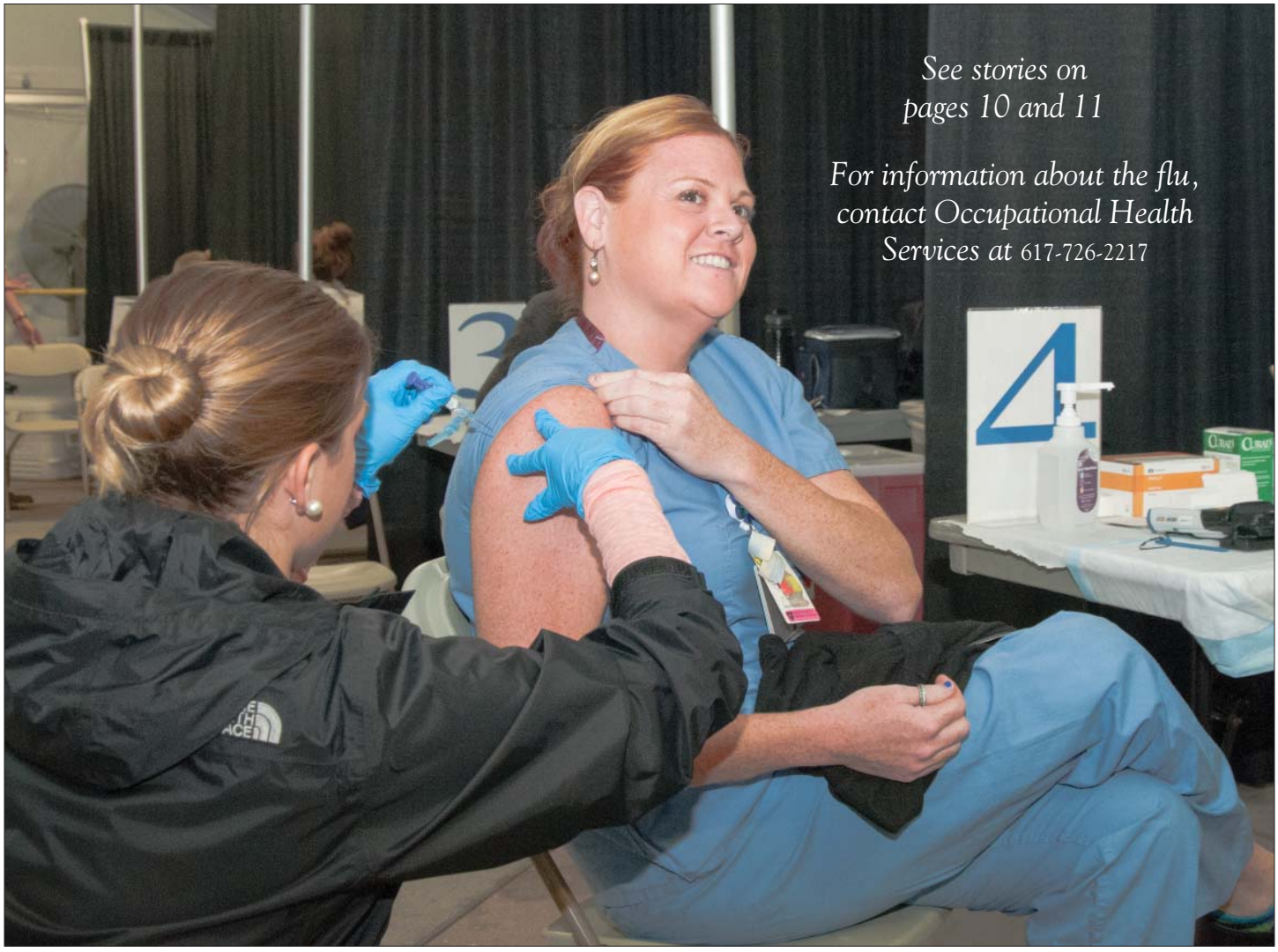
Caring Headlines
October 2, 2014

Flu season is here

The single most effective means of preventing the flu is getting a flu shot



See stories on pages 10 and 11

For information about the flu, contact Occupational Health Services at 617-726-2217

Radiologic technologist, Christin Ahern, RTR, does her part to keep patients safe; pictured above getting a flu shot from occupational health nurse, Corie Davison, RN.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Now more than ever, Innovation Units are key

helping to make care more effective, efficient, and affordable

Data collected pre- and post-Innovation-Unit launch and feedback from staff suggest a palpable change in organizational culture; a shared appreciation for the attending nurse role; and enhanced teamwork and collaboration among clinical disciplines.

Recently, the Patient Care Services Executive Committee came together for the first in a series of strategic planning retreats for 2015. It's a process we engage in every fall to ensure our efforts are aligned with the hospital's goals and our resources are appropriately and realistically allotted for the coming year. It's also an opportunity to look back at what we've accomplished, celebrate our successes, and take stock of the challenges ahead. As we considered the current environment, both inside and outside of MGH, I have to admit, it was difficult to prioritize with so many formidable projects on our to-do list: preparing for our next Joint Commission visit; optimizing patient flow; improving the patient experience; gearing up for our transition to Partners *e*Care; the imperatives put forth by hospital leadership to control costs, enhance the underpinnings of our mission, and realize the full potential of our workforce... to name only a few. Demands on our time and energy are substantial.

That's why, sitting in that conference room deliberating with my PCS colleagues, one thought kept coming back to me over and over: Now, more than ever, the work we're doing on Innovation Units is crucial. We set out to make care more effective, efficient, and affordable by introducing 'top-priority' interventions (see list on next page). We wanted the experience of every MGH patient to go smoothly from start to finish; we wanted patients to know who was taking care of them; and we wanted a coordinated, multi-disciplinary plan for a safe and timely discharge to start the moment patients set foot on the unit. I remember thinking of Innovation Units as a 'grand experiment' to improve clinical outcomes, enhance patient- and staff-satisfaction, and reduce costs and lengths of stay. Today, our experiment is yielding promising results.

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

Data collected pre- and post-Innovation-Unit launch and feedback from staff suggest a palpable change in our organizational culture; universal appreciation for the attending nurse role; enhanced teamwork and collaboration among clinical disciplines; and a positive impact on our bottom line.

Jeff Adams, RN, director of The Center for Innovations in Care Delivery, tells us that, "In looking at data from Phase I Innovation Units,

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each component of patient-satisfaction shows a clinically significant, positive trend following implementation of the fifteen interventions. And in the categories of Staff Responsiveness, Quiet in Room, and Room Cleanliness, there is a statistically significant increase."

