

Caring

Headlines

September 4, 2014

I-PASS

standardizing hand-over communication to ensure greater continuity and safer care



On White 10 General Medical Unit, staff nurses, Elizabeth Andrews, RN (left), and Elzbieta Gilbride, RN, use I-PASS communication tool during change-of-shift report.

I-PASS provides a checklist of information to be included in every hand-over:

- Illness severity
- Patient assessment
- Action list
- Situational awareness and contingency planning
- Synthesis by the receiver

(See Q&As on page 13)

Diversity, kindness, and preserving our pale blue dot...

I keep thinking,
where's the
conversation? How
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(or disagreement)
if there's not first a
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all progress, all
understanding?

Recently, I attended the wedding of a dear friend and his partner. It was a beautiful celebration of love and life. At the reception, we shared great conversation, at one point acknowledging that there was a time when this couple's union would not have been recognized by any state in the country.

I still remember the first wedding announcement I received from two female friends, with its banner, "God Bless the Commonwealth of Massachusetts." We were the first state in the nation to legalize same-sex marriage, but the decision did not come lightly or without thoughtful deliberation. There was public debate about values and beliefs. There was an exchange of ideas both between individuals and in the media. Learning took place as people let themselves imagine what it would be like to depart from long-held traditions. As with any major change, when the law was passed, some people celebrated, and some didn't. But there was a conversation.

Like so many others, I've been deeply troubled by the news coming out of Ferguson, Missouri; Iraq; reports of the Ebola virus ravaging the impoverished nations of West Africa, and the savage murder of journalist, James Foley. Such tragic, senseless losses. Why?

I keep thinking, where's the conversation? How is this going to get better? How can there be agreement (or disagreement) if there's not first a conversation? Isn't that the starting point of all change, all progress, all understanding?



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

This current unrest brings to mind a passage by author, scientist, and humanitarian, Carl Sagan, in his book, *Pale Blue Dot: A Vision of the Human Future in Space*. The pale blue dot he speaks of is our planet Earth as it appears from 6 billion kilometers away in a photograph taken by the Voyager 1 Space Probe.

"Look again at that dot..." says Sagan. "That's home. That's us. On it, everyone you love, everyone you know, everyone you ever heard of, every human being who ever was, lived out their lives... Thousands of confident religions, ideologies, and economic doctrines, every hunter and forager, every hero and coward, every creator and destroyer of civilization, every king and peasant, every young couple in love, every mother and father, hopeful child, inventor and explorer, every teacher of morals, every corrupt politician, every 'superstar,' every 'supreme leader,' every saint and sinner in the history of our species lived there — on a mote of dust suspended in a sunbeam.

"Think of the endless cruelties visited by the inhabitants of one corner of this pixel on the scarcely

continued on next page

At the first meeting of our new diversity committee, we asked members to share stories of their diversity journeys. The narratives that followed were powerful... It was the beginning of an important conversation, a conversation that I hope will lead to greater understanding, acceptance, and inclusion.

distinguishable inhabitants of some other corner, how frequent their misunderstandings, how eager they are to kill one another, how fervent their hatreds. Think of the rivers of blood spilled by all those generals and emperors so that, in glory and triumph, they could become the momentary masters of a fraction of a dot.

“Our planet is a lonely speck in the great cosmic dark. In our obscurity, in all this vastness, there is no hint that help will come from elsewhere to save us from ourselves... Like it or not, for the moment, the Earth is where we make our stand.

“There is perhaps no better demonstration of the folly of human conceits than this distant image of our tiny world. To me, it underscores our responsibility to deal more kindly with one another, and to preserve and cherish the pale blue dot, the only home we’ve ever known.”

At MGH, we recently convened a general executive committee to address issues related to diversity. When news of the committee was announced, I

asked to co-chair it, and I was delighted when Dr. James Brink, chief of Radiology, was named my co-chair. Our planning sessions were enlightening; both Dr. Brink and I have worked actively over the years to improve equity in care-delivery and work-

force-development. At our first meeting, we asked fellow committee members to share stories of their diversity journeys. The narratives that followed were powerful. I admit, I cringed at some of the stories of ignorance and intolerance. But it was the beginning of an important conversation, a conversation that I hope will lead to greater understanding, acceptance, and inclusion.

I think Carl Sagan’s words hold great wisdom and compassion. In the care we provide, in the example we set for the next generation, in the lives we lead every day, I hope we all live up to our, “responsibility to deal more

kindly with one another.” And when it comes to understanding and working through our differences, please, let us all add our voices to that conversation.



Earth, as seen from 6 billion kilometers, appears as a pale blue dot in the vast darkness of space.

