Caring Headlines
April 2, 2015

Celebrating National Social Work Month

See stories on pages 4-7

Clinical social worker, Susie Ross, LICSW, meets with Ed Saliba, the father of a patient in the Respiratory Acute Care Unit.

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

Jeanette Ives Erickson

2015 PCS Strategic Plan

Goal #4

Goal #4
Workforce:
be an employer
of choice known
for embracing
diversity, inclusion,
and staff-
engagement in
order to foster
an informed, self-
sustaining, creative
workforce

The last installment in our series describing our 2015 PCS Strategic Plan (see opposite page), focuses on Goal #4, Workforce. This goal speaks to our desire to create a strong, positive work environment for every employee and to attract the best and brightest new clinicians and support staff to ensure the long-term sustainability of a diverse, motivated, and satisfied workforce.

Goal #4

- Workforce: be an employer of choice known for embracing diversity, inclusion, and staff-engagement in order to foster an informed, self-sustaining, creative workforce

Tactics:

- Develop/enhance communication strategies to leverage existing groups and advisory groups

Discussion about this goal centered around the idea that open dialogue and communication foster increased understanding, and increased understanding fosters respect and collaboration. Since MGH and Patient Care Services already boast a robust network of committees, advisory councils, and other existing groups, and since diversity and workforce development are central to our strategic plan and guiding principles, we will leverage the existing committee structure to educate ourselves and staff about how to foster a culture of inclusion and instill a sense of personal accountability for the engagement and motivation of our workforce.

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

Learning to manage a diverse workforce is accelerated when based in real-life scenarios, as we saw in our recent Black History Month event, "Let's Talk about Race." These large-group discussions will continue with meaningful dialogue among all roles groups, and these discussions may become the topics of other regularly scheduled meetings.

On April 6th from 8:00am–3:15pm in O'Keeffe Auditorium, the PCS Diversity Committee is presenting, "Providing Culturally Competent Care to a Diverse Patient Population." All staff are welcome and encouraged to attend. For more information, contact any Diversity Committee champion.

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- Equip managers to support optimal individual performance

Staff in The Knight Nursing Center and The Institute for Patient for Care are developing programs to support and enhance staff performance. The courses, Transforming the Team, Conflict Resolution, and Peer Review, will be offered this spring to help improve staff communication and teamwork. And Human Resources is developing a training module for managers and supervisors to help cultivate optimal performance of all staff.

- Help hiring managers pursue more venues toward leadership diversity recruitment

Human Resources is working with managers to create hiring strategies that ensure all potential avenues are explored to increase the pool of diverse candidates. We'll optimize these hiring opportunities with increased awareness among hiring managers of the need for and benefits of a diverse workforce and leadership team.

- Increase/develop accommodations for employees with disabilities

Our commitment to diversity includes ensuring that employees with disabilities have everything they need to be successful. Hiring individuals with disabilities is just the beginning; we must connect employees with disabilities to established resources, groups, and programs, and educate the entire workforce about our policies and practices of inclusion. The MGH Accessibility Resource Site and Excellence Every Day Disability portal page offer access to resources, equipment, events, news articles, and links to related internal and external sites. The Council on Disability Awareness meets quarterly to update organizational initiatives and provides a forum for speakers on various disability-related topics. And Partners Ergonomics offers guidance on workplace accommodations and adaptive equipment for all MGH employees.

The Employee Disability Resource Group provides a forum for discussion, mentoring, and collaboration for anyone interested in improving the environment for individuals with disabilities.

Goal #4 is a crucial part of our strategic plan if we're to remain an employer of choice and reflect the true values of a Magnet hospital. As always, the success of our strategic plan depends on the investment and engagement of the entire PCS workforce. I hope you'll familiarize yourselves with our 2015 goals and tactics. I look forward to working with you as we implement and hone these tactics in the coming months.

2015 PCS Strategic Plan

- Excellence Every Day: optimize the patient experience by providing the highest quality, safest, most efficient care that meets or exceeds the expectations of patients, families, the hospital, or external organizations
- Partners eCare: implement and evaluate the use of standardized documentation tools to support the process of optimizing the patient experience and outcomes
- Innovation in Care-Delivery: enhance the patient experience, ensuring a coordinated, standardized, and evidence-based model of care-delivery throughout the Patient Journey
- Workforce: be an employer of choice known for embracing diversity, inclusion, and staff-engagement in order to foster an informed, self-sustaining, creative workforce

In this Issue

Social Work Month 1

Jeanette Ives Erickson 2-3
- PCS Strategic Plan: Goal #4

Social Work Month 4-5

Checking in with the New Director of HAVEN 6-7

Clinical Narrative 8-9
- Jennifer Neveu, PT

Exercise your Excellence Fair 10

Health Care Proxies 11
- Myths and Misconceptions

In Memoriam 12-13
- Carolyn Anderson, RN
- Mary Williams, RN

Fielding the Issues 14
- Metavision

Announcements 15

HCAHPS 16

(Cover photo by Paul Batista)