We're seeing downward trends in falls; hospital-acquired pressure ulcers; catheter-associated urinary tract infections (CAUTIs); and central-line-associated bloodstream infections (CLABSIs). We're seeing improvement on our HCAHPS scores. When I go to patient-care units, I see cohesive teams caring for patients in new ways. I see clinicians who *know* their patients, and support staff who are integrally involved in daily operations. I see staff communicating with smart phones, bringing a whole new level of efficiency and responsiveness to patient care, not to mention quiet.

It's one thing to look at dashboards and graphs and see the progress we're making. It's quite another to see that look of trust on a patient's face, to hear the confident interaction of clinicians during inter-disciplinary rounds, or to imagine the number of falls we're preventing by checking on patients at regular intervals with hourly rounding.

We set out to re-design care in a way that would improve the patient experience, reduce costs through standardization when appropriate, and utilize our human and technological resources to do the greatest good for patients and staff.

It's still early in the Innovation-Unit story. But by all meaningful indications, this story has a happy ending.

We're all busy. There's much good work going on behind the scenes. Which is why now, more than ever, Innovation Units are key. This is where our ideas, abilities, and creativity are coming together to make a difference for patients and families.

Innovation Unit Interventions

- Adopt a philosophy of relationship-based care
- Implement attending nurse role
- Have attending nurses use business cards
- Enhance hand-over communication
- Articulate estimated discharge date and disposition upon admission
- Create a Welcome Packet
- Ensure across-the-board understanding of each discipline's domains of practice
- Implement daily inter-disciplinary rounds
- Introduce smart-phone technology
- Utilize wireless tablets and/or computers
- Implement quiet hours
- Implement hourly rounding with the Four Ps
- Install in-room white boards
- Install electronic white boards
- Conduct follow-up discharge phone-calls

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In this Issue

The AMMP Scholarship Program

helping to bridge the education gap

— by Waveney Small Cole, AMMP Scholarship Committee chairperson

Once again this year, the Association of Multicultural Members of Partners (AMMP) made it possible for a number of MGH employees to pursue higher education through its annual AMMP Scholarship Program. At this year's scholarship presentation ceremony, September 4, 2014, seven MGH employees were awarded scholarship funds: Thaisha Guerrier, Tirza Martinez, Abdul Musanur, Jennifer Nunes, Karima Ricketts, Rozanna Riley, and Sandra Thomas.

AMMP Scholarship Committee chairperson, Waveney Small Cole (right), presents Rozanna Riley with certificate of achievement.

(Photos by Walter Reeves)

AMMP chairperson, Dianne Austin, welcomed recipients and applauded their efforts to expand their knowledge through higher education. Jeff Davis, senior vice president for Human Resources, congratulated recipients, noting the value and security that comes with advancing one's education. Said Davis, "The more education you have the more employable you are and the more job security you have." Davis thanked Waveney Small Cole for her service as chair of the AMMP Scholarship Program for the past four years.

In recognition of their accomplishments, Small Cole read excerpts from the applications of the recipients. Tirza Martinez, patient care associate on the White 9 Medical Unit, wrote, "Life is full of unexpected twists and turns, but with determination I will reach my goal of becoming a nurse."

Jennifer Nunes, senior clinical research associate, is pursuing a degree at Northeastern University. Nunes wrote, "I am very appreciative of the AMMP scholarship. Not only does it give me financial assistance, it's inspiring to know that AMMP sees the potential in me that I see in myself."

Rozanna Riley, practice access coordinator for Physical Therapy Services, is enrolled in a degree program at Northeastern University. She wrote, "Is there ever going to be a light at the end of this tunnel?"

Said Small Cole, "We hope this scholarship helps Rozanna find that light."

Karima Ricketts, supervisor in the MGH Center for Integrated Diagnostics, is pursuing a degree at

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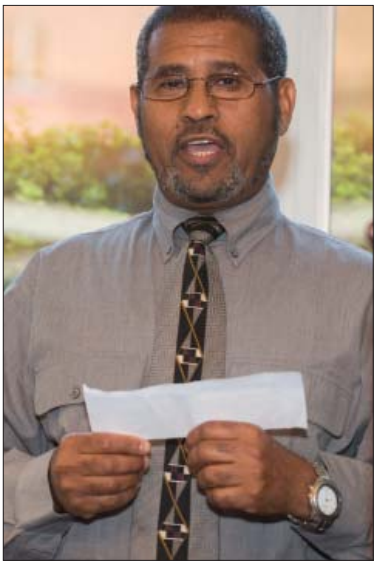
Simmons College. Wrote Ricketts, "People tell me my goals aren't possible. But I'm confident in my abilities."

Sandra Thomas, administrative assistant in the PCS Office of Quality & Safety, is pursing an undergraduate degree at the University of Massachusetts. Thomas is grateful for the support she's received. Wrote Thomas, "I have invested seventeen years at MGH, and MGH has invested seventeen years in me."

In 2011, Small Cole introduced a new component to the scholarship ceremony called, a 'drop of culture,' where scholarship recipients share some aspect of their culture so those present can get to know more about their customs and traditions. Abdul Musanur, distribution handler in the Materials Management Receiving Department, shared, "As an Eritrean (small country in eastern Africa), we celebrate sunset breakfast during the holy month of Ramadan. When fasting begins, we make a special dinner for friends and neighbors. Our famous dish is injera (soft homemade bread) with doro wot (chicken with spicy sauce and boiled eggs), and rice with meat and beans. After dinner, we have a special cultural coffee ceremony."