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Depression: signs and symptoms

—by Mary Susan Convery, LICSW, clinical social work specialist

The recent death of beloved entertainer, Robin Williams, brought the topic of depression and addiction into the public conversation once again. Williams' suicide was covered extensively in the media and raised questions about what depression is and how it can be treated. Though depression is a common occurrence in modern society, it is not widely acknowledged or understood. It's estimated that one in five adults suffers from depression in his/her lifetime. Many people experience sadness or feel 'blue,' but clinical depression is characterized by prolonged feelings of hopelessness, guilt, or lack of interest in day-to-day activities. Depression can be accompanied by anxiety or fatigue, and frequently co-exists with addictions and other chronic illnesses.

Sometimes referred to as an 'invisible' disorder, misconceptions about depression keep many individuals from seeking the support they need. As a result, they suffer in isolation unaware that resources are available to help. The good news is that with appropriate help, depression is treatable.

There is no single cause of depression. Research shows that a combination of psychological, biological, and social issues contribute to the onset of depression. Symptoms and causes vary, so treatment is highly individualized.

Signs and symptoms of depression include:

- Feelings of helplessness and hopelessness. A bleak outlook, as if nothing will get better and there's nothing you can do to improve your situation
- Loss of interest in daily activities. No interest in former hobbies, pastimes, social activities, or sex. No ability to feel joy or pleasure
- Changes in weight or appetite. Significant weight loss or weight gain (a change of more than 5% of body weight in a month)

- Changes in sleep patterns. Either insomnia, especially waking in the early hours of the morning, or sleeping too much (also known as hypersomnia)
- Anger or irritability. Feeling agitated, restless, even violent; tolerance is low, temper is short
- Loss of energy. Feeling fatigued, sluggish, or physically drained. Your whole body may feel heavy; small tasks are exhausting and take longer to complete
- Self-loathing. Strong feelings of worthlessness or guilt; you harshly criticize yourself for perceived faults and mistakes
- Reckless behavior. You engage in escapist behavior such as substance-abuse, compulsive gambling, reckless driving, or dangerous sports
- Concentration problems. Trouble focusing, making decisions, or remembering things
- Unexplained aches and pains. An increase in physical complaints such as headaches, back pain, sore muscles, or stomach pain

If you or a loved one experience any of these symptoms, help is available. While your primary care physician is a good place to start, The MGH Employee Assistance Program (EAP) is available to help assess problems and guide you or your family member to the appropriate resources.

For more information, go to:

- the EAP website for a free, anonymous, EAP on-line screening (<http://www.mentalhealthscreening.org/screening/partners>)
- the EAP addiction website (http://www.eap.partners.org/WorkLife/Addiction/Addiction_Intro/Addiction_intro.asp)
- the EAP depression website (<http://www.eap.partners.org/WorkLife/MentalHealth/Depression/IntoDepression.asp>).

To speak with an EAP counselor, call 1-866-724-4EAP (4327).

Paving the way for a new era of nursing

—by Patricia Daoust, RN, associate director of Nursing, MGH Center for Global Health

On June 9 and 10, 2014, the MGH Center for Global Health (CGH) and Mbarara University of Science and Technology (MUST) in Uganda co-sponsored the university's inaugural nursing conference, "Paving the

Way for a New Era in Nursing." According to Florence Beinempaka, interim head of the department of Nursing at MUST, the goal of the conference was, "to propel nurses in the direction of professionalism with higher education, greater autonomy, and a strengthened research agenda." The conference welcomed more than 100 nursing leaders from across the country and provided an opportunity to share common professional challenges and deliberate on the way forward.

For nearly 15 years, the CGH has partnered with MUST to train and retain critical healthcare providers and educators. Recently, the partnership ex-

panded to include nursing. CGH has collaborated with MUST's nursing faculty to address a critical shortage of human resources and other infrastructure and leadership-related issues.

Like many other nursing schools in low-resource settings, MUST faces a staggering deficit of nursing faculty; thus the idea for a national nursing conference. The highly successful event helped consolidate support within the Ugandan nursing community and provided a forum to explore ways to improve nursing and nursing education in Uganda.

The partnership between MUST and CGH continues to grow. Our strategic plan incorporates program and faculty enhancement with professional and leadership development. As one MUST faculty member observed, "Our new collaboration with

MGH brings confidence to our department of Nursing. We are learning how to be more assertive and push for the essential things we need."

For more information about the CGH, contact Kate Hutchins at 617-724-0829; for information about CGH Nursing, contact Julie Anathan, RN, at 617-643-2610.

At "Paving the Way for a New Era in Nursing" conference, MGH attendees, Sara Groves, RN, MUST nurse faculty advisor (front row, purple top), and Pat Daoust, RN, associate director of Nursing at the CGH (center with red scarf), Julie Anathan, RN, international nurse program manager, also attended but is not pictured. At right: Florence Beinempaka, interim head of the department of Nursing at MUST.



