Caring Headlines
December 3, 2015

Celebrating Respiratory Care Week

See story on page 4

As part of her asthma education class, respiratory therapist and chronic care coordinator, Nancy Davis, RRT, shows young patient how to use a metered dose inhaler with spacer.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Results of the 2015 MGH Patient Safety Culture Survey

"Safety first" may be an adequate mantra for most industries. But not health care. To accurately represent the importance of safety in the health-care setting, the saying would have to be: "Safety first, last, and always." Because in my mind, there's no separation between safety and patient care. Safety is as much a part of care delivery as walking up to the bedside and introducing yourself. It's the very fabric from which patient care is derived. Which is why I was thrilled that, despite escalating *e*Care preparations, unprecedented census, annual required training, and other surveys in the field, a record 70% of MGH staff completed the recent Patient Safety Culture Survey administered by the MGH Center for Quality & Safety.

I was thrilled that, despite escalating eCare preparations, unprecedented census, annual required training, and other surveys in the field, a record 70% of MGH staff completed the recent Patient Safety Culture Survey administered by the MGH Center for Quality & Safety.

It's so important for staff to have a mechanism by which to make their perceptions of patient safety known. Not only does the Patient Safety Culture Survey help raise awareness about patient safety and enable us to assess the current culture, it's an evidence-based tool that allows us to identify strengths and weaknesses and articulate trends in our patient-safety culture over time. Studies show that a strong safety culture can help minimize adverse events, re-admissions, and certain hospital-acquired conditions.

Results of this year's Patient Safety Culture Survey show an improvement in some areas compared to our 2012 scores. Teamwork Across Units went up 13%; Teamwork Within Units went up 4%. Hand-offs and Transitions went up 4%; and Organizational Learning-Continuous Improvement went up 3%.

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

We remained constant in Non-Punitive Response to Errors; Communication Openness; Overall Perceptions of Patient Safety; Feedback and Communication About Errors; Staffing; and Frequency of Events Reported

And we declined slightly in Management Support for Patient Safety (down by 4%) and Supervisor Expectations and Promoting Patient Safety (down by 2%).

The chart on the opposite page shows MGH results in a side-by-side comparison with teaching hospitals that also report their results to the Agency for Healthcare Research and Quality. Scores reflect the percentage of positive responses to questions in each of the 12 domains measured. As you can see, our strongest areas are Teamwork within Units and Organizational Learning-Continuous Improvement.

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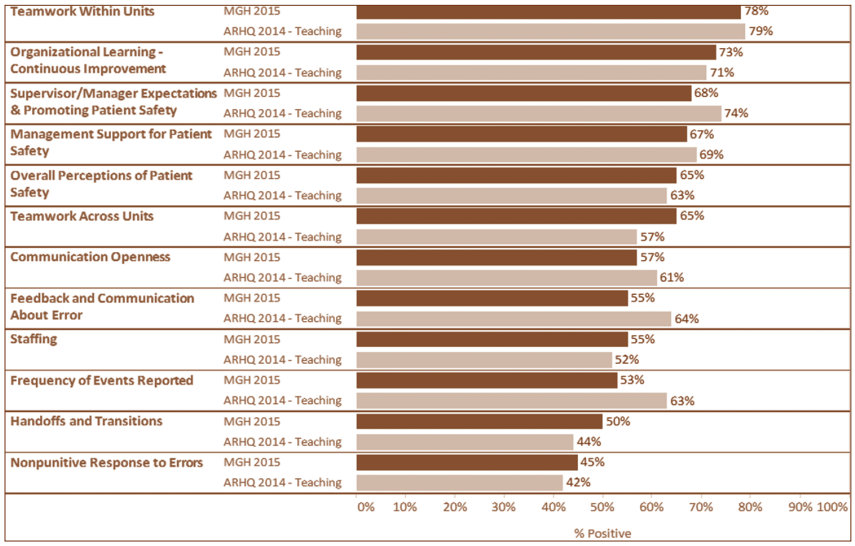
Approximately 65% of all reports filed are submitted by staff of Patient Care Services. These reports provide valuable information that help identify quality issues, systems breakdowns, and barriers to communication. Many reports of 'near misses' alert us to potential risks so we can avert serious harm to patients and/or staff.