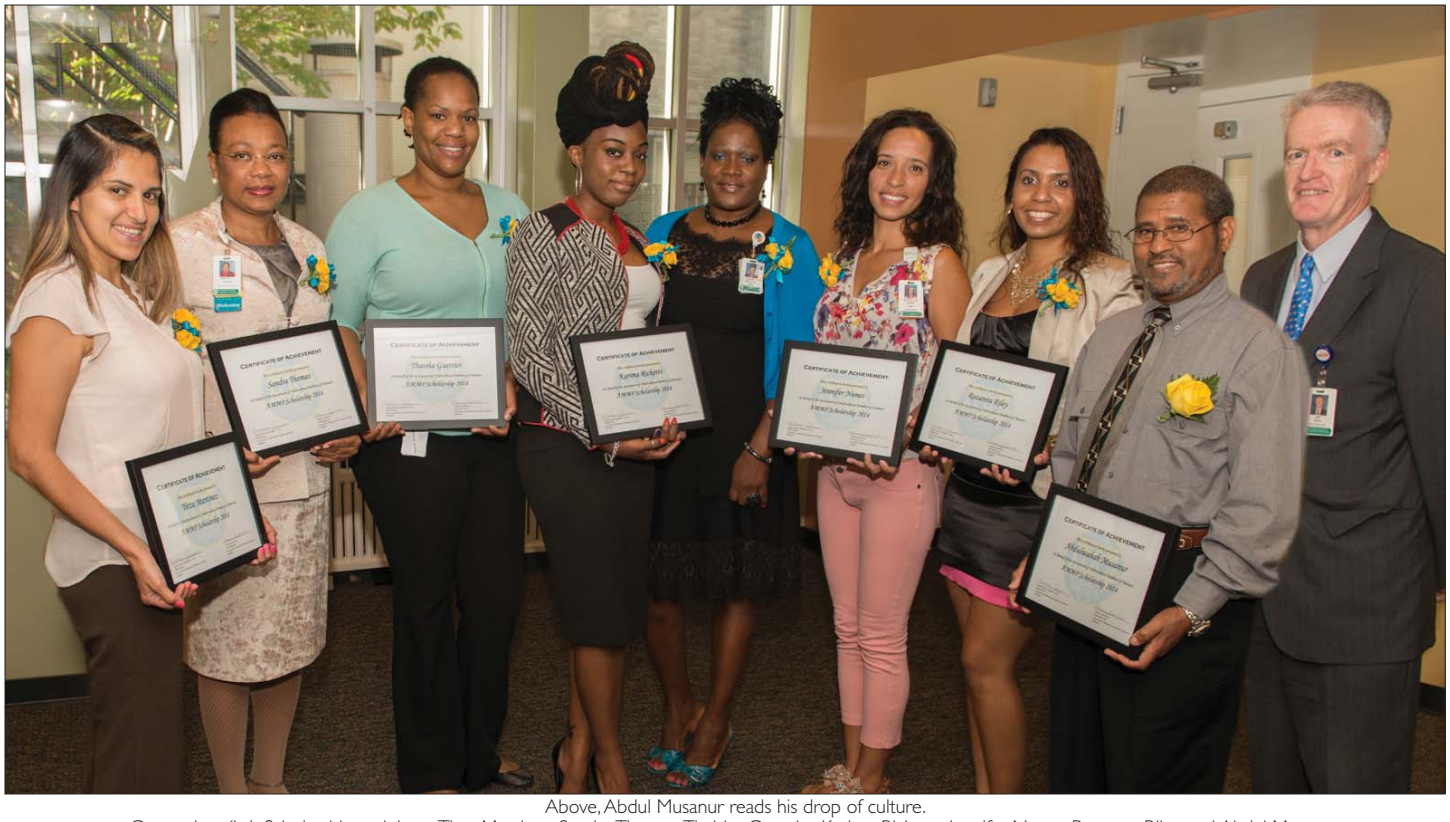


Thaisha Guerriera, administrative assistant in the Department of Medicine, shared, "In Haiti, it is tradition to serve soup joumou (pronounced joo-moo) on January first to celebrate the New Year and commemorate the date of Haiti's liberation from France. Soup joumou is pumpkin or winter squash soup made with vegetables, pasta, and beef."

AMMP has long recognized the importance of advancing education, but giving back to the MGH community is an equally important part of the AMMP Scholarship Program. Tirza Martinez, four-time AMMP scholarship recipient, shared, "I look for ways to give back to AMMP and the MGH community, and I can honestly say, each time I volunteer, it is very gratifying."

Said Sandra Thomas, "Over the years, I've served on the AMMP Nominating Committee, the Membership Committee, and the Scholarship Selection Committee. I'm pleased to give back to an organization that has given me so much."

For more information about the AMMP Scholarship Program, e-mail: phsammp@partners.org.



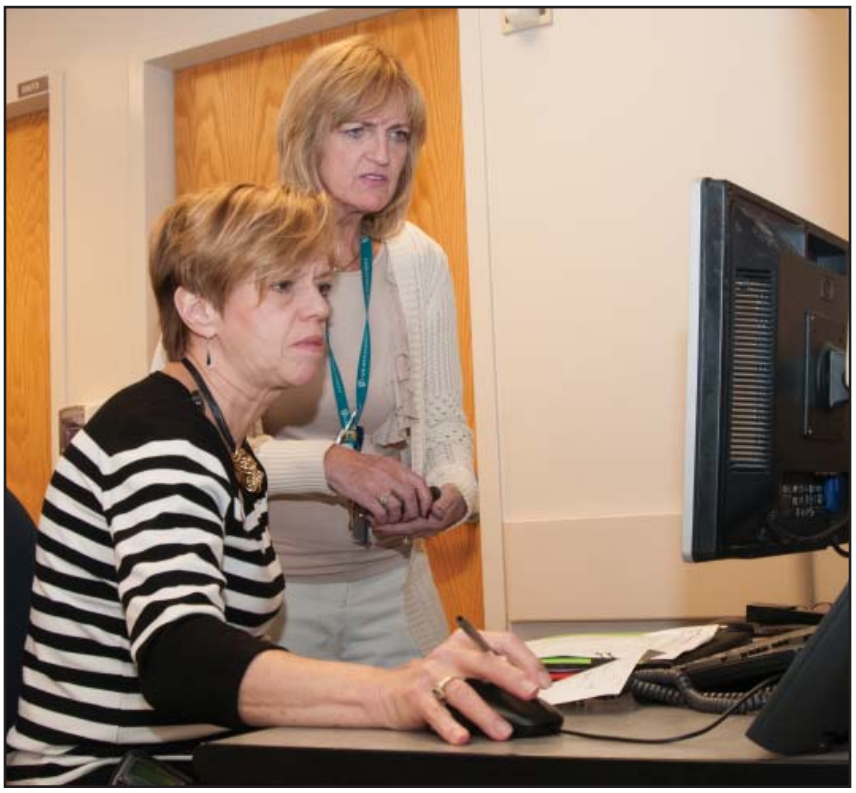
Above, Abdul Musanur reads his drop of culture.
Group shot (l-r): Scholarship recipients, Tirza Martinez, Sandra Thomas, Thaisha Guerrier, Karima Ricketts, Jennifer Nunes, Rozanna Riley, and Abdul Musanur, with Small Cole (center), and Jeff Davis, senior vice president for Human Resources (right).

Case Management at MGH

—by Janice LaMontagne, RN, case manager

This October, Case Management celebrates its 19th year at MGH, and it has been a year of many changes within the department. In December, we began documenting in *e*Bridge, the electronic medical record, making case-management documentation accessible to all clinicians at MGH.