MGH-Huashan Hospital Nurse-Leader Twinning Fellowship

—by Jane Keefe, RN, professional development manager

This year marked the fifth iteration of the annual MGH-Huashan Hospital Nurse-Leader Twinning Fellowship that brings MGH nurse leaders together with nurse leaders from Huashan Hospital for a comprehensive ‘twinning’ experience. This unique partnership began in 2009 in an effort to advance nursing care in China.

Each year, nurses from Huashan Hospital come to MGH to work with and learn from preceptors in their respective areas of focus, and MGH nurses have traveled to Shanghai to provide on-site education there, as well. The fellowship helps Huashan nurses develop leadership skills that enable them to advocate for a more professional practice environment and care-delivery model. Each Huashan nurse

is paired, or twinned, with an MGH preceptor who provides guidance and mentorship throughout their stay. And each preceptor is supported by a team of MGH nurse leaders who in turn share their knowledge and expertise. Visiting nurses have an opportunity to observe clinical care, attend meetings and rounds, dialogue with staff, and get a sense of the resources available at MGH. In addition to time spent on units with their twinning teams, Huashan nurses attend educational sessions and collaborative-governance meetings, furthering their understanding of nursing education, research, quality and safety, Magnet-preparedness, and informatics.

On July 8, 2014, this year’s class of Huashan nurses was recognized for their participation at a special reception in their honor. Huashan nurses had a chance to express their appreciation for the program and for the opportunity to engage in this partnership of mutual learning and enrichment.

Said one fellow, “The program changed how I view nursing and patient care. I want to bring this patient-centered perspective back to my colleagues at Huashan Hospital.”

Fellows were particularly impressed by the dynamic communication among providers and their respect for life and holistic care. Preceptors and members of the twinning teams acknowledged that MGH is fortunate to have the kind of resources that allow us to care for the whole patient and have a voice in how that care is delivered.

For more information about the MGH-Huashan Hospital Nurse-Leader Twinning Fellowship, call Jane Keefe, RN, at 4-0340.

Huashan nurses (seated, l-r): Yan Xu; Yujie Zhao; Huiming Qiu; Liwei Lang; Zhiyue Yan; and Xiaotian Ge, with members of their MGH twinning teams, coaches, and advisors.



(Photo provided by staff)

Summer Jobs Program

*giving students a glimpse at a career
in health care*

—by Susan Leahy, communications manager, MGH Center for Community Health Improvement

Behind the successful implementation of Partners eCare revenue cycle, there are many stories of strategies employed to meet the challenges of this complex system launch. For PCS Clinical Support Services (CSS), part of the plan was enlisting the aid of students from the MGH Summer Jobs for Youth program to augment operational support. CSS provided training then placed student interns on inpatient units where they were needed most. Says Stephanie Cooper, associate director of CSS, “We were looking for students who were interested in working with patients. After training, students helped opera-

Edward M. Kennedy Academy student, Hillary To (center) works with operations associates, Tamika Davis (left) and Eulawn Heron, on Bigelow 14 as part of the MGH Summer Jobs program.



tions associates and unit service associates with everything from answering phones, to running errands, to assisting visitors, and performing project work.”

Adanna Aniagboso, a senior at John D. O’Bryant School of Math and Science, was an MGH Summer Jobs student. Working on Bigelow 12 with operations associate, Angela Solis, Aniagboso’s position involved interacting with patients, working on projects, and assuming some clerical responsibilities. Says Aniagboso, “I knew I wanted a career in health care. Now I know I want to become a nurse practitioner. My summer experience showed me the importance of being organized in the workplace and setting priorities among all my assignments.”

Aniagboso’s supervisors were operations managers, Kathy Johansen and Carolyn Washington. Having worked with Summer Jobs students for more than 20 years, Washington has learned to set goals for students and develop plans to help them achieve those goals. Washington also sets standards for behavior, attitude, appearance, and job performance. Said Washington, “Adanna excelled because she was anxious to learn and always had a warm, confident smile. I hope this summer helped her see what it takes to be a nurse practitioner. I know she enjoyed being near patients.”

Cooper is pleased with the results. “Both the hospital and the students benefited from this pilot. Students provided an extra set of hands, freeing up OAs and USAs to learn Partners eCare. And students had an opportunity to get a behind-the-scenes look at how a hospital operates.”

For more information about MGH Summer Jobs for Youth or any of the other programs coordinated by the Center for Community Health Improvement, contact Susan Leahy at 617-643-5288.

There's more to surgical nursing than what goes on in the OR

I learned of a case involving a patient who was 30 weeks pregnant and scheduled to undergo a tracheal resection and reconstruction due to an obstructed airway... It was possible that the patient would go into full labor during surgery.

