the late-winter, Jewish holiday that celebrates the events in the *Scroll of Esther*, or the *Megillah*; it falls exactly one month before Passover. The story describes how beautiful Queen Esther and her uncle Mordecai saved the Jews of ancient Persia from the evil prime minister, Haman. Reading the *Megillah* aloud is one of the four mitzvot, or religious commandments, of Purim; the others are giving gifts to the poor, sharing food with friends, and feasting.

Participants in this year's Purim celebration in full *Megillah* regalia.

The *Megillah* was read aloud by MGH staff and students of the Clinical Pastoral Education Program dressed in costumes for the occasion. The reading was primarily in English, except for two parts, which were read in Hebrew by Devora Baronofsky and Rabbi Shulamit Izen, respectively. Izen read from an actual unfurled *Scroll of Esther*. Throughout the reading, the congregation used graggers, Yiddish for noisemakers, in response to every mention of evil Haman's name.

The service was broadcast on Channel 16 so patients could view it from their rooms.

Following the service, participants enjoyed a Purim kiddush, a sanctification of the Purim day over drink. On most holidays, the kiddush is a solemn blessing invoking the serious themes of the day; on Purim, in keeping with the topsy-turvy mode of the celebration, the kiddush is a random compilation of popular Jewish songs and tunes from other holidays. Rabbi Ben Lanckton's kiddush included a number of Beatles tunes, a translingual play on the words, "bittul Torah," which means frivolous pursuits in Hebrew, but can be translated as, "the teaching of the Beatles" in English.

If you would like to participate in the reading of the *Megillah* next year, or for information on any of the Chaplaincy's educational or celebratory events, call the MGH Chaplaincy at 617-726-2220.

Celebrating the practice of GI nurses

—by Janet King RN, staff nurse, and June Guarente, RN, clinical nurse specialist

In observance of GI Nurses and Associates Day, March 28, 2014, staff of the GI Endoscopy Unit hosted an informational table in the Main Corridor. GI nurses were on hand to answer questions, promote GI nursing, and raise awareness about the services provided by the Endoscopy Unit. Posters highlighted the work of GI nurses and support staff in the three Endoscopy areas: Blake 4 Endoscopy; the Charles River Endoscopy Unit (CRP); and the Pediatric Endoscopy Suite on Gray 4. Most people associate colonoscopies with the Endoscopy Unit, but many other diagnostic tests and treatments are performed there, including:

- esophagogastroduodenoscopy (EGD)
- endoscopic retrograde cholangiopancreatography (ERCP)
- endoscopic ultrasound (EUS)
- esophageal ablation
- cryotherapy
- dilation
- endoscopic mucosal resection (EMR)
- percutaneous gastrostomy tube (PEG)
- liver biopsy
- fecal transplant
- esophageal motility
- impedance
- pH probe
- anorectal manometry
- smart pill
- capsule endoscopy
- Bravo pH

Consult your physician to find out when you should schedule your colonoscopy.

For more information about GI nursing or the Endoscopy Unit, call 617-724-5407.

Janet King RN, staff nurse, and June Guarente, RN, clinical nurse specialist, staff the GI Nurse booth in the Main Corridor.

MGH Patient and Family Education Materials and Resources Website

—submitted by the Patient Education Committee

Recently, a new website was created to help clinicians find patient-education materials for patients and families with greater ease. Locating evidence-based information and navigating through websites can be time-consuming. For that reason, The Maxwell and Eleanor Blum Patient & Family Learning Center, in collaboration with the PCS Patient Education and Informatics committees, launched a website called, MGH Patient and Family Education Materials and Resources.

Clinicians can access the site through two pathways:

- Partners Handbook > Patient Education Information > MGH Patient Education Website
- Partners Application > PCS Clinical Resources > MGH Patient and Family Education Materials & Resources