You may notice a cross-over between the domains measured in the Patient Safety Culture Survey and those measured in our Staff Perceptions of the Professional Practice Environment Survey. Both instruments show that staff bring considerable knowledge, talent, and commitment to the care they provide. They work in teams to achieve the best outcomes for patients and families. They value change and innovation in their pursuit of safe, high-quality care. And they recognize the importance of effective leadership in fostering work satisfaction, teamwork, and professional growth and development.

A critical part of our robust safety culture is our safety reporting system. Safety reports are reviewed daily by staff of the MGH Center for Quality & Safety. Approximately 65% of all reports filed are submitted by staff of Patient Care Services. These reports provide valuable information that help identify quality issues, systems breakdowns, and barriers to communication. Many reports of 'near misses' alert us to potential risks so we can avert serious harm to patients and/or staff.

I want to thank everyone who took the time to respond to the Patient Safety Culture Survey. It's an extension of your commitment to exceptional patient care and one more example of how you consistently embody: "Safety first, last, and always."

MGH vs. National Teaching Hospital Average



In this Issue

MGH celebrates Respiratory Care Week

—submitted by the Respiratory Care Department

This year, National Respiratory Care Week fell during the week of October 26, 2015, the same week as the 68th anniversary of the creation of the Respiratory Care Department at MGH. Our observance of Respiratory Care Week centered around education, giving back to the community, and acknowledging the myriad contributions of respiratory therapists throughout the hospital. On August 29th, members of the department participated in the second annual Cure Spinal Muscular Atrophy five-kilometer run/walk around Lake Quannapowitt in Wakefield. Respiratory therapists formed 'Team Generals' to raise money for the Spinal Muscular Atrophy Foundation. Spinal muscular atrophy is the leading genetic cause of infant death; the annual run/walk helps fund research and support families affected by spinal muscular atrophy.

Respiratory Care hosted an educational booth in the Main Corridor showcasing the diverse aspects of respiratory therapy and offering informational materials to the public. The booth was augmented by a poster display with photographs and quotes from past and present respiratory therapists. The day was also an opportunity to publicize the MGH Respiratory Care Mentorship program designed to support new employees as they transition into the MGH community.

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At Lake Quannapowitt, Respiratory Care 'Team Generals,' includes: Cathy Kotowski; Misty Partridge; Victoria Harding; Karla Schlichtmann; director of Respiratory Care, Robert Kacmarek; Lindsey Panagiotou; Mary Gillen; Tarina Perez; and Daniel Charest (with son, Bradley, and wife, Kristin).

(Photo provided by staff)

What MGH respiratory therapists are saying

"My family's life was completely changed in 2009. My son was born at another hospital, in respiratory distress, requiring intubation and mechanical ventilation. He was transferred to MGH, where we met the most amazing professionals. It was at that point I knew I wanted to become a respiratory therapist. Leaving my profession and putting my life on hold to go back to school for Respiratory Care was an easy decision. To this day, I feel humbled and blessed to be a respiratory therapist, working alongside the best of the best."
—Rob Lyons, RRT,
respiratory therapist at MGH for 3 years

"It's so rewarding being a respiratory therapist—helping a patient with a tracheostomy use her voice after weeks of being silent, being the voice of a patient who's unable to speak while on a ventilator, hearing a newborn cry after you've helped him take his first breath. We're not just therapists and clinicians, we're advocates."
—Mary Gillen, RRT,
respiratory therapist at MGH for 4 years