My name is Therese Nearhos, and I am an operating room nurse. My most unforgettable case this year, one that epitomizes the power of cooperation and communication, occurred a few months ago while I was assigned to Thoracic. I learned of a case involving a patient who was 30 weeks pregnant and scheduled to undergo a tracheal resection and reconstruction due to an obstructed airway. These cases are always challenging because the oxygen supply to the patient has to be carefully orchestrated between the surgeon and anesthesiologist throughout the procedure. And given that a fetus was also depending on this oxygen, the risk was exponentially higher. It was also possible that the patient would go into full labor during surgery. The High Risk Neonatal Team would have to be in the room.

The patient, Ms. R, had three young daughters and was pregnant with her first son. Six months earlier, before she was aware she was pregnant, her youngest daughter had died from a brain tumor. In her grief, she had attempted to take her own life. As a result, she had been intubated for several weeks, which had led to tracheal stenosis. I could only imagine the emotions this young mother must have been experiencing—fear, perhaps guilt, anguish.

In a message to the team leader, I suggested the surgery be double-staffed with experienced scrub



Therese Nearhos, RN, operating room nurse

nurses in addition to the full delivery team. An already difficult surgery was going to get a hundred times more intense.

On the day of surgery, I learned that I was going to be the circulating nurse on the case. I hadn't expected this since I'm not the most experienced nurse in that area, but I was excited to take on the challenge.

The neonatal team was first to arrive with their oxygen and suction requirements for the bassinet. Room placement needed to be worked out for this team and the second nursing team that would be constantly monitoring the fetal heart rate. Between the additional anesthesia personnel, two surgeons, and additional residents, the pre-operative huddle was the most intense and prolonged I've ever participated in—there were so many scenarios to consider and prepare for. The neonatal team gave me very specific instructions about how to summon the emergency C-section team, if needed, and exactly

continued on next page

I think this case is a perfect example of collaboration and communication in the operating-room setting. No one team was more important than another; mutual respect, involvement, and consultation combined to produce an excellent result. I truly felt great on the train going home that night.

what I needed to say to the dispatcher. Nothing could be omitted. I wrote it down and taped it to a surface near the phone. We discussed what would happen if Ms. R went into labor and how that would affect the case. It was decided that we would set up the table for delivery to avoid delays in case that scenario transpired. There was discussion over where to place the table—little details took on great importance. The surgeon wisely counseled everyone not to get caught up in unknowns; focus on performing the operation the way we did it every day. That made perfect sense.

When Ms. R arrived, as I had expected, she was an emotional vortex. She was young, her eyes were red. She was sobbing, fearful about the possibility of losing another child. I spoke from my heart. I assured her she was in the best hands. I told her that even if her baby was delivered that day, which was unlikely, he'd be developed enough to survive, and he had a remarkable group of people waiting to take care of him. I encouraged her to share her fears so we could address them one by one. Once she settled down, we talked about her other children and the son she was carrying. Her mood lifted as she spoke, she even managed to smile. The anesthesia staff was intuitive and gentle with her. Soon she was ready to go into the room.

Logistically, getting started was nearly overwhelming. Every team had its own set of needs requiring me to move quickly around the operating table (even under it a couple of times) to accommodate everyone. Fortunately, we had an extra set of hands in the form of additional staffing for the day. Eventually, the case fell into the well-choreographed dance it always does. The surgery went very well, with few surprises. Ms. R had sufficient trachea to allow resection of the stenosed area. About three hours into the surgery, monitors detected a slower heart rate for the fetus and signs of contractions. Surgery was suspended for a few minutes to verify and re-assess. There was a short discussion among the surgeons, anesthesiologists, and neonatologists. There was a strong sense of cooperation and communication as they voiced and considered every option. The decision was made to continue with surgery while the neonatal team gave anti-labor medications and watched for a response via monitoring. After about ten minutes, Ms. R and her baby settled down, and the case went on uneventfully.

As my shift came to a close, the surgeons finished up, and it was time to breathe a collective sigh of relief. Ms. R awoke from anesthesia and was easily extubated and hemodynamically stable while her son kicked enthusiastically letting us know he was glad it was over. There were smiles everywhere. Everyone had performed at their best, and we knew it.

I think this case is a perfect example of collaboration and communication in the operating-room setting. No one team was more important than another; mutual respect, involvement, and consultation combined to produce an excellent result. I truly felt great on the train going home that night.

One week later, Ms. R was brought back to the OR to have her sutures removed. Though I wasn't her nurse that day, I did slip in to say hello. She was happy to see me and said she had a huge favor to ask. She told me that when she was in the recovery room the week before, she'd seen a window with flowers etched into the glass. She had taken great comfort in seeing the flowers, seeing them as a message from her lost baby girl. She asked if I could find the window and take a picture of it for her. I ran to my locker and got my phone, and sure enough, after a little investigating, I found her window. I snapped a picture and sent it to her.