Social Work Month

110 years of paving the way for change

—by Samantha Nock, project coordinator, and Ellen Forman, LICSW, program manager

March is National Social Work Month, and the theme of this year's celebration is, "Paving the way for change." MGH has paved the way for change since the very beginning, boasting the world's first hospital-based social work department. This year marks the 110th anniversary of social work at MGH. As integral members of the healthcare team, social workers help advance the mission of patient- and family-centered care by identifying and supporting personal strengths and assisting patients, families, and colleagues in overcoming challenges. Social workers provide clinical counseling, facilitate access to resources, and advocate for the respect and dignity of each member of our diverse community. For 110 years, MGH social workers, as members of the inter-professional healthcare team, have been proud to lend our clinical skill and talents to the care of patients and families.

In celebration of National Social Work Month, the Social Service Department held a number of events to raise awareness of what social workers do at MGH and recognize the hard work and dedication of our staff. Events included a poster display in the Main Corridor and an information booth staffed by social workers.

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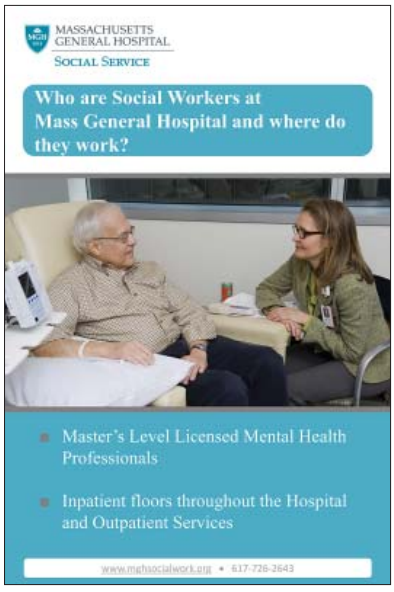
Below: founding director of MGH Social Service Department, Ida M. Cannon, at work. At right: posters displayed in the Main Corridor during Social Work Month.

(Above photo submitted by staff)



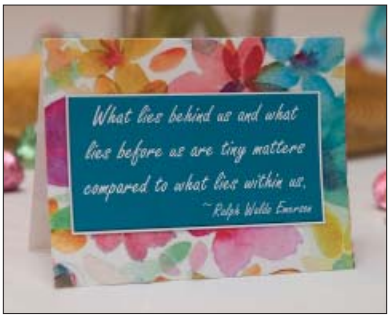
Staff engaged in a little friendly competition with, 'Penny Wars' (an idea borrowed from the MGH My Giving Helps campaign), in which the winning team chose the charity to receive the money raised.

A common social work refrain emphasizes the importance of self-care for patients, families and caregivers. In an attempt to take our own advice, and in appreciation for the dedicated service (and monumentally challenging winter), the department offered a chair yoga session, led by social worker, Laura Malloy, LICSW, of the Benson-Henry Mind Body Institute, and chair massage sessions.

Social workers came together for a celebratory brunch attended by senior vice president for Patient Care, Jeanette Ives Erickson, RN, with remarks by director of Social Service, Marie Elena Gioiella, LICSW. Invoking this year's theme, Gioiella noted, "You pave the way for change every time you greet a confused patient with compassion; connect a family member to a support group in their home town; advocate for a patient's wishes; provide hospitality to an international patient at Beacon House; provide a safe haven for someone in an abusive relationship; or mentor a developing colleague. You represent the best of what MGH Social Work has to offer."

Social Work Month events concluded with the Grand Rounds presentation, "Clarity, Control, and Compassion: how Boundaries Help Providers in Health Care," presented by Carrie Stack, founder and CEO of Say Yes Institute.

For more information about the services provided by MGH social workers or our history at MGH, go to: www.mghsocialwork.org, or call 617-726-2643.



(Photos by Paul Batista)

(Clockwise from top left): Carrie Stack, founder and CEO of the Say Yes Institute, speaks at Social Work Grand Rounds. Inspirational messages on display at Social Work brunch. Director, Marie Elena Gioiella (at podium), recognizes Social Work Month Planning Committee members (l-r): Renee Bigaud-Young; Barbara Olson; Sandra Elien, chair; Lindsey Streahle; Samantha Nock; and Anne Lafleur. Laura Malloy, LICSW, of the Benson-Henry Institute for Mind Body Medicine, leads chair yoga class.