In February and March, we switched from M-CAP to Interqual Clinical Review as our utilization review tool. This required extensive training and monitoring and utilization-review is now done entirely on-line.



Case managers, Brenda Donovan, RN (seated), and Beth MacLellan, RN, confer before going in to meet with patient in the Emergency Department.

In May and June, when the Partners *e*Care revenue cycle went live at MGH, we were able to adopt a more standardized approach to case management throughout Partners.

And in August, Case Management returned to a dyad approach, where some case managers focus on utilization-management while others focus on discharge-planning with direct patient contact.

Change is often accompanied by stress. I've worked in many settings across the state as a nurse case manager, and I've never seen a group of people handle change as well as the Case Management Department at MGH. The focus is, and always will be, the patient.

Maria Seavey, RN, is case manager for the Emergency Department, the ED Observation Unit, and the Short Stay Unit. She works in partnership with Dawn Williamson, RN, addictions nurse, developing acute care plans for patients who suffer from substance abuse, psychiatric disorders, or who are homeless. Last spring, Seavey was invited to present a poster at the American Case Management Association annual conference. Following, is one of the cases she presented.

Mr. Q, suffered from mood disorder, hypertension, atrial fibrilation (not on Coumadin due to falls), chronic pain, alcohol- and benzodiazepine-abuse, had numerous ED presentations with a wide range of mental-health, substance-use, cardiac, and pain-related issues. Mr. Q would be brought to the ED, refuse treatment, and leave against medical ad-

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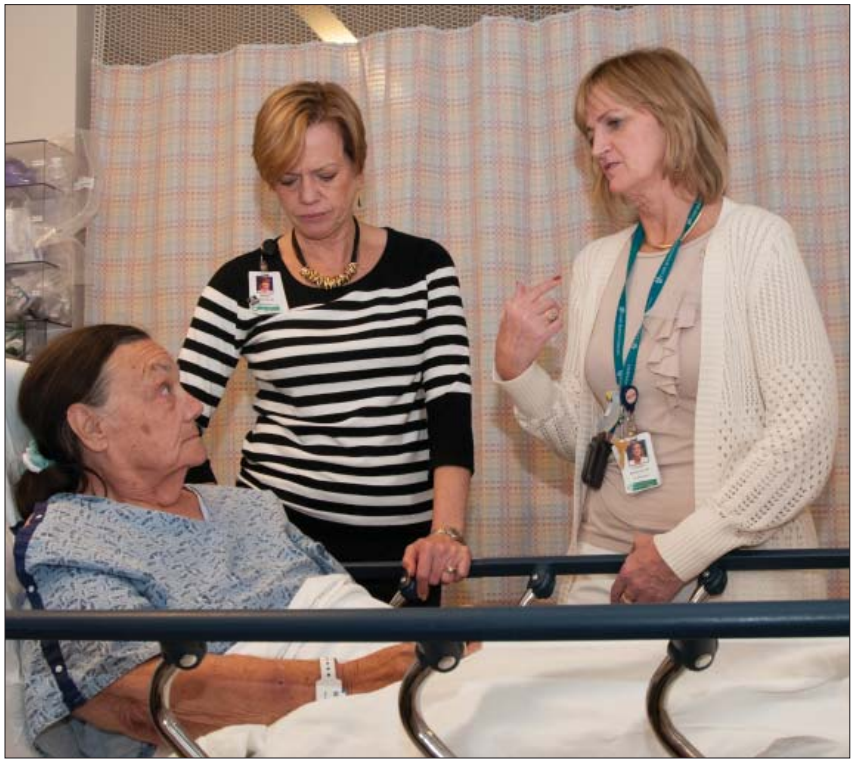
vice. Serious depression with paranoia prevented him from allowing visiting nurses into his apartment. He was non-compliant with cardiac meds but took large doses of Klonopin that exacerbated his cardiac issues.

Acute care plan for Mr. Q:

- Medical stabilization of paroximal atrial fibrilation
- Treat for Klonopin withdrawal
- Hold for psychiatric evaluation as his judgment is declining and his impairment puts him at risk for harm
- Assist with placement for addictions treatment and paranoia
- Encourage nursing-home placement or assisted living

Mr. Q completed admission for psychiatric and addiction treatment. Afterward, he was less paranoid and expressed a desire to remain sober. He was accepted at an assisted-living facility where he is thriving.

Case manager, Beth MacLellan, RN, works in the Integrated Care Management Program (ICMP) overseeing the skilled-nursing-facility waiver program. Certain ICMP patients who require rehab but don't need to be admitted to the acute-care setting can have their Medicare three-day qualifying stay waived. Recently, waivers have also been extended to patients who are part of an accountable care organization (ACO), have a Partners physician, or are on Medicare. Recently, MacLellan placed an ACO patient from the patient's home directly into a skilled nursing facility using the new waiver parameters. This was a first for the waiver program.



Donovan and MacLellan conduct case-management assessment of patient in the ED.

Mrs. L was a 91-year-old, fiercely independent woman who lived in her own elevator-accessible apartment in the North End. At baseline, she performed activities of daily living independently, prepared meals, and went shopping with her daughter. She used no ambulation devices and enjoyed being outdoors.

Mrs. L presented to MGH after a fall at home that dislocated her shoulder. She was in terrible pain, and her balance was off as a result. She was definitely a candidate for rehab, and luckily, she was part of the Partners ACO program, making her eligible for a waiver and admission to a skilled nursing facility without a three-day qualifying stay. MacLellan met Mrs. L in the ED Observation Unit. Despite the efforts of the unit-based case manager, Mrs. L's daughter, and MacLellan, they were unable to convince Mrs. L to go to a skilled nursing facility for rehab. Visiting-nurse services were arranged, and Mrs. L was able to go home.

The next morning, MacLellan received a call from Mrs. L's daughter saying things weren't going well at home, and Mrs. L was now amenable to going to rehab. MacLellan was able to transfer Mrs. L to a facility in Peabody under the extended waiver parameters. Mrs. L was at rehab for ten days before transitioning home, where she has remained since discharge.

In both of these situations, the role of case manager was vital to ensuring the health and safety of the patient. Case Management operates smoothly and efficiently in large part because of a dedicated support staff, the clinical leadership of Rachael McKenzie, RN, and Debra Connolly, RN, and director, Nancy Sullivan.

This year, our celebration of Case Management Week begins Friday, October 10th, with a poster presentation in the Main Corridor. Posters will be on display until Friday, October 24th. A Case Management information table will be set up in the Main Corridor on October 14th and 16th.