The original plan was for Ms. R to come back to MGH for a scheduled delivery closer to her due date, but eight weeks post-op, she went into rapid labor. Her son was born at her local hospital weighing six pounds, and despite some GI problems, is neurologically intact and meeting all his developmental milestones.

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

Terry understood and anticipated the challenges related to Ms. R's complex surgery. Ms. R was 30 weeks pregnant and still grieving the loss of her young daughter. Terry knew that Ms. R, her unborn son, and the memory of her daughter all figured prominently in this scenario. She gently eased Ms. R into a state of calm prior to surgery knowing that when she came out of anesthesia she'd still be in a peaceful state of mind. Terry continued to support Ms. R even when she was no longer officially her patient, undertaking to find the special window and taking a picture of it for Ms. R. A wonderful example of family-centered care.

Thank-you, Terry.

The Ben Corrao Clanon Memorial Scholarship

—by Mary Ellin Smith, RN, professional development manager

On Monday, August 18, 2014, staff of the Newborn Intensive Care Unit (NICU) came together to celebrate the practice of colleague, Jean Gardner-Amore, RN, and to remember Ben Corrao Clanon.

Gardner-Amore is this year's recipient of the Ben Corrao Clanon Memorial Scholarship, established in 1987 to recognize NICU nurses who demonstrate exemplary practice, a commitment to primary nursing, and ongoing support and advocacy for patients and families. Says Mary

Ellin Smith, RN, long-time coordinator of the Corrao Clanon scholarship, "Twenty-eight years after Ben's tragic death, he continues to teach and inspire us."

In her remarks, nursing director, Peggy Settle, RN, noted, "Primary nursing teaches us many lessons. First among them is that time does not lessen the love a family has for their child. Second is that presence, expertise, and compassion are mainstays of primary nursing. Jean Gardner-Amore epitomizes those qualities and much more. Jean enters the world of a family and with great skill, helps them bond with their infant, showing them how to focus on the beauty and uniqueness of their child, not on the illness or the prognosis or the technology."

Accepting the award, Gardner-Amore said, "No family wants their child to be in the NICU. But once there, my role is not only to deliver expert care to their child, but to come to know them in an open, non-judgmental way so a true relationship can be built." Gardner-Amore thanked her colleagues and the parents and families of all the babies she's cared for.

Speaking on behalf of his family who was unable to attend due to illness, Jeff Clanon thanked NICU nurses for their specialized skill and compassion, and for doing the impossible — making the unbearable, bearable.

For more information about the Ben Corrao Clanon Memorial Scholarship for NICU nurses, contact Mary Ellin Smith, RN, professional development manager, at 617-724-5801.

Representing the Corrao Clanon family, Jeff Clanon (left) with scholarship recipient, Jean Gardner-Amore, RN (center), and her family.



(Photo by Paul Batista)

Professional Achievements

Adams appointed

Jeffrey Adams, RN, director, The Center for Innovations in Care Delivery, was appointed executive nurse fellow by the Robert Wood Johnson Foundation, August 4, 2014.

Beauchamp consults

Kathryn Beauchamp, RN, clinical nurse specialist, PICU, served as pediatric critical care technical consultant, for the film, *Black Mass*, the *Whitey Bulger Story*, from May to June, 2014.

Erler appointed

Kimberly Erler, OTR/L, occupational therapist, was appointed practice representative for the Ethics Committee of the American Occupational Therapy Association, July 1, 2014.

Mulgrew presents

Jackie Mulgrew, PT, physical therapist, presented, "Application of Normal and Abnormal Exercise Physiology in the Adult Population," for an on-line webinar sponsored by Allied Health, Inc., May 6, 2014.

Therapists publish

Physical therapists, Marianne Beninato, PT; Arlene Fernandes, PT; and Laura Plummer, PT, authored the article, "Minimal Clinically Important Difference of the Functional Gait Assessment in Older Adults," in the June, 2014, *Physical Therapy*.

McAdams presents

Mary McAdams, RN, professional development specialist, presented, "Designing Level 3 Evaluations for Continuing Education Programs: Self-Report and Observation of Practice," at the annual convention of the Association of Nursing Professional Development in Orlando, Florida, July 18, 2014.

Oertel honored

Lynn Oertel, RN, clinical nurse specialist, Anticoagulation Management Service, received the John Q. Sherman Award for Excellence in Patient Engagement, from engagingpatients.org, in July, 2014.

Doyle certified

Catie Doyle, RN, family nurse practitioner, Cardiac Interventional Unit, received the Family Nurse Practitioner certification from the American Nurses Credentialing Center, in July, 2014.

Lieppman certified

Lauren Lieppman, RN, family nurse practitioner, Cardiac Interventional Unit, received the Family Nurse Practitioner certification from the American Nurses Credentialing Center, in July, 2014.