Checking in with the new director of HAVEN

—by Debra Drumm, LICSW, HAVEN director

As the new director of HAVEN, I thought National Social Work Month would be an opportune time to share some of the services HAVEN (Helping Abuse and Violence End Now) has to offer and highlight some of the new programs we'll be implementing. Since 1997, HAVEN has provided free, confidential services to survivors of intimate-partner abuse. With advocates on the main campus and in the Chelsea and Revere healthcare centers, HAVEN serves patients, families, employees, and members of the community who've been affected by intimate-partner violence. Our multi-lingual, multi-cultural staff is available to provide advocacy, counseling, support, and safety-planning. We help connect individuals to community resources and provide workshops and support groups. Abusive relationships can affect people of every culture, race, class, religion, age, gender, and sexual orientation. Persons with disabilities, linguistic challenges, chronic medical issues, immigrants, and refugees often face hardships that can further impact their safety. Whether the abuse is current or happened many years ago, HAVEN staff are available to assist.

Since 1997, HAVEN has provided free, confidential services to survivors of intimate-partner abuse... Our multi-lingual, multi-cultural staff is available to provide advocacy, counseling, support, and safety-planning.

Debra Drumm, LICSW, director of Social Service's HAVEN program

In addition to direct services, HAVEN provides training to caregivers around best practices for screening, responding to, and understanding the impact of domestic violence on the health of our patients. In situations where patients may not be ready or able to safely access HAVEN services, advocates provide consultation to staff while ensuring patient safety and confidentiality. Last year, HAVEN served nearly 600 clients as a result of 5,400 contacts and provided 60 formal training sessions for 410 staff members.

HAVEN is proud to be collaborating with caregivers at MGH and the Mass Eye and Ear Infirmary in establishing the Facing Forward program. Facing Forward provides medical treatment for patients who've sustained long-term injury as a result of violence by an intimate partner. We know the impact

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In addition to client support services, HAVEN offers legal services through a partnership with a local domestic-violence service, shelter, and support agency. Through this partnership, HAVEN clients are afforded access to timely consultation with an attorney regarding their rights, child custody, visitation, restraining orders and other concerns related to family court.

trauma and intimate-partner violence can have on a patient's ability to access and experience health care. Long-term injuries, scarring, and medical complications can impede survivors' ability to rebuild and move on with their lives. HAVEN works closely with medical staff to provide care free of charge and in a manner that enhances survivors' emotional and physical recovery while respecting their dignity and autonomy.

In addition to client support services, HAVEN offers legal services through a partnership with a local domestic-violence service, shelter, and support agency. Through this partnership, HAVEN clients are afforded access to timely consultation with an attorney regarding their rights, child custody, visitation, restraining orders and other concerns related to family court. This partnership between health care, domestic violence advocates, and the legal system is unique to MGH. Last year, the HAVEN Legal Partnership worked with 60 clients and provided legal consultation to HAVEN advocates who supported an additional 51 clients.

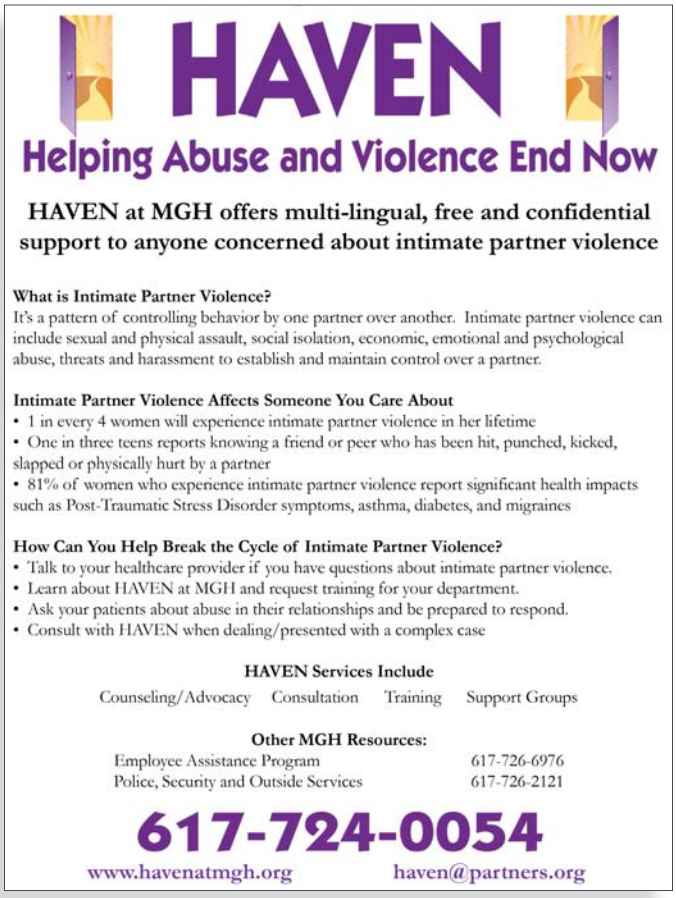
At the Revere HealthCare Center, HAVEN advocates work closely with the Teen Health Center and Revere High School around issues of violence and teen dating. This unique bridge between the high school and the health center allows HAVEN to provide services to clients who may not otherwise self-identify. Since 2013, 400 young people have participated in the *In Her Shoes* curriculum, an interactive learning experience that allows students to walk through the true story of a survivor of teen dating violence. As part of the Revere High School Youth Empowerment Club, HAVEN sponsors an annual poster contest and has developed a public service announcement used to help raise awareness about teen dating violence. This work was featured on *Better Living* with Liz Walker in July, 2014, to highlight ways teens are responding to trauma in their neighborhoods.