For more information, call the Case Management Department, at 617-726-3665.

Listening, learning, at the heart of meaningful pastoral care

When I called to find out the circumstances, the nurse informed me I'd be seeing Mrs. W, a woman in her early 80s who was transitioning to hospice care. Mrs. W was comfortable and sedated.

My name is Ben Lanckton; I am a rabbi and Jewish chaplain at MGH. One afternoon recently, I received an urgent page to see a Jewish patient on the Lunder 9 Oncology Unit. When I called to find out the circumstances, the nurse informed me I'd be seeing Mrs. W, a woman in her early 80s who was transitioning to hospice care. Mrs. W was comfortable and sedated. Two of her three adult daughters were with her and had asked if I would come and pray with them. I stopped by the chapel and got a prayer book for my visit.

I entered Mrs. W's room with the prayer book, known in Hebrew as a siddur, in hand. Both daughters expressed gratitude for my coming. I asked if it would be okay if I sat so I could learn a little about them and their mom. They invited me to sit. To get a sense of their background and the context of this experience, I began by asking if their mother's illness had come on suddenly.

Gently finishing each other's sentences, the two daughters explained that their mother had been healthy for most of her life, she'd been diagnosed just a few weeks before, and had taken a turn for the worse in the past few days. They were sad and solemn, but not upset. Both from their words and affect, I saw that they had come to grips with the fact that their mother was, after a long life, going to die; they were concerned that she not suffer and that her death happen in a spiritual context.

Rabbi Ben Lanckton, chaplain

I asked them how religion had been part of their mother's life. I always try to phrase this as neutrally as possible but in a way that invites a broad variety of answers. The daughters were clear and united in their response. Their mother had not been religious in the traditional sense—observing the rituals and rules of Jewish tradition. But Jewish holidays, culture, and especially her love of Hebrew music and language were important to her, things she connected with on a very deep level.

I learned that one of the daughters attended synagogue in New York City where I had done my internship, a place where modern musical renderings of ancient Hebrew prayers were an essential part of the worship experience. Our conversation digressed for a while as we exchanged stories of common "Jewish geography." I find these diversions often help establish trust and connection more effectively than clinical conversations. One of my best teachers in chaplaincy practices, Ron Hindelang, imbued in me the importance of relationship before everything.

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I invited them to recite a prayer. They were amenable, and I suggested the Mi Shebayrach, which translates to, "the One Who blessed," as in the One Who blessed our ancestors with healing mercy. They recognized the prayer. I took a moment and explained a distinction that my teacher, Rabbi Amy Eilberg, likes to make—we can pray for healing even when physical cure is not likely, because spiritual healing is always possible. Then I asked for their mother's Hebrew name, which as I anticipated, they knew. I asked for their grandmother's (the patient's mother's) Hebrew name, because we pray in the name of the woman whose womb nurtured this person from almost nothingness to personhood. I chanted the blessing from memory in Hebrew then recited the translation in English. I told them they could page me any time, and I left the siddur (prayer book) with them so they could recite the prayers of their choosing after I left. I let them know I'd return the next day to check on them.

As it turned out, they urgently paged me the next morning at 9:45. Mrs. W was declining. I got my rabbi's manual and went to the room as fast as I could. I found Mrs. W surrounded by all three of her daughters and her male companion of 20 years. The nurse came in and out of the room at regular intervals to check on Mrs. W's pain medication. Based on previous experience, I asked if there was a need to say the final confession, the only 'last prayer' we have in Judaism. The daughters agreed that that would be too traditional for their mother, but they felt she would enjoy the prayer I sang the day before. They asked if I'd sing it in Hebrew for her again. The essential last words a Jew is supposed to pronounce before dying are from the Torah, a verse called, the Sh'ma, which translates to, "Hear O Israel, the Lord is our God, the Lord is One." I suggested it might be appropriate for me to sing the Sh'ma. The daughters and Mrs. W's companion held hands around her as I closed my eyes and sang the tune, almost as a lullaby.

The four non-patients in the room clearly appreciated the verse, and I could only hope it was helping Mrs. W, as well. I picked up the siddur and found Psalm 23, "The Lord is my Shepherd," a psalm Jews often use at funerals and other sad occasions. I asked if I could read it in English, then sing it in Hebrew, and once again the group agreed and took hands. Mrs. W's breathing was barely audible. I read the psalm in English, then closed my eyes and sang in Hebrew. Just as I finished the psalm, which includes the much-quoted line, "Yea, though I walk through the valley of the shadow of death, I will fear no evil, for You are with me," one of the daughters said, "I think she's gone."

The nurse came in and verified that Mrs. W had stopped breathing. Calmly and serenely, she had died during the reading of the psalm. The family hugged each other, then me, and wept softly. I led them in one of the strangest yet most needed blessings in the Jewish tradition, the blessing for bad news: "Baruch Dayan Ha'emet—blessed is the True Judge."

Experience has shown me that once death has occurred, the family needs time to be by themselves, both to absorb the loss and to begin to prepare for the funeral and burial. I made sure they had a way to get in touch with me and the name of a Jewish funeral home, then I wished them a Shabbat Shalom.

A few hours later, one of the daughters called and asked if I would do the funeral service. Unfortunately, I was unavailable, but I arranged for one of my chaplain colleagues to do the service, and I was told she did a very good job.

This experience reinforced for me the value of listening. Taking the time to listen to Mrs. W's daughters on my first visit gave me a clear picture of her life and preferences. Allowing the daughters to decline the 'final confession' actually cleared the way for a much more meaningful, end-of-life prayer experience. On a mystical level, I can only imagine that Mrs. W, beginning her journey to the next world while listening to that ancient song, was as close to God's comfort as she'd ever been in her time on this earth.

This experience reinforced for me the value of listening. Taking the time to listen to Mrs. W's daughters on my first visit gave me a clear picture of her life and preferences. Allowing the daughters to decline the 'final confession' actually cleared the way for a much more meaningful, end-of-life prayer experience.

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

Rabbi Lanckton's narrative is instructive not only in end-of-life traditions of the Jewish faith, but in the importance of clergy and clinicians understanding a patient's faith traditions, or lack thereof. Ben let Mrs. W's daughters lead his understanding of the place religion held in their mother's life. Open-ended questions and a non-judgmental approach encouraged engagement. At the end of her life, Mrs. W and her family were comforted by the beliefs and traditions she had always held dear.

Thank-you, Ben.