Lessar certified

Stephanie Lessar, RN, family nurse practitioner, Cardiac Interventional Unit, received the Family Nurse Practitioner certification from the American Nurses Credentialing Center, in July, 2014.

Morris certified

Kristin Morris, PT, physical therapist, received the Neurologic Clinical Specialist certification from the American Board of Physical Therapy Specialists, in July, 2014.

Callahan presents posters

Janet Callahan, PT, physical therapist, presented two posters, "A Kinematic Analysis of Gait in Lower Extremity Dystonia: a Single Subject Study Design," and "Non-Surgical Non-Pharmacological Interventions for Cervical and Extremity Dystonia: a Systematic Review," at the annual congress of the International Parkinson and Movement Disorders Society, in Stockholm, in July, 2014.

O'Donnell certified

Susan O'Donnell, RN, staff nurse, Hematology-Oncology, became certified in blood and marrow transplant nursing by the Oncology Nursing Certification Corporation in June, 2014.

Orpin certified

Joy Orpin, PT, physical therapist, received the Neurologic Clinical Specialist certification from the American Board of Physical Therapy Specialists, in July, 2014.

Skrzyniarz certified

Nicole Skrzyniarz, PT, physical therapist, received the Neurologic Clinical Specialist certification from the American Board of Physical Therapy Specialists, in July, 2014.

Tremaglio certified

Cristina Ann Tremaglio, PT, physical therapist, received the Neurologic Clinical Specialist certification from the American Board of Physical Therapy Specialists, in July, 2014.

Lowe presents

Colleen Lowe, OTR/L, occupational therapist, presented, "Musculoskeletal Work Injuries: Evaluation and Treatment," at Tufts University in July, 2014.

Lessard certified

Erica Lessard, RN, family nurse practitioner, Cardiac Interventional Unit, received the Family Nurse Practitioner certification from the American Nurses Credentialing Center, in July, 2014.

Beyzarov honored

Gennady Beyzarov, senior data and project manager, PCS Office of Quality & Safety, received the Clinical Activity Suite Star Performer Award from the Faculty Solutions Center of the University HealthSystems Consortium, in Chicago, June 12-13, 2014.

Cox honored

Erin Cox, RN, clinical nurse specialist, Vascular Surgical Service, received the John Q. Sherman Award for Excellence in Patient Engagement from engagingpatients.org, in July, 2014.

Rushfirth presents

Katherine Rushfirth, CNM, nurse midwife, presented, "Interconceptional Care: Eat Your Fruits, Vegetables, and Birth Control Pills," at the regional meeting of Women, Infants, and Children, (WIC), in Framingham, July 24, 2014.

Scott presents

Staff chaplain, Katrina Scott, presented, "Religious Aspects at the End of Life," at the Summer Bioethics Program at the Yale Interdisciplinary Center for Bioethics in New Haven, in June, 2014.

Clinical Recognition Program

Clinicians recognized
March 1- August 1, 2014

Advanced clinicians:

- Michele Allen, RN, General Medicine
- Sarah Calderone, RN, Newborn ICU
- Breanna Dunne, RN, Operating Room
- Kimberly Erler, OTR/L, Occupational Therapy
- Katherine Johnson, RN, Inpatient Psychiatry
- Katherine Kruczynski, RN, Labor & Delivery
- Melissa Mattola-Kiatos, RN, Operating Room
- Victoria Peake, OTR/L, Occupational Therapy

Clinical scholars:

- Susan Ahern, RN, Labor & Delivery
- Janet King, RN, GI/Endoscopy
- Laura Sanders, RN, Labor & Delivery

Clinical Recognition Program

formally recognizing clinical staff for their expertise in caring for patients

The CRP doesn't measure experience by seniority or the passage of time; it looks at engagement, study, and reflection on the work of caring for patients. The decision to recognize is based on whether the applicant consistently practices at the level being sought based on the criteria for that level.

Question: I'm interested in applying for the Clinical Recognition Program but I'm not sure where to start.

Jeanette: I'm glad you're interested in applying for clinical recognition. The Clinical Recognition Program formally recognizes clinical staff for their expertise in caring for patients at four distinct levels of practice. To begin the process, you should review the criteria for each of the four levels (<http://www.mghpcs.org/IPC/Programs/Recognition/Index.asp>). Look at the criteria for entry level; if examples come quickly to mind, proceed to the clinician, advanced-clinician or clinical-scholar level. Recognition at the entry and clinician level occurs at the unit or department level. Recognition at the advanced-clinician and clinical-scholar levels are voluntary and require your director's endorsement.

Question: If my director says no, what can I do?

Jeanette: To apply for advanced-clinician and clinical-scholar recognition, your director needs to endorse you. This is just an added layer of screening to ensure that applicants are applying at the appropriate level. Unlike a performance appraisal where your director explains why he or she gave you a particular score, when seeking endorsement for clinical recognition, you need to demonstrate why you feel you meet the criteria for the level you're seeking. Your director may or may not realize that you consistently practice at that level. It might be necessary to have a conversation, to look at recent examples of your practice to see whether you do, in fact, consistently meet the criteria.