In the coming year, the MGH community will hear more about trauma-informed care as HAVEN reconvenes the multi-disciplinary MGH Interpersonal Trauma and Violence Committee. This group is developing strategies to help clinicians understand the impact trauma has on patients *and* caregivers and how to integrate that knowledge into our practice. HAVEN has been part of a Partners-wide movement exploring these issues.

In the near future, HAVEN will welcome a new staff member, a violence intervention advocate, who will work with patients/victims/survivors of community violence. This position is not new to the hospital but will be newly connected to HAVEN, increasing our collaboration and ability to respond to interpersonal and community-based violence.

If you're interested in helping HAVEN combat intimate-partner violence, consider joining the MGH Domestic Violence Working Group or the MGH Men Against Abuse Group; both meet monthly to help raise awareness about intimate-partner violence.

For more information about any of these programs, call HAVEN at 617-724-0054 or go to: www.mghpcs.org/socialservice/Programs/Haven/.



Physical therapist learns not to put too much stock in first impressions

My colleague had told me that 'Jeanne' needed to be seen for gait and balance training as she was scheduled to be transferred to rehab today. As I arrived, the patient was in a heated discussion with the case manager and a family member. She was clearly angry.

My name is Jennifer Neveu, and I am a senior physical therapist. As I donned my gown and gloves outside the room of a patient I was about to see for a physical therapy colleague of mine, I heard the following rant: "You tell me what to do, when to do it, and how to do it. I need to go home and help my daughter and granddaughter, and you expect me to stay here! I'm going home today. I'm fine to go home."

My colleague had told me that 'Jeanne' needed to be seen for gait and balance training as she was scheduled to be transferred to rehab today. As I arrived, the patient was in a heated discussion with the case manager and a family member. I could hear her from half-way down the corridor. She was clearly angry. In the early days of my career, I might have just walked away and tried again another time, not wanting to get in the middle of this current conflict.

But I knew Jeanne had physical-therapy needs; she was unsteady on her feet and refusing to use a walker. And from the sound of it, she was not in agreement with the rehab plan that was being recommended. Her walking and balance issues were of major concern if, in fact, she'd be going home soon as she was requesting. It looked like getting involved in the conflict would be of utmost importance in ensuring a safe discharge for Jeanne.

Jennifer Neveu, PT
senior physical therapist

Jeanne, her family member, and the case manager were discussing discharge. I had important information to provide and, it seemed, a very short time in which to do it. Given Jeanne's current state of mind, it was going to be a challenge to provide any intervention. So rather than enter on the offensive, I took a different approach.

I went into her room and sat down, making sure I was at eye-level with Jeanne.

"You seem upset," I said. "Do you want to talk about it? I'm a mother of daughters myself. I know it's not always easy."

I wanted to connect with her as a mother, establish a relationship, and gain her trust—as much as you can in a few minutes. I knew it would be crucial to develop a relationship with Jeanne before I could have a meaningful discussion with her about her PT needs, especially if we were going to disagree on what her discharge plan should be.

Jeanne immediately opened up about her situation at home. While still visibly upset, she began to

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At the end of our session, she was so happy that I had taken the time to listen to her personal issues and not just considered the medical data and recommendations... I think in this situation, my ability to identify with Jeanne, think quickly in the moment, and communicate effectively in a difficult situation were instrumental in ensuring Jeanne's safe discharge home.

calm down as she talked about it. She wanted to be discharged home so she could help her daughter and granddaughter who had a complex set of challenges. I sympathized with her issues and told her how lucky her daughter and granddaughter were to have her support. I was able to quickly establish a relationship with Jeanne, which was necessary in order to move forward with treatment for her physical-therapy impairments. I knew it was important to maintain a calm, gentle, and empathetic demeanor if we were going to be able to move forward with a meaningful physical-therapy intervention.