"I love my job as a registered respiratory therapist. I enjoy collaborating with all members of the medical team, making patient care my top priority. I take pride in making a difference with every patient every day."
—Michelle Ouellette, RRT,
respiratory therapist at MGH for 4 years

"I enjoy working with clinicians who put patient care, safety, and respect above all else."
—Danielle Doucette, RRT,
respiratory therapist at MGH for 20 years

"The field of respiratory care is always evolving and advancing, giving me more to learn each day. I'm excited to join the MGH team where patient care is everyone's highest priority. I'm happy to be here!"
—Andrea Barry, RRT,
respiratory therapist at MGH for 3 months

As we turn the page to 2016, the Respiratory Care Department looks forward to more advances in respiratory care and the opportunity to continue to make a difference in the lives and care of our patients. We hope the MGH community will join us in celebrating the achievements and services provided by the Respiratory Care Department. For more information, call 617-724-4493.

After spending months in intensive-care and step-down units for treatment of her burns, soon-to-be-8-year-old Janaesia Gary, celebrates her long-awaited discharge from Shriners Hospital with some of her closest friends and caregivers. MGH respiratory therapists are active members of the dynamic patient-care team at Shriners. Janaesia is pictured at right with respiratory therapist, Elizabeth DeBruin, RRT.

Celebrating our Every Day Heroes

the annual Disability Breakfast of Champions Award

—by chairs of the MGH Employee Disability Resource Group, Linda Akuamoah-Boateng and Brian Holt

On Tuesday October 27, 2015, the MGH Employee Disability Resource Group hosted its third annual Breakfast of Champions award ceremony. The event began in 2013 to give the MGH community an opportunity to formally recognize employees who show exemplary commitment to disability advocacy and increasing accessibility for individuals with disabilities.

Individuals from many role groups representing many different departments throughout the hospital were nominated, but the distinction of being named 2015 disability champion went to Joseph Crowley, senior manager for Police, Security & Outside Services.

This year's celebration coincided with the 25th anniversary of the passage of the Americans with Disabilities Act and the 70th anniversary of the inception of National Disability Employment Awareness Month. MGH has made great strides toward making our hospital more accessible, more welcoming, and more aware of the issues that impact individuals with disabilities. As a community, we take pride in our commitment to ensure equitable access for anyone and everyone seeking care at MGH.

In his remarks, MGH president, Peter Slavin, MD, described our efforts to create a more 'disability-friendly' environment. "In 2009," said Slavin, "we committed more than seven million dollars to the purchase of ADA-approved medical equipment and other enhancements to our physical structure. Some of those funds were put toward renovations such as the installation of automatic doors in public areas and practice locations. A million dollars went toward structural improve-

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ments and the purchase of new adaptive exercise equipment for the hospital-owned Clubs at Charles River Park."

Nominees for the disability champion award must meet at least one of the following criteria:

- Exhibit extraordinary commitment to disability issues or persons with disabilities beyond the duties and responsibilities associated with their job
- Enhance the patient and/or work experience of individuals with disabilities as well as their families and visitors
- Establish and/or promote relationships within MGH or external agencies to strengthen MGH's commitment to persons with disabilities

Individuals from many role groups representing many different departments throughout the hospital were nominated, but the distinction of being named 2015 disability champion went to Joseph Crowley, senior manager for Police, Security & Outside Services. Presenting the award to Crowley, Slavin, said, "Joe is widely known as one of MGH's 'go to' people when it comes to issues of physical accessibility. His devotion to the MGH mission and values and his empathy and caring attitude make him a strong advocate for individuals who may need assistance or special accommodations during their visit to MGH."

Slavin presented certificates of recognition to other nominees, including:

- Susan Fergus, Dermatology
- Maria Isabel Gonzalez, Environmental Services
- Benjamin Majewski, Genetics
- Jamie Micco, Psychiatry
- Charles Tsun-Zhi Pu, Department of Medicine
- Jennifer Scalia, Neurology
- Lisa Susser, Practice Support Unit

In closing, Linda Akuamoah-Boateng, chair of Employee Disability Resource Group, encouraged attendees to seek opportunities in their own ways to make MGH more welcoming and accessible. Said Akuamoah-Boateng, "Each and every one of us can make a difference, we just need to recognize and seize the opportunities when we see them."

The Employee Disability Resource Group seeks to establish a venue and provide a voice for members of the MGH community to ensure our hospital is a safe, accessible, and welcoming place for all.

For more information about the Employee Disability Resource Group or the Disability Champion Award, send e-mail to: MGHEmployee Disability Resource Group@partners.org. Membership is open to all employees.

Opposite page (front row, l-r): Benjamin Majewski; Jamie Micco; Lisa Susser. (Back row): Charles Tsun-Zhi Pu; JosephCrowley; Maria Isabel Gonzalez; and Susan Fergus. (Jennifer Scalia, not pictured.) Below: senior vice president for Human Resources, Jeff Davis; chair of the MGH Employee Disability Resource Group, Linda Akuamoah-Boateng; and disabilities champion, Joe Crowley, with MGH president, Peter Slavin

(Photos by Jeffrey Andree)

Stepping up to care for complex patient hits close to home for one nurse

My name is Sarah Pollard, and I am an *e*Care nurse resident on Ellison 19. Although Ellison 19 is known as a Thoracic Surgery Unit, ten beds are actually designated for medical patients. When I first started on Ellison 19, I rarely engaged in self-reflection. During orientation, I was frequently reminded of the importance of reflecting on personal thoughts, feelings, and beliefs, especially when working with challenging patients. But it wasn't until I worked with 'John' that I discovered how reflective practice can help you become a stronger, more compassionate, more self-aware caregiver.

As a nursing student and patient care associate, my personal life and work life rarely intersected. However, on September 25, 2015, my personal and work lives collided, and my whole world changed. At 56 years old, my mother was diagnosed with a glioblastoma multiforme (GBM). In other words, my seemingly healthy mother had a stage IV astrocytoma, the most aggressive form of brain cancer.

I took some time off to be with my mother during her treatment. When I returned to work, I was determined not to let this new obstacle in my personal life impact how I functioned professionally. On my third day back, I was assigned to care for John. As I read his nursing progress notes, I saw a blurb about his discharge plan. His social workers were trying to arrange home hospice care for him.

I thought of the irony of being assigned to this particular patient less than a week after my mother's diagnosis... I knew I was the right person to care for this family because of my first-hand experience with what John and his family were going through.

Sarah Pollard, RN, eCare nurse resident
Ellison 19, Thoracic Surgery

As I was wondering why he needed hospice care, my preceptor approached me.

The first thing she said was, "I'm so sorry you were put in this position. If you'd prefer to care for a different patient, I'm happy to ask the resource nurse if you can switch."

I had no idea what she was talking about until I looked back at the nursing note. What moments before had been a small word buried among a long list of other clinical problems now seemed to jump off the page. That word was, 'astrocytoma.'

I thought of the irony of being assigned to this particular patient less than a week after my mother's diagnosis. Not wanting my emotions to impact my care, I reflected long and hard on my feelings about working with a patient suffering from brain cancer. The more I thought about caring for John, the more I understood the importance of my taking this assignment. I thought back to the week before when I was sitting at my mother's bedside, advocating on

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I didn't know if I had the strength to care for a patient who was essentially a crystal ball into my mother's future. Fortunately, caring for John had the opposite effect. Working with him made me feel stronger, more empowered, and more capable as a provider. John helped me realize my capacity to be an effective advocate for my patients

her behalf for the best care possible. I knew I was the right person to care for this family because of my first-hand experience with what John and his family were going through. With true understanding of what it means to deal with terminal cancer, I had the empathy to be able to provide compassionate care and advocacy for John just as I was doing with my mother.

I introduced myself to John. My primary goal was to assess his neurological status. Per report, he was waxing and waning in terms of orientation and was on high alert for aspirating. I'd read that he could become angry or aggressive when disoriented, so I was pleased to find him awake and very friendly. John was oriented to who he was, but didn't know where he was or why he was in the hospital. Despite that, he was able to follow commands. Not only was John compliant with commands, he was one of the sweetest, funniest patients I've ever worked with.

Also per report, John was supposed to go for hemodialysis at 8:00am to help improve his renal function. However, when 8:30 rolled around and John was still on the unit, I knew something was wrong. I called the Dialysis Unit and was informed that John had completed his dialysis the week before and no longer needed treatment. With conflicting stories from the dialysis team and the nursing notes, I knew I needed to resolve this problem quickly. I looked at John's labs. I knew he was a high-acuity patient and would most likely need to continue dialysis. After speaking with the medical team, it was determined that the dialysis team had been misinformed and, in fact, John was to continue receiving dialysis treatment. After a long conversation with the dialysis team, transport soon came, and John was taken for his treatment before lunchtime.

After helping transport John to dialysis, my preceptor commended me for recognizing the problem and advocating for timely access to treatment. As I sat in the break room having lunch, I was struck by how much my self-esteem and confidence had grown in the past few hours. I remember thinking how unexpected it was to feel such positive emotions after working with a patient suffering from the same disease my mother has. In all honesty, part of me expected I might have a bit of an emotional breakdown. I didn't know if I had the strength to care for a patient who was essentially a crystal ball into my mother's future. Fortunately, caring for John had the opposite effect. Working with him made me feel stronger, more empowered, and more capable as a provider. John helped me realize my capacity to be an effective advocate for my patients.

This experience showed me how essential it is for caregivers to use self-reflection in our everyday practice. We all have something going on in our personal lives that has the potential to impact our professional practice. No one is immune to human emotion. There's always going to be a patient who reminds us of a friend or family member, or a personal crisis that triggers an emotional response — sometimes positive, sometimes negative. What's important is that as providers, we look deeply into our feelings and recognize when certain situations stir emotions within us. If we reflect on those emotions, we'll know if those feelings could impact the care of the patient. And if there's the potential for a provider's emotions to adversely affect the care of a patient, we must do what's in the best interest of the patient, even it means shifting care to another provider.

The patient is our highest priority. It's our responsibility to reflect on our practice to prevent our personal lives from negatively impacting the care of our patients. Ultimately, John taught me that even our toughest patients can be our most valuable teachers because they transform us into the providers we were destined to be. And for that, I am eternally grateful.

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

Veteran caregivers know the value of self-reflection and the impact it can have on clinical practice. It's gratifying to read Sarah's narrative and glimpse the moment in her evolution as a nurse that she discovered the power of reflection. Not to mention the courage she showed in choosing to care for John despite her personal tribulations. That was a thoughtful and meaningful decision, one that will continue to impact Sarah's practice as she matures into a seasoned clinician.

Thank-you, Sarah. Our thoughts are with your and your family.

Spiritual Care Week 2015

meeting the spiritual needs of individuals from many different cultures, traidtions, and beliefs

—by Daphne Noyse, staff chaplain

The care of body, mind, and spirit took center stage during Spiritual Care Week, October 25–29, 2015. An annual observance at MGH, this year's activities ranged from daily services in the MGH Chapel, to educational offerings, to the much-anticipated blessing of the hands. Services in the Chapel encompassed many different traditions, cultures, and beliefs: Roman Catholic Mass, recitation of the rosary, a musical service featuring Taizé chants, Being Human: a Guided Meditation, Hindu Sunderkand, Jewish services of Minchah (daily prayer) and Pre-Shabbat gathering, a Healing Circle of Prayer, nurse's meditation, Buddhist meditation, and Jummah, Muslim Friday prayers (which took place in the Thier Conference Room). And the labyrinth was available every day for meditative walking.

Chaplains and chaplain residents offered the blessing of the hands: "May your hands be blessed with love and compassion, resilience and tenderness. May your hands create healing and connection."

In collaboration with the HAVEN Program, the Chaplaincy co-sponsored the presentation, "Faith and Domestic Violence: Resources and Roadblocks," with keynote speaker, Reverend Anne Marie Hunter, executive director and founder of Safe Havens Interfaith Partnership Against Domestic Violence. Panelists, Rabbi Ben Lanckton, Rebecca Smith, and Danish Zaidi, provided Jewish, Christian, and Muslim perspectives, respectively.

The unique and often unmet needs of the transgender community were the topic of a presentation by primary care physician, Tom Barber, MD, who has extensive experience and expertise caring for transgender individuals. Barber offered tips on how to support transgender patients and families with sensitivity and compassion.

The Spirituality in Nursing Conference capped off the week with, "Providing Spiritual Care: a Collaborative Approach," sponsored by the Chaplaincy and The Knight Nursing Center. Following a case study, chaplains from various traditions offered commentary on the role of spirituality in caregiving.

Director of the Chaplaincy, Reverend John Polk, noted, "The visibility that this week brings to our profession has a long-term impact and strengthens our relationships with other health professions. For the entire MGH community, it was a week of inspiration, education, diversity, and celebration."

For more information about the MGH Chaplaincy, call 617-726-2220.

At the Faith and Domestic Violence: Resources and Roadblocks presentation, (above left): Reverend Anne Marie Hunter, founder and director of Safe Havens; and (right): panelists (l-r) MGH chaplain, Rabbi Ben Lanckton (Jewish); Rebecca Smith, MGH HAVEN Program (Christian); and Danish Zaidi, Safe Havens and Harvard Divinity School (Muslim).

Celebrating Perioperative Nurse Week

—by Melissa Mattola-Kiatos, RN,

Celebrated each November, Perioperative Nurse Week is an opportunity to acknowledge the invaluable contributions of perioperative nursing care and the impact it has on patients in the surgical setting. Perioperative nurses practice in various roles and settings throughout the Center for Perioperative Care, including the Pre-Admission Testing Area, the Operating Rooms, and the Post-Anesthesia Care Unit. Perioperative nurses work closely with one another within and between settings to ensure safe, high-quality care throughout the continuum.

Perioperative nursing care begins when a patient is scheduled for surgery. The patient has a phone interview with a nurse or is scheduled to visit a nurse practitioner in the Pre-Admission Testing Area, depending on their individual needs. Perioperative care resumes on the day of surgery when the patient checks in to the Center for Perioperative Care, and it continues throughout their time in the Operating Room and Post-Anesthesia Care Unit. Perioperative nurses embrace a team approach, understanding the impact that each role has on the surgical process and on every patient undergoing surgery.

On November 9, 2015, Perioperative nurses staffed an educational booth in the Main Corridor. For more information about perioperative nursing, e-mail Patrice Osgood, RN, at posgood@partners.org.

Above: perioperative nurses, Melissa Mattola-Kiatos, RN, (left) and Sarah Cobb Moran, RN, staff educational booth in the Main Corridor. At right: Mattola-Kiatos shares information about the perioperative nursing care plan and what goes on 'behind closed doors.' PACU nurse, Julie McCarthy, RN (not pictured), also staffed the informational booth, on Monday, November 9, 2015.

(Photos by Jeffrey Andree)

Comfort and Support after Loss Memorial Service

—by Leslie Kerzner, MD, neonatologist

"Grief is like a big, hot rock with pointy edges," said Blythe Lord, founder of Courageous Parents Network and speaker at the 24th annual Mass-General Hospital *for* Children's Comfort and Support after Loss Memorial Service, held November 1, 2015. "At first, you can't touch it, but in time, the edges soften, and it cools."

"Grief is like a big, hot rock with pointy edges," said Blythe Lord, founder of Courageous Parents Network