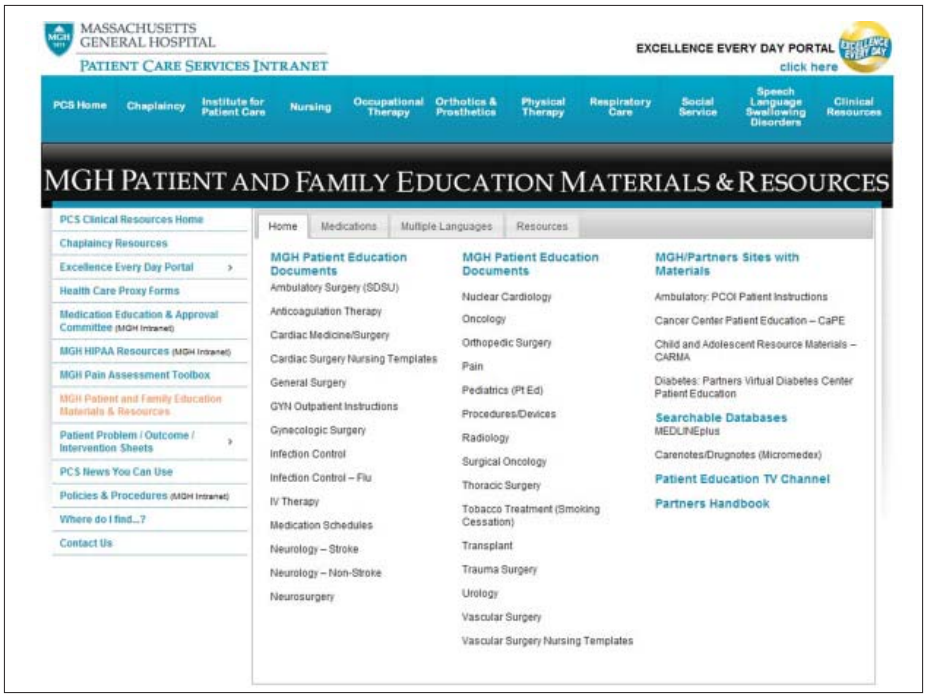
The website contains links to preferred sites as well as patient-education materials and resources. MGH-produced documents are presented first in the hope that clinicians will use them, ensuring standardized patient education. Being able to reach the site in just a few steps should decrease the time spent searching for materials. The website organizes existing patient-education documents and sites currently being utilized. The goal is to improve the user experience while fostering standardization of documents and promoting best practice.

On the website you'll find links to sites such as: CAPE for Oncology, CARMA for Pediatrics, and links to medication sites and materials in multiple languages.

In the future, clinicians will be able to access the website directly from CAS.

Explore the site and incorporate it into your daily practice. Use the materials to address patient and family needs, and be consistent in the documents you disseminate.

For more information or to make suggestions, e-mail: the Blum Center at PFLC@partners.org.



Boston Strong/MGH Proud

Commemorating the one-year anniversary of the Boston Marathon bombings

As we approach the one-year anniversary of the Boston Marathon bombings, we've had an opportunity to reflect on some of the more positive events that took place that day. In the face of great evil, we saw goodness, and courage, and strength. In a spirit of celebration for the resilience and unity of our great city, MGH will mark the occasion with a series of special events:

Russell Museum Lecture and Anniversary Exhibit

April 8th, 6:00–8:00pm
Paul S. Russell, MD, Museum of Medical History and Innovation
"Planning for Disaster: What Works and Why"
presented by Paul Biddinger, MD, chief of the Emergency Department's Division of Emergency Preparedness and medical director of operations for Emergency Services.
Space is limited.
RSVP by e-mail to: mghhistory@partners.org.

Monday–Friday, 9:00am–5:00pm, throughout the month of April
MGH Paul S. Russell, MD Museum of Medical History and Innovation
A special exhibit will highlight the role of first responders, the importance of emergency preparedness, and the perspectives of patients and staff.

MGH First Responders: Perspectives and Lessons Learned

April 15th, 10:00–11:00am
O'Keeffe Auditorium
Panelists include: Ann Prestipino (facilitator), Aaron Baggish, MD; Paul Biddinger, MD; Maryfran Hughes, RN; David King, MD; Marie Elena Gioiella, LICSW; and David Reisman.
Introductory remarks by former mayor, Thomas M. Menino

Remembrance and Resilience: Music, Prayer, and Reflection

April 15th, 7:00–9:00am and 6:00–8:00pm,
Drop by the MGH Chapel at your convenience for quiet reflection, music, and readings.

April 15th, 2:30–3:15pm
Commemoration and Service of Peace
O'Keeffe Auditorium

April 15th, throughout the day
Prayer trees will be located in the lobbies of the White, Wang, and Yawkey buildings for members of the MGH community to share thoughts and messages of hope.
Musicians will perform in the main lobby.