Time was of the essence as Jeanne was hoping to go home later that day. As I said, rehab was no longer an option as she was determined to go home so she could be there for her granddaughter. Initially, Jeanne had declined to use a rolling walker and refused a home PT program, but I felt it was necessary to re-visit these options. Jeanne said she didn't see the value of a rolling walker, but I didn't think she was making that assessment from a place of knowledge. If Jeanne declined a rolling walker after seeing what it could do for her, that was her decision. But I wanted to make sure she knew what she was refusing.

I asked Jeanne to walk without the walker, and then again with the walker so she could see the difference. Her gait was much improved with the walker, and she recognized this immediately. I reminded her that if she went home and fell because she was unsteady when walking, she'd most likely end up back in the hospital. She knew that meant being separated from her granddaughter, and she was highly motivated not to let that happen. Jeanne agreed to use the walker, which I was convinced would go a long way toward keeping her safe at home.

Then we talked about a home physical-therapy program. I explained the role of a home physical therapist, the frequency of visits, duration of visits, and the goals she'd likely be able to achieve if she worked with a physical therapist at home. She saw the merits of continuing her treatment at home.

Jeanne reported that she wouldn't be able to have 24-hour supervision at home as recommended because, by necessity, she'd be home alone sometimes. To help ensure her safety, I compiled a list of compensatory strategies to minimize the need to ambulate when she was home alone. Those strategies included:

- showering when help is available
- having a family member prepare meals ahead of time and keeping them in a cooler close to her recliner so she wouldn't have to walk and carry food at the same time
- using the rolling walker at all times
- avoiding the second floor of the house
- sitting whenever she experienced any symptoms such as leg-shaking, light-headedness, etc.

Jeanne was pleased with these strategies, actually agreeing that they were a good idea. At the end of our session, she was so happy that I had taken the time to listen to her personal issues and not just considered the medical data and recommendations. She was so thankful she was in tears and asked to give me a hug.

Afterward, I met with the nurse, case manager, and medical team to let them know what had happened in our session. I felt that Jeanne would be able to safely manage at home with the rolling walker and the strategies we had implemented. She knew a physical therapist that she trusted through her home-care agency, so she'd be able to continue to work on her gait and balance at home. I followed up with my colleague, Jeanne's primary therapist, about the quick change in Jeanne's discharge plan and how I had handled it.

I think earlier in my career, I might not have known how to gain this patient's trust. I would have been intimidated by her anger and demeanor, so I wouldn't have been able to re-focus her attention on her PT impairments or come up with a safe home-mobility plan. I think in this situation, my ability to identify with Jeanne, think quickly in the moment, and communicate effectively in a difficult situation were instrumental in ensuring Jeanne's safe discharge home.

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

As soon as Jennifer disclosed that she herself was a mom, the temperature in the room changed, allowing Jennifer to partner with Jeanne in finding safe, mutually acceptable solutions. This narrative beautifully demonstrates Jennifer's advanced problem-solving skills, her ability to assess alternative solutions, and her understanding that trust goes a long way toward earning a patient's willingness to invest in her own care plan.

Thank-you, Jennifer.

Exercise your Excellence Fair

—by Gino Chisari, RN, and Kathleen Larrivee RN,
The Norman Knight Nursing Center for Clinical & Professional Development

The Joint Commission accredits more than 20,500 healthcare organizations in the United States. Joint Commission accreditation reflects a commitment to meeting certain performance standards and validates the practice of clinicians in all disciplines. To help prepare staff in Patient Care Services for our upcoming Joint Commission survey, The Norman Knight Nursing Center for Clinical & Professional Development partnered with the PCS Office of Quality & Safety to develop a three-part curriculum. On Thursday, February 26, 2015, more than 125 people visited the Knight Nursing Center to participate in the Exercise your Excellence Fair. Exercise Your Excellence is an extension of our Excellence Every Day philosophy, "offering patients, families, and one another our very best in every moment." The fair consisted of a series of 'skills stations' where attendees could move from station to station to learn about a variety of topics, such as: performance-mprovement, mock-survey interviews, National Patient Safety Goals, best and/or unacceptable practices, bedside focus areas, alarm safety, patient-education, and the new ellucid® Policy Manager. Five participants won gift cards to the MGH General Store.

As senior vice president for Patient Care, Jeanette Ives Erickson, RN, reminds us, "Showcasing our practice and advocacy for patients is one of the most important jobs we have during a Joint Commission visit. A successful Joint Commission survey is one way we demonstrate our commitment to excellence every day and all that we do for patients and families."

For more information about the Exercise your Excellence Fair, call 617-726-3111.

(Clockwise from top): staff specialist in the PCS Office of Quality & Safety, Deb Frost, RN, (right); professional development specialists in the Knight Nursing Center, Carole MacKenzie, RN; and Sheila Golden-Baker, RN, staff skill stations during Exercise your Excellence Fair.