Preparing for Influenza Season

protecting patients and staff

—provided by Infection Control

The single most effective means of preventing the flu is getting a flu shot each year. Vaccination is essential for healthcare workers. The National Quality Forum has included vaccinating healthcare workers against influenza as one of its *30 Safe Practices for Better Health Care.*

Protecting patients and families is our highest priority at MGH. As we enter influenza season, it's important for staff to understand how to protect themselves and their patients from influenza, or the 'flu.' Influenza is a highly contagious, viral, respiratory illness that usually appears in late fall and lasts through early spring. Some people don't think of influenza as a serious illness, but every year more than 200,000 people in the United States are hospitalized, and as many as 36,000 die from influenza-related issues. The single most effective means of preventing the flu is getting a flu shot each year. Vaccination is essential for healthcare workers. The National Quality Forum has included vaccinating healthcare workers against influenza as one of its *30 Safe Practices for Better Health Care*.

Flu vaccine is offered free of charge to all MGH employees. Everyone who is able to receive the vaccine is expected to be vaccinated. Staff can receive the vaccine by contacting the flu champion on their unit or going to Occupational Health Services at 165 Cambridge Street, Suite 404. Walk-in hours are between 7:00am and 5:00pm, Monday through Friday. Appointments can be arranged by calling 617-726-2217. For information on staff flu-shot clinics at MGH satellite locations, call 617-726-2217.

The Centers for Medicare and Medicaid (CMS) and the Massachusetts Department of Public Health (MDPH) mandate that all hospitals report their healthcare-worker vaccination rates and post these rates publicly. Employees vaccinated by Occupational Health or a flu champion will have their vaccine documented in PeopleSoft and their Occupational Health record for them. Employees vaccinated elsewhere or declining vaccine need to go to PeopleSoft and document their status themselves (go to Partners Applications>PeopleSoft>HRMS Production>Main Menu>Self Service>Personal In formation>Vaccinations.

Staff who don't receive flu vaccine must adhere to the MGH mask policy, which is activated when flu begins to circulate in the community. This policy requires that masks be worn by un-vaccinated staff when providing patient care. Un-vaccinated staff can potentially incubate the flu before symptoms begin and unwittingly expose patients to the flu, which can be spread up to 24 hours before the onset of symptoms. A notice will be sent to all staff when this policy goes into effect. For un-vaccinated staff, wearing a mask is required to protect patients from potential exposure. This year, vaccinated healthcare workers will be identified by a pink sticker on their ID badges.

A link to detailed information on isolation precautions for flu patients and other flu-related information can be found on the MGH Influenza Information SharePoint site (accessible on your computer desktop by clicking Start>Partners Applications>Clinical References>MGH Influenza Information.

For more information on the flu or our precautions for the 2014-2015 flu season, call Occupational Health Services at 617-726-2217.

Frequently asked questions about the flu

separating fact from fiction

—provided by Infection Control

Question: Is it true that the flu vaccine can cause influenza?

Answer: No. This is a common misconception. The injectable influenza vaccine contains only dead viruses and cannot cause influenza. You may experience mild soreness at the injection site, which should subside within 24 hours.

Question: If I get the seasonal flu vaccine in the fall, will I be protected through the winter?

Answer: Yes. Immunity from the vaccine lasts up to a year.

Question: What should I do if I start feeling sick and think I might have the flu?

Answer: If you develop a fever and a cough, sore throat, or muscle aches, stay home and contact Occupational Health Services at 617-726-2217. If you become ill at work, immediately stop working, don a mask, notify your supervisor and Occupational Health Services, and go home.

Question: How long do I need to stay out of work?

Answer: You will need to remain out of work for at least 24 hours after resolution of fever, without the use of fever-reducing medicines, such as acetaminophen. Staff should not care for patients in Protected Environment rooms (e.g., bone-marrow-transplant patients) for seven days or until resolution of symptoms, whichever is longer. Staff should contact Occupational Health Services before returning to work if out of work for more than five days.

Question: Is there anything I can do besides getting a flu shot to prevent the spread of flu?

Answer: Yes, there are several ways staff can help prevent the spread of flu:

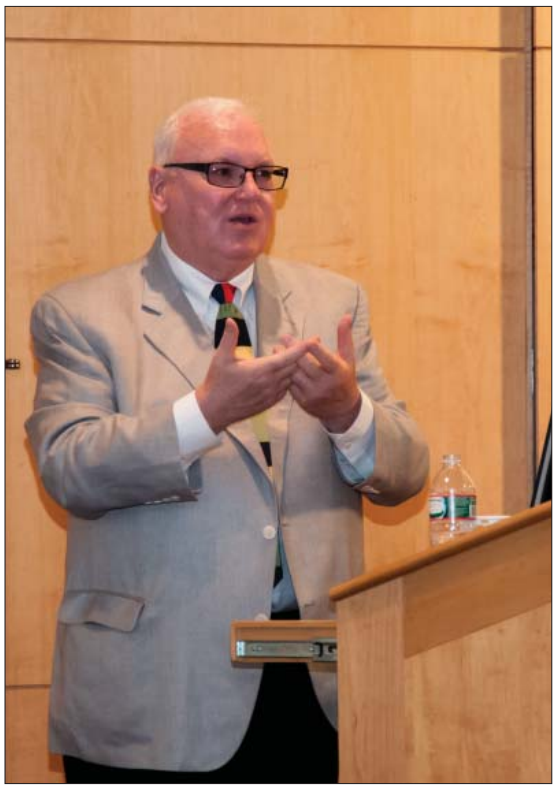
- Hand hygiene is key to minimizing the risk of infection from flu. Using an alcohol-based hand sanitizer, like Cal Stat, is effective in reducing the transmission of the flu virus and should be used frequently. It should always be used before and after contact with a patient or with the patient's environment
- Friends and family members who are ill should be encouraged to delay their visits until they're no longer ill. Educate patients and families regarding good cough etiquette—cough or sneeze into a tissue and dispose of it immediately; alternatively, cough into your upper sleeve. Clean hands immediately after coughing and sneezing using Cal Stat or by washing with soap and water. Avoid touching eyes, mouth, and nose
- Staff should not come to work if they have a fever of 100.5° F or higher and one or more of the following symptoms: runny nose, nasal congestion, sore throat, cough, or body aches
- Staff who have the flu are required to remain out of work until the fever is gone for 24 hours without the use of anti-fever medication

For more information, call Occupational Health Services at 617-726-2217

Norman Knight Visiting Scholar

—by Mary Ellin Smith, RN, professional development manager

On Thursday September 4, 2014, Michael Bleich, RN, Maxine Clark and Bob Fox dean, professor, and president of the Goldfarb School of Nursing at Barnes-Jewish College, spent the day at MGH as this year's Norman Knight visiting scholar. Bleich's focus was on the collaborative work being done by MGH and the MGH Institute of Health Professions to create an inter-professional education model.