Boston Marathon Runners Event

April 16th, 2:00–4:00pm, under the Bulfinch Tent
An event to support and celebrate the 2013 and 2014 employee runners.
At 2:15pm, remarks by famed Boston marathoner, Bill Rodgers.

Marathon Monday

April 21st, throughout the day
Musicians will perform in the main lobby.

Announcements

Partners eCare video

To view the new Partners eCare video on implementation of the electronic health record and administrative system at MGH, go to:

http://partnersecare.partners.org/hospital-networks/mgh/.

Special Schwartz Center Rounds®

"Boston Marathon Caregivers One Year Later: Moving Forward with Healing and Renewed Compassion"

Exclusively for hospital staff, first responders and medical-tent volunteers.

These confidential sessions will bring together caregivers who treated patients following the Marathon bombings to discuss how they're coping.

Sessions will be held:

Thursday, April 3rd
8:00–9:30am
Inn at Longwood Medical, The Fenway Room
342 Longwood Avenue, Boston
Register by March 27th

Wednesday, April 9th
6:00–7:30pm
Boston Park Plaza Hotel, Terrace Room
50 Park Plaza at Arlington Street, Boston
Register by April 2nd

Registration is required
Please e-mail schwartzcenter@partners.org with your: name; e-mail address; organization; and session(s) you plan to attend.

Your contact information will be used for registration purposes only.

Education in ExtraCorporeal Membrane Oxygenation

Save the date

24th annual SEECMO (Specialist Education for ExtraCorporeal Membrane Oxygenation) conference.

April 4–6, 2014
Omni Hotel
Providence Rhode Island

For ECMO specialists, respiratory therapists, nurses, perfusionists, and physicians who have an interest in the clinical application, research, and continuing development of ECLS.
Jointly sponsored by MGH, Rhode Island Hospital, and Yale New Haven Hospital.

For more information, or to register, go to: http://www.rhodeislandhospital.org/SEECMO_2014.html.

ACLS Classes

Certification:

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

Day one:
June 20, 2014
10:30am–5:00pm

Day two:
June 23rd
8:00am–1:00pm

Re-certification (one-day class):
April 9th
5:30–10:30pm

For information, call 617-726-3905.

Class locations will be announced upon registration.
To register, go to:
http://www.massgeneral.org/emergencymedicine/assets/Library/ACLS_registration_form.pdf.

Senior HealthWISE events

All events are free for seniors 60 and older

"Aging with a strong body"
Thursday, April 3, 2014
11:00am–12:00pm
Haber Conference Room
speaker: Jacobo Hincapie Echeverri, MD, geriatric fellow

"Protect yourself from financial frauds and common scams that target seniors"
Thursday, April 17th
11:00am–12:00pm
Haber Conference Room
speaker: Betsey Crimmons, senior attorney, Elder Abuse Prevention Project of Greater Boston Legal Services

"Careful, Careful, Don't Fall"
Thursday, May 1st
11:00am–12:00pm
Haber Conference Room
speaker: Bernardo Reyes, MD, geriatric fellow

For more information, call 4-6756.

Clinical Pastoral Education

Fellowships for Healthcare Providers

Three Schwartz Center fellowships are available for the fall, 2014, Clinical Pastoral Education Program.
This opportunity is available to clinicians from any discipline who work directly with patients and families and who wish to integrate spiritual caregiving into their professional practice.

Group sessions meet Mondays from 8:00am–5:00pm.
Clinical hours are negotiated.

Applications are due by April 18, 2014.

For more information call Reverend Angelika Zollfrank at 724-3227 or go to: MGHChaplaincyCPE.org.

Third Annual MGH Global Health Expo

Wednesday, May 7, 2014
1:00–3:00pm
under the Bulfinch Tent

Save the date for the annual MGH Global Health Expo, showcasing more than 25 departments, divisions, and organizations working in global health at MGH.

- Learn more about international and domestic opportunities for all staff
- Network with colleagues and meet new collaborators
- Enjoy food and refreshments

All are welcome.
Sponsored by the MGH Center for Global Health:
www.massgeneralcenterforglobalhealth.org

For more information, call 617-724-3194

Boston Strong MGH Proud T-shirts

Boston Strong/MGH Proud ribbons and pins will be available to mark the one-year anniversary of the Marathon bombings and celebrate runners of the Boston Marathon. Ribbons can be picked up at any of the special Marathon events (see schedule on page 17) and in the Employee Access Center beginning April 15th, Monday through Friday, 8:00am–4:30pm.