(Photos by Paul Batista)

Health Care Proxies

myths and misconceptions

—by Janet Madden, RN, staff specialist

When I shared with colleagues that I was going to facilitate the Guardianship Pilot in the Neuroscience areas, those who knew of my background in the Newborn Intensive Care Unit, asked what I knew about guardianship. The truth was, I knew nothing. I had no idea what 'guardianship' for adults meant, let alone when it was required or how it could be prevented.

What I have learned is that there are many misconceptions about guardianship held by healthcare professionals and lay people alike. I've learned that ignorance, indifference, and misconceptions about guardianship can result in our healthcare choices and those of our patients not being honored. My naivety allowed me to look at guardianship with fresh eyes. And the lessons I learned demand to be shared.

Having spent 25 years in an environment where parents are the legal decision-makers for their babies, I was unaware that Massachusetts does not have a next-of-kin law. That means that relatives don't automatically become the decision-makers for family members (18 years old or older) who lose the capacity to make certain healthcare decisions. So if an adult patient has not appointed a health care proxy (HCP) and becomes unable to do so, his or her next of kin is not legally able to provide consent for transfer to a rehabilitation or other long-term care facility. In those cases, MGH must request a court-appointed guardian to make those decisions. In most cases, the guardian ends up being the person who would have been the HCP if one had been appointed. Once I understood the ramifications of *not* having a health care proxy, I immediately understood why the Joint Commission requires that we ask patients if they have an advance directive or health care proxy, and why our Ethics in Clinical Practice Committee hosts an Advance Care Planning booth every year.

Like so many others, I had labored under the misconception that health care proxies were for the sick and elderly. The reality is that *everyone*, 18 years old or older, should have a health care proxy. If you don't have one, you should appoint one today. If a patient in your care doesn't have one, assist them in appointing one today. As clinicians, we know all too well that lives change unexpectedly every day. Having a health care proxy ensures that patients' wishes are known and that their care will be carried out accordingly.

MASSACHUSETTS HEALTH CARE PROXY

YOUR BIRTH DATE (mm/dy): ___/___/___

1 I, _____, residing at
(Principal: PRINT your name)

_____
(Street) (City/town) (State/ZIP)

appoint as my **Health Care Agent**: _____
(Name of person you choose as Agent)

of _____
(Street) (City/town) (State/ZIP)

Agent's tel (h) _____ (w) _____ E-mail _____

OPTIONAL: If my agent is unwilling or unable to serve, then I appoint as my **Alternate Agent**:

_____
(Name of person you choose as Alternate Agent)

of _____
(Street) (City/town) (State/ZIP) (Phone)

2 My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, *if any*, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3 **Signed**: _____ **Date**: ___/___/___ (mo/day/yr)

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

_____ _____
(Name) (Street)

_____
(City/town) (State/ZIP)

4 **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.
In our presence, on this day ___/___/___ (mo / day / yr).

Witness #1 _____ Witness #2 _____
(Signature) (Signature)

Name (print) _____ Name (print) _____

Address _____ Address _____

_____ _____

Health Care Proxy forms are available in the Blum Patient & Family Learning Center (in English and Spanish); they can also be found on the EED portal (http://intranet.massgeneral.org/pcs/Proxy_Forms/Health_Care_Proxy_Forms.asp) and on the Massachusetts Medical Society website (http://www.massmed.org > Patient Care > Health Topics > Health Care Proxies & End of Life Care). Information about guardianship can be found on the LOS tab of the EED portal (http://intranet.massgeneral.org/LOS/). For more information, contact staff specialist, Janet Madden, RN, at 6-4996.

Carolyn Anderson, RN

strong, quiet nursing leader

The MGH community was saddened to learn of the untimely passing of former nursing director, Carolyn Anderson, RN, on March 6, 2015. Some may recall that Anderson began her career at MGH in 1969 and was a prominent nurse leader in Cardiac Surgery until she retired in 2007.

Says nursing director, Tony DiGiovine, RN, "Carolyn had very high standards in the Cardiac SICU. She could be an intimidating presence but underneath had a very dry sense of humor. I recall one day being a float nurse on her unit, assigned to my first balloon patient. I was petrified, but she had every confidence in me. And she was right, as usual. Godspeed Carolyn, and thank-you for your devotion to cardiac surgery patients."

Cynthia Finn, RN, recalls, "Carolyn mentored so many staff members, not just nurses. She was instrumental in my personal growth, encouraging me to better myself and always project a positive image of cardiac nursing. She pushed for shared governance, insisted on leading by example, and was profoundly supportive of continuing education. She forgave my mistakes and helped me learn from them going forward. I'll always be grateful for her mentorship and guidance."

Says Diane Gay, RN, "Carolyn was my nurse manager from 1983 until the day she left. She was totally devoted to MGH and the Cardiac SICU. She was a strong, quiet presence who guided us through many changes. She was there for me as I cared for my terminally ill parents. I can't say enough about this strong, supportive woman who helped me to become the nurse that I am today."