Michael Bleich, RN, Maxine Clark and Bob Fox dean, professor, and president of the Goldfarb School of Nursing at Barnes-Jewish College, this year's Norman Knight visiting scholar.

Bleich met with members of the MGH-IHP Inter-Professional Education Steering Committee, observing that their model is further along than many in the country. He noted the importance of role-clarification among faculty members and recommended focusing on the goals of each discipline, which can sometimes be in opposition. This would give students an opportunity to see how each discipline moves from conflict to resolution.

Currently, MGH has two inter-professional education units: Bigelow 11, a general medical unit, and Ellison 8, the post-cardiac-surgery unit. Bleich visited both areas and spent time talking with leadership and staff. In addition to brainstorming and problem-solving with them, Bleich offered an innovative idea—students should write narratives from the patient's point of view. The idea being that putting themselves in their patients' 'shoes' would give them an awareness of what patients hear, any inconsistencies in the plan, and where disciplines send different messages.

Bleich met with an inter-disciplinary group of attending nurses and clinical instructors from the inter-professional education units and had a chance to hear about their experiences with the model and ideas for improving it. He suggested students shadow attending nurses to see the levels of collaboration among disciplines.

The visit culminated with Bleich's presentation, "Strengthening Inter-Professional Engagement." Building on the events of the day, Bleich cautioned that all disciplines need to be aware of the mental models they bring to the bedside—models shaped by history, science, gender and status, recognizing that these mental models give us greater awareness of the shift from single-discipline to inter-professional practice.

The Knight Visiting Scholar Program is made possible through the generosity or Mr. Norman Knight and supports nationally recognized nursing scholars coming to MGH to share their knowledge and expertise through consultation, teaching, mentorship, and research.

For more information about the Knight Visiting Scholar Program, call Mary Ellin Smith, RN, professional development manager, at 617-724-5801.

Safe Patient Transport

Enhancing the safety of patients who come to MGH for diagnostic testing or appointments

Approximately 29,000 patients are transferred to MGH for diagnostic tests or appointments each year. The Safe Patient Transport initiative strives to ensure these patients receive the safest possible care while they're at MGH.

Question: I've heard there's an initiative to improve the safety of patients temporarily transferred to MGH from other institutions?

Jeanette: Approximately 29,000 patients are transferred to MGH from other institutions for diagnostic tests or appointments each year. The Safe Patient Transport initiative strives to ensure these patients receive the safest possible care while they're at MGH.

Question: What, specifically, is the goal of the Safe Patient Transport initiative?

Jeanette: The goal is the same as what we strive for every time a patient is transferred from one caregiver to another—the appropriate transfer of information to ensure the safety of each and every patient in our care.

Question: What is the process?

Jeanette: First, a warm hand-over. Staff at the referring institution call the receiving location at MGH, clearly defining the status of the patient. Staff at MGH provide appropriate instruction regarding preparation for the appointment. Staff at the referring institution are asked to complete a transfer form detailing the patient's status and any potential concerns (similar to the 'Ticket to ride' process here at MGH when patients are sent from medical/surgical units for diagnostic tests). Staff at MGH ensure an appropriate hand-over back to the referring institution when the patient returns.

Question: Does the process differ for more vulnerable patients?

Jeanette: We estimate that about 5% of the 29,000 patients temporally transferred to MGH are highly vulnerable. This includes patients who:

- require a cardiac monitor
- have an artificial airway (endotracheal or tracheostomy tube)
- require mechanical ventilation (invasive or non-invasive)
- require more than 50% oxygen to keep their SpO_2 greater than 90%
- receive continuous infusions
- are disorientated, unable to communicate, or comatose
- are totally or significantly dependent

For highly vulnerable patients, we ask the referring institution to send a clinician capable of providing the necessary care to accompany the patient.

Question: Is there anything else we should know?

Jeanette: Everyone can help by ensuring we provide a proper hand-over when transferring patients regardless of location or circumstances. In the near future, information about the Safe Patient Transport initiative will be part of the discharge packet for all patients transferred from MGH to other institutions.

For more information, call Bob Kacmarek, RRT, director, Respiratory Care Services, at 617-724-4490.

Announcements

Senior HealthWISE events

All events are free for seniors 60 and older

"Swallowing Over 60"
Thursday, October 2, 2014
11:00am–12:00pm
Haber Conference Room

Speaker: Stacey Sullivan, SLP, speech-language pathologist, will discuss normal changes in swallowing as we age, signs of swallowing problems, and evaluations by a speech pathologist.

"Hip and Knee Arthritis: Options for Staying Healthy"
Thursday, October 16th
11:00am–12:00pm
Haber Conference Room

Speaker: Jonathon Spanyer, MD, fellow, department of Orthopedic Surgery, will talk about symptoms, diagnosis, and treatment options for hip and knee arthritis.

"Rejuvenate Your Brain"
Thursday, November 6th11:00am–12:00pm
Haber Conference Room

Speaker: Marie Pasinski, MD, neurologist, will provide tips to rejuvenate your brain at any age. Learn how to boost your memory and brain power. Investing in your brain is the most important investment you can make!

For information on any of the above events, call 4-6756.

ACLS Classes

Certification:

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

Day one:
November 6, 2014
8:00am–3:00pm

Day two:
November 7th
8:00am–1:00pm

Re-certification (one-day class):
October 8th
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.

New Fibroid Program at MGH

Radiology and Obstetrics & Gynecology are introducing the new Fibroid Program to provide access to a multi-disciplinary team of specialists who collaborate to offer a full range of treatments for women with uterine fibroids. A nurse coordinator helps navigate care throughout the course of treatment, including scheduling and connecting patients to available resources.

Treatments and services include:
- Diagnostic imaging
- Minimally invasive surgery
- Image-guided procedures

Consultations are available on Tuesdays from 8:00am–12:00pm in the the Yawkey 4 OB-GYN suite.

For more information go to: massgeneral.org/fibroids.
For appointments, call 857-238-4733 or submit an on-line appointment request.

New Pneumonia Patient-Education Material

To see the new patient-education document on pneumonia, go to: http://handbook.partners.org/content/pdf/MGHPtEdDischPneumonia.pdf. Or go to Partners Applications, Clinical References, Partners Handbook, and follow the prompts to Patient Education Documents, Respiratory. Document contains information on:

- Prevention
- What to expect
- When you're doing well
- When and whom to call when you're not doing well
- Follow-up appointment details
- Definition of pneumonia

Provider Order Entry (POE) began supporting the new pneumonia patient-education document (for adult patients 18 years old or older) on September 30th. POE now prompts clinicians similar to the way they're prompted for heart-failure patients, with a link to open the document directly.