Question: My director has encouraged me to apply, but I'm hesitant because other more senior staff members haven't applied yet.

Jeanette: The Clinical Recognition Program doesn't measure experience by seniority or the passage of time; it looks at engagement, study, and reflection on the work of caring for patients. The decision to recognize is based on whether the applicant consistently practices at the level being sought based on the criteria for that level.

Question: I understand there's a 'pre-review' process available to applicants before they submit a portfolio for consideration. How can I take advantage of that?

Jeanette: Yes, there's an anonymous process that allows applicants a one-time (per level) opportunity to receive feedback on their portfolios from former CRP Review Board members. Reviewers offer comments on whether the portfolio shows sufficient evidence of each theme, examples of clinical reasoning, clinically sound risk, and influence on practice at the unit or institutional level.

For more information, or if you'd like to submit a portfolio, send e-mail to MGH PCS Clin Rec.

I-PASS

enhancing continuity of hand-over communication throughout the continuum

Question: I heard we're switching to a new format for hand-over report. What's that about?

Jeanette: As an organization, we've adopted the I-PASS format for all patient hand-overs. I-PASS stands for: Illness severity; Patient assessment; Action list; Situational awareness and contingency planning; and Synthesis by the receiver. Adhering to this format for all hand-overs will enhance continuity across the continuum and increase patient safety. A recent Joint Commission (JC) report states that the most common cause of healthcare-related sentinel events is poor or ineffective communication among providers. Our own data confirms that communication issues are a dominant factor in serious adverse events, and most of those issues occur during change of shift between staff on the same unit.

Question: How will using I-PASS help?

Jeanette: The last two components of I-PASS are particularly important as they relate directly to patient safety and aren't always included in other hand-over communication models. Research tells us that staff receiving a hand-over may synthesize information differently from the person doing the handing over. An opportunity for dialogue and discussion between giver and receiver is built into the I-PASS format, creating a 'shared mental model,' reinforcing patient safety.

Question: Why did we choose I-PASS?

Jeanette: I-PASS incorporates two important elements not always present in other hand-over tools: situational awareness and synthesis by the receiver. Situational awareness and contingency planning are key aspects of patient safety because they engender true understanding of the patient's condition, and contingency scenarios are articulated in clear terms. I-PASS gives providers the impetus to review critical elements of the care plan and the patient's response.

Question: Is I-PASS already being used by nurses on any of our inpatient units?

Jeanette: Yes, nurses and other clinicians on White 9, White 10, and Ellison 19 were part of the original I-PASS pilot program, and they have continued to use it as their hand-over format. The pilot included education coordinated by the Norman Knight Nursing Center, pre- and post-education observations, and a survey of current reality. Pilot units further restructured hand-over communication by moving report closer to the patient and, when appropriate, to the bedside with the patient. Though many nurses read the medical record prior to getting I-PASS report, feedback from staff has been positive. Education for physicians is being coordinated by the Center for Quality & Safety.

Question: When will everyone move to the I-PASS format?

Jeanette: The Norman Knight Nursing Center coordinated an I-PASS retreat on August 21st where attendees discussed a roll-out schedule. Based on their recommendation, we're planning a full-scale educational launch beginning in October.

Question: Do you know what the plan is for educating PCS staff?

Jeanette: Education will be a combination of unit-based learning and classes offered through the Norman Knight Nursing Center. The pilot program showed us that we need to come together and discuss I-PASS as well as engage in hands-on practice in order to fully understand how each component of the tool contributes to patient safety. We will share more information about the educational plan when details are finalized.

For more information, call Gino Chisari, RN, director, the Norman Knight Nursing Center, at 3-6530.

Announcements

Trauma Care:

Preparation, management and recovery

Presented by the MGH Nurses' Alumnae Association

Friday, September 26, 2014
8:00am–4:30pm
O'Keefe Auditorium

Presenters: Stephanie Kwormick RN; Joseph Blansfield, RN; Marc DeMoya, MD; Peg Baim, RN; Constance Cruz, RN; Donna Slicis, RN; and members of the MGH Chaplaincy

A continuing-education program
\$40 for MGH alumnae and employees.
\$50 for non-Partners employees.

For more information, or to register, by September 14th, call the Alumnae office at 6-3144.

Marjorie K. Ionta Symposium

The MGH Institute of Health Professions and MGH Physical Therapy present the annual Marjorie K. Ionta Symposium. This year's theme: "Innovations in Rehabilitation of Lower-Extremity Amputees from Blast Injuries."

Target audience is rehabilitation caregivers, including physical therapists, occupational therapists, physical therapy assistants, occupational therapy assistants, and nurses.