(Photo provided by staff)

Carolyn Anderson, RN
former nursing director, Cardiac Surgical ICU

Says David Torchiana, MD, president and CEO of Partners HealthCare, who served as Cardiac Surgery chief for many years during Anderson's tenure, "I admired and respected her very much. She was an incredibly effective leader and manager."

"Carolyn was the foundation on which the Cardiac SICU was built," says Jane Kelley Maiorana, RN. "I was there the first year of her leadership thirty-seven years ago, and we mentored and taught each other every year since. I love you and miss you, my friend."

There's no doubting the indelible impression Carolyn Anderson left on MGH and those of us fortunate enough to have worked alongside her. Her legacy will be felt for generations.

There's no doubting the indelible impression Carolyn Anderson left on MGH and those of us fortunate enough to have worked alongside her. Her legacy will be felt for generations.

Mary Williams, RN

a caring, passionate nurse

Friends and colleagues of former staff nurse, Mary Williams, RN, were saddened to hear of her passing, on March 12, 2015. Williams worked at MGH from July, 1971, until she retired in October of 2009 to become a minister in her church. She worked the latter half of her nursing career in the Burn ICU. During her time at MGH, Williams was active in the Minority Nurse Recruitment and Retention Committee and the New England Regional Black Nurses Association, and she was a two-time participant in the PCS African American Pinning Ceremony.

Below: Mary Williams, RN (left), pins staff nurse, Joy Williams, RN, during annual African American Pinning Ceremony, on February 14, 2003,

Says Deborah Washington, RN, director of PCS Diversity, "Mary was the ultimate diversity advocate. With her elegant, accented English, Mary enjoyed telling stories of those who were challenged and able to overcome. She was a wonderful mentor, a passionate advocate, a caring clinician. When I was a staff nurse, Mary was a float nurse. We were always so glad to see her on our unit because of her wonderful nursing practice."

(Photo provided by staff)

Mary Williams, RN,
former staff nurse, Burns Unit

Ronald Tompkins, MD, director of the Center for Surgery, Innovation & Bioengineering, was chief of the Burn Service during Williams' tenure. Says Tompkins, "Mary was such a wonderful, strong woman. She represented our center well. We will miss her so much."

Tony DiGiovine, RN, Williams' long-time nursing director, recalls, "Mary was an amazing person. I remember working with her when I was a nursing assistant. She taught me a great deal about caring for patients. Ten years later, I worked with Mary as her nurse manager, and for the next twenty years she continued to teach me about patient care, diversity, leadership, and so much more."

Williams was a kind and generous person, and an exceptional MGH nurse. She will be missed.

Metavision: a continuous electronic patient record in the perioperative setting

Question: What is Metavision?

Jeanette: Over the past few years, the Perioperative Nursing Services, along with the Metavision analyst team, have developed and implemented an electronic system that integrates nursing and anesthesia documentation with the goal of enhancing continuity of care for perioperative patients. Metavision has been used by the MGH Anesthesia Department for several years, and it's now being used for nursing documentation in the perioperative setting, as well. This is a transitional step in preparation for Partners *e*Care, which goes live in 2016. The integrated system provides a continuous flow of patient information from the start of the perioperative encounter through discharge from the Post-Anesthesia Care Unit.

Question: Where is Metavision being used?

Jeanette: Metavision is being used in:

- the Pre-Admission Testing Area (PATA)
- the Center for Perioperative Care (CPC) and the Lunder perioperative areas
- the Operating Room (Anesthesia only)
- the Post-Anesthesia Care Units (PACUs)

Question: What data do nurses document in Metavision?

Jeanette: PATA and pre-operative nurses input the full admission process, including admission assessment, vital signs, BMI calculations, risk assessments, allergy review, and the Initial Nursing Assessment. Prior to the patient going to the operating room, the nursing record is e-signed and sent to CAS for providers involved in the patient's care. Select documentation goes to the anesthesia record for anesthesia care providers. Post-operatively, anesthesia providers input post-procedure information for nurses in the PACU. PACU nurses enter vital signs, physical assessments, including wounds, tubes, and drains, medications, fluids, nursing interventions, observations, and discharge documentation. The nurse completes and validates the record, which is sent to CAS for viewing in the OpNotes section.

Question: How does Metavision help perioperative nurses transition to *e*Care?

Jeanette: The shift from paper to electronic documentation is a major change in practice, but perioperative nurses made the transition easily and are now competent with electronic documentation, a key skill for Partners *e*Care. And some of the Metavision language aligns with the language used in *e*Care software.

Question: How does Metavision benefit our patients?