Boston Strong/MGH Proud and Boston+Mass General: Together We Finish T-shirts and other merchandise will be on sale at the MGH Gift Shop. A portion of the proceeds will go to support MGH marathon teams and the patients and departments they're running for.

For more information, call 617-643-9670.

Professional Achievements

Patten appointed

Annemarie Patten, RN, RRT, staff nurse, Cardiac SICU, was appointed a member of the Massachusetts Board of Respiratory Care, in February, 2014.

Reedenauer certified

Michelle Reedenauer, RN, staff nurse, Cardiac Surgery, became certified as a trauma nurse by the Emergency Nurses Association, in February, 2014.

Capasso certified

Virginia Capasso, RN, clinician nurse specialist, became certified as an adult clinical nurse specialist by the American Nurses Credentialing Center, in January, 2014.

Capasso

Virginia Capasso, RN, clinical nurse specialist, presented the keynote address, "Nursing Scholarship in Wound Healing—a Patient Journey," at the New Member Induction Ceremony of the Gamma Epsilon Chapter of Sigma Theta Tau International, at Northeastern University, February 21, 2014.

Arnstein elected

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, was elected a member of the Nominating Committee of the American Pain Society in Chicago, February 21, 2014.

Nurses present

Julie Cronin, RN, clinical nurse specialist, Gynecology/Oncology; Adele Keeley, RN, nursing director, Gynecology/Oncology; and, Katie Fauvel, RN, staff nurse, Gynecology/Oncology, presented, "The Phillips 21 CIT Experience," at the Care Innovations and Transformation Conference of the American Organization of Nurse Executives, in Ft. Lauderdale, February 12, 2014.

Vega-Barachowitz appointed

Carmen Vega-Barachowitz, CCC-SLP, director, Speech, Language, Swallowing & Reading Disabilities, was appointed a representative of the Joint Commission's Professional Technical Advisory Committee of the American Speech-Language-Hearing Association, in Rockville, Maryland, in February, 2014.

Vega-Barachowitz, was also appointed alternate representative of the Relative Value Update Committee of the Health Care Professionals Advisory Committee.

Adams appointed

Jeffrey Adams, RN, director of the Center for Innovations in Care Delivery, was appointed a member of the Board of the American Organization of Nurse Executives Foundation, in February, 2014.

Nurses publish

Lee Ann Matura, RN; Annette McDonough, RN; and, Diane Carroll, RN, recently authored the article, "Health-Related Quality of Life and Psychological States in Pulmonary Arterial Hypertension," in the *Journal of Cardiovascular Nursing*.

Adams publishes

Jeffrey Adams, RN, director of the Center for Innovations in Care Delivery, authored the guest editorial, "How do We Know if We're Innovating? A strategy for Innovation Evaluation in a Practice Setting," in the *Journal of Nursing Administration*, in February, 2014.

Adams also authored the article, "The Influence of Emerging Administrative Scientists: an Interview with Dr. Christopher Friese," in the *Journal of Nursing Administration*, in February, 2014.

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

Next Publication
April 24, 2014

Inpatient HCAHPS Results

2013–2014

Measure	2013	2014 Year to Date	2013-2014 Change
Nurse Communication Composite	81.9	82.7	+.8
Doctor Communication Composite	82.5	81.3	-1.2
Room Clean	74.5	74.0	- .5
Quiet at Night	50.2	49.8	- .4
Cleanliness/Quiet Composite	62.4	61.9	- .5
Staff Responsiveness Composite	64.7	63.0	- 1.7
Pain Management Composite	72.3	72.5	+.2
Communication About Meds Composite	65.5	69.2	+ 3.7
Discharge Information Composite	91.8	92.9	+ 1.1
Overall Rating	81.2	80.8	- .4
Likelihood to Recommend	90.4	90.9	+ .5

Data complete through November 30, 2013
All results reflect Top-Box (or 'Always' response) percentages
Pull date: January 16, 2014

2014 results reflect areas of progress and areas for continued improvement. Nursing Communication is at its highest level ever. Communication About Medicines and Discharge Information are very positive, and Pain Management is improving. We are seeing a slight decline in Staff Responsiveness and Quiet. Enhanced attention to Hourly Rounding and Quiet Times will help address these important measures.

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April 3,

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