For more information, contact:
Michelle Anastasi, RN, at 617-724-1582;
Monica Staples, RN, at 617-643-5059;
or Deb Connolly, RN, at 617-724-9499.

Disability Champion Award

Call for Nominations

Join the MGH Employee Disability Resource Group (EDRG) for the second annual presentation of the Disability Champion Award at the:

Breakfast of Champions
October 21, 2014
8:00am
East Garden Dining Room

Nominate someone who:
- goes above and beyond to help individuals with disabilities
- always takes time to make sure patients have the resources they need

Nominees must have at least one year of continuous service and be full- or part-time employees in good standing. Nominees must meet at least one of the following criteria:
- Shows extraordinary commitment to disability issues/persons with disabilities beyond the duties and responsibilities associated with their job
- Enhances the experience of patients, staff, families, and visitors with disabilities
- Fosters relationships to strengthen the hospital's commitment to persons with disabilities

To nominate a colleague, go to: sharepoint.partners.org/mgh/mghedrg, or e-mail MGHEDRG@partners.org for more information.

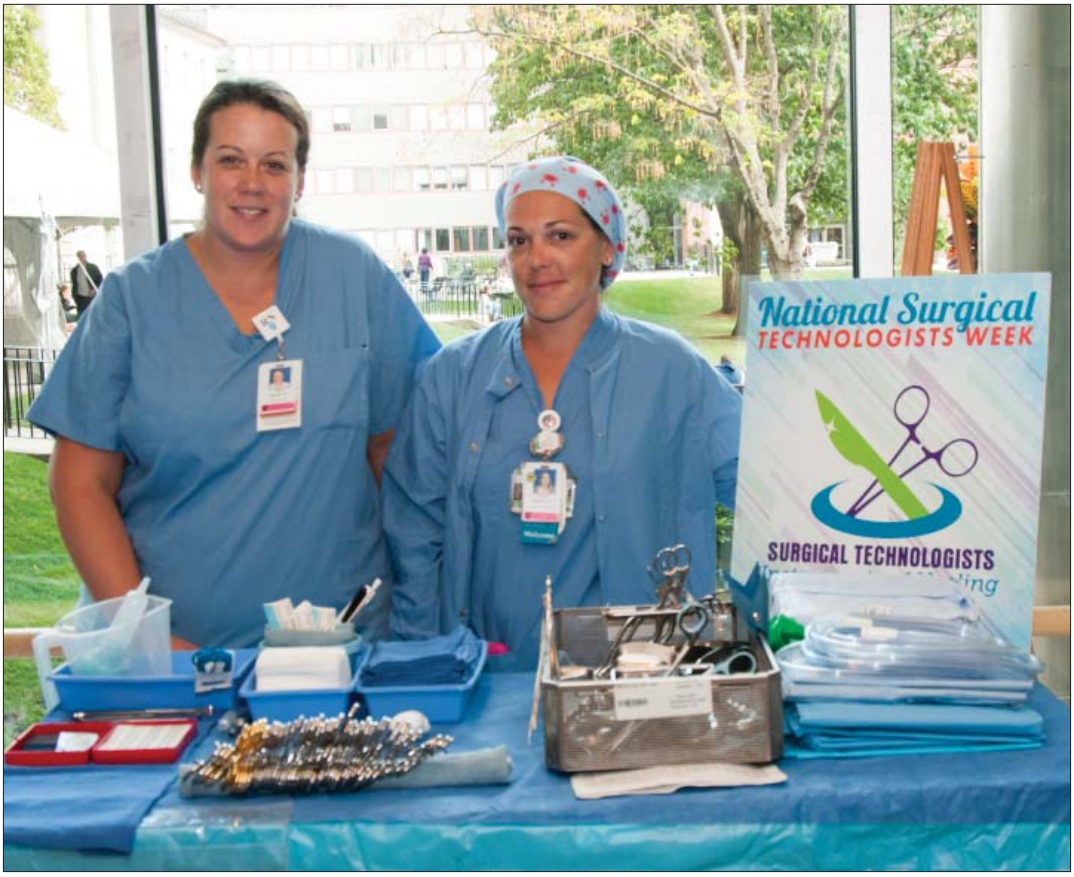
New Hand-Over Tool

Surgical Technologists Week

celebrating vital members of the operating-room team

September 21–27, 2014, the MGH community celebrated the many contributions of surgical technologists during National Surgical Technologists Week. Surgical technologists help create an optimal environment in the operating room, functioning in a sterile capacity during surgical procedures and performing other non-sterile duties throughout the day. There are more than 400 accredited surgical technologist programs in the United States.

For more information on the role of surgical technologists or a list of accredited programs, call Patrice Osgood, RN, at 617-724-3604.



Surgical technologists, Keri Beaver, RN (left), and Natalie Serrano, CST, staff educational booth in the Main Corridor during Surgical Technologists Week.

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for Patient Care

Managing Editor
Susan Sabia

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Milton Calderon, 617-724-1755

Submissions
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For more information, call: 617-724-1746

Next Publication
October 16, 2014

Inpatient HCAHPS Results

2013–2014

Measure	2013	2014 Year to Date	2013-2014 Change
Nurse Communication Composite	81.9	82.6	0.7
Doctor Communication Composite	82.5	81.8	-0.7
Room Clean	74.5	73.3	-1.2
Quiet at Night	50.2	49.9	-0.3
Cleanliness/Quiet Composite	62.4	61.6	-0.8
Staff Responsiveness Composite	64.7	64.2	-0.5
Pain Management Composite	72.3	72.4	0.1
Communication about Meds Composite	65.5	66.9	1.4
Discharge Information Composite	91.8	92	0.2
Overall Rating	81.2	80.3	-0.9
Likelihood to Recommend	90.4	89.7	-0.7

Nurse Communication, Pain-Management, and Communication about Medication Composite continue to outperform our baseline from 2013. Quiet at Night is improving, at its highest to date. We still need to focus our efforts on Staff Responsiveness and continue our work with Quiet Times as they are slightly below baseline.

Data complete through June, 2014
All results reflect Top-Box (or 'Always' response) percentages
Pull date: September 15, 2014

Caring Headlines
October 2, 2014

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Bigelow 10 Nursing Office,
MGH, 55 Fruit Street
Boston, MA 02114-2696

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