\$125 for the general public
\$75 for MGH Institute alumni, employees, and MGH employees. Includes registration, continental breakfast, lunch, and networking event

September 27, 2014
8:00am–5:00pm
MGH Institute of Health Professions
Charlestown Navy Yard

CEUs are available
For more information, call
Stephanie Gomez at
617-643-3821

ACLS Classes

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

Day one:
September 12, 2014
8:00am–3:00pm

Day two:
September 22nd
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.

Register for fall courses

Register for prerequisite or non-degree courses at the MGH Institute of Health Professions to jump-start a career in nursing, physical therapy, occupational therapy, speech-language pathology, or as a physician assistant.

Discount for Partners-affiliated employees. Classes begin September 8, 2014.

For information, go to: www.mghihp.edu.

SAFER FAIR

Join champions from collaborative governance to learn how we're working to make a SAFER environment for patients, families and the MGH community.

Games, refreshments, and prizes!

September 17, 2014
11:00-2:00pm
under the Bulfinch Tent

For information, call Mary Ellin Smith, RN, at 4-5801.

Demystifying marijuana: a multi-disciplinary examination

Hands-on workshop for the entire healthcare team on the prevalence, risks, and health impacts of marijuana.

September 13, 2014
8:00am–4:30pm
Auditorium A300

Bunker Hill Community College

MDs/doctoral-level professionals
\$180 before August 22nd
\$195 after August 22nd

Other Professionals
\$150 before August 22nd
\$165 after August 22nd

Presented by the MGH Psychiatry Academy and the MGH Institute of Health Professions.

For more information,
call 617-643-0875

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

Nominations due by
September 10, 2014

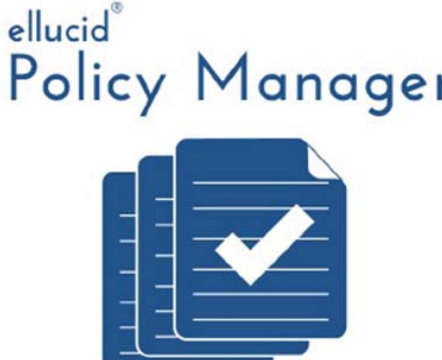
To nominate a colleague, go to:
sharepoint.partners.org/mgh/mghedrg, or e-mail MGHEDRG@partners.org for more information.

Trove to be replaced by ellucid® Policy Manager/Library


Looking for a policy and not sure where to go? The Office of Corporate Compliance is pleased to announce that MGH and the MGPO are switching from Trove to ellucid® Policy Manager/Library this fall to provide better access to policies for all. The Office of Corporate Compliance manages the hospital's 1,435 policies; individual policy owners and managers are responsible for formatting, revising, and approving their departments' policies.

- Trove will be available through April, 2015
- The Office of Corporate Compliance is working with policy owners and managers who currently keep policy collections on Trove to ensure a smooth transition

- Policy owners and managers who don't have policies on Trove and would like to convert to ellucid® Policy Manager should contact Kelly Staples or Julia Austin in the Office of Corporate Compliance by September 30, 2014
 - A training module comprised of video tutorials is being developed for end-users and will be available on the ellucid® Policy Manager/Library website
- For more information, contact MGH-MGPO Office of Corporate Compliance project managers, Kelly Staples, at 617-643-5493, or Julia Austin, at 617-726-5109.



- **Easy to use**
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- **Powerful search engine**
- **Highly secure data center**
- **Links to Policy Library**
- **Instant e-mail compliance notifications via StayAlert!**



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

Next Publication
September 18, 2014

Inpatient HCAHPS Results

2013–2014

Measure	2013	2014 Year to Date	2013- 2014 Change
Nurse Communication Composite	81.9	82.8	0.86
Doctor Communication Composite	82.5	81.9	-0.62
Room Clean	74.5	73.6	-0.95
Quiet at Night	50.2	49.6	-0.61
Cleanliness/Quite Composite	62.4	61.6	-0.83
Staff Responsiveness Composite	64.7	64.1	-0.56
Pain Management Composite	72.3	72.5	0.23
Communication about Meds Composite	65.5	67.1	1.57
Discharge Information Composite	91.8	91.9	0.11
Overall Rating	81.2	80.4	-0.78
Likelihood to Recommend	90.4	89.7	-0.66

Nurse Communication, Pain Management, and Communication about Medication Composite scores continue to outperform our baseline from 2013. Staff Responsiveness is improving, at its highest to date. We need to continue to work on Staff Responsiveness and Quiet Times on inpatient units as they remain below our 2013 baseline.

Data complete through June, 2014
 All results reflect Top-Box (or 'Always' response) percentages
 Pull date: August 18, 2014



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 Bigelow 10 Nursing Office,
 MGH, 55 Fruit Street
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