Jeanette: Patients have *one* electronic record allowing patient information to flow seamlessly through all phases of the perioperative journey. This record is available simultaneously to any member of the care team anywhere in the hospital through CAS. Good communication and integration of information are the cornerstones of quality care. Metavision enables us to:

- standardize workflows and documentation
- improve accuracy and completeness of the patient's record
- ensure legibility of documentation
- avoid duplicate documentation
- streamline patient hand-offs between anesthesia and nursing
- support data-collection for quality-improvement, research, and operational initiatives

For more information about Metavision, call Ellen Kinnealey, RN, Perioperative Nursing Informatics, at 617-930-9689, or Pam Wrigley, RN, clinical nurse specialist, at 617-724-2395.

Announcements

Providing Culturally Competent Care

The PCS Diversity Committee will sponsor the educational program: "Providing Culturally Competent Care to a Diverse Patient Population"

April 6, 2015
8:00am–3:15pm
O'Keeffe Auditorium

For more information, contact any Diversity Committee champion or call the PCS Institute for Patient Care, at 617-726-1345.

Save the Date

Local NENIC educational event

April 30, 2015
8:00am–4:00pm
"Trends in Clinical Informatics: a Nursing Perspective"

To register or submit an abstract about practice innovation or informatics research, go to: http://www.nenic.org.

For more information, contact Mary Kennedy, RN, at program@nenic.org; or Joanna Jung, RN, at 617 549-2812.

Senior HealthWISE events

All events are free for seniors 60 and older

"Living with Hearing Loss"
Thursday, April 16, 2015
11:00am–12:00pm
Haber Conference Room, MGH

Speaker: Ellen O'Neil, associate director, Department of Audiology, Mass Eye and Ear Infirmary; Instructor, Harvard Medical School

For more information, call 4-6756.

Mid-Life Women's Health Conference

Staying healthy and well

Free educational event, presented by The Mass General Mid-Life Women's Health Center, focuses on the unique and complex health needs of women at mid-life.

Tuesday, May 5, 2015
4:00-6:30pm
O'Keeffe Auditorium

Topics will include cardiovascular health, nutrition, hot flashes, and insomnia.

To register, e-mail Emilia O'Brien. For more information, go to: www.massgeneral.org/obgyn/CommunityHealthEvent

Fourth annual MGH Global Health Expo

Wednesday, May 6, 2015
12:00–3:00pm
under the Bulfinch Tent

The MGH Global Health Expo will showcase more than 30 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
- Food and refreshments
- Stop by any time throughout the afternoon

Sponsored by the MGH Center for Global Health: www.massgeneralcenterforglobalhealth.org.
For more information, call Rachel Rifkin at 617-724-3194.

Benson-Henry Institute for Mind Body Medicine

Online Course:
"Stress and The Relaxation Response"
Next class starts April 6, 2015
For information, go to: http://bensonhenryinstitute.org/professional-training/online-training.

Live CME course:
Mind Body Medicine and Cardiovascular Disease
May 1st
8:30am–4:30pm
Newton-Wellesley Hospital, Bowles Conference Center
For information, go to: http://mghcme.org/courses/course-detail/mind_body_medicine_and_cardiovascular_health.

Or call 617-726-5387 for more information on either class.

ACLS Classes

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

Day one:
April 13, 2015
8:00am–3:00pm

Day two:
April 27th
8:00am–1:00pm

Re-certification (one-day class):
May 13th
5:30–10:30pm

Locations to be announced.
Some fees apply.
For information, contact Jeff Chambers at acls@partners.org

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

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For more information, call: 617-724-1746

Next Publication
April 16, 2015

Inpatient HCAHPS

2015 calendar year, to date

Measure	2014	2015 Year to Date	2014-2015 Change
Nurse Communication Composite	82.1	82	**-0.1**
Doctor Communication Composite	81.6	82.9	**1.3**
Room Clean	72.2	74.9	**2.7**
Quiet at Night	49.7	54	**4.3**
Cleanliness/Quiet Composite	60.9	64.5	**3.6**
Staff Responsiveness Composite	63.8	64.7	**0.9**
Pain Management Composite	71.7	73.3	**1.6**
Communication about Meds Composite	65.8	66.9	**1.1**
Discharge Information Composite	91.6	91.8	**0.2**
Overall Rating	79.8	79.4	**-0.4**
Likelihood to Recommend	90	89.7	**-0.3**

Data complete through January, 2015
All results reflect Top-Box (or 'Always' response) percentages
Pull date: March 16, 2015

Initial patient-experience survey results for 2015 have begun to come in. January data is now complete, and results from February and March are beginning to be included in this month's dashboard. Overall, we're seeing strong, positive results thanks to the hard work and diligence of staff throughout the hospital. Keep up the good work.

Caring Headlines
April 2, 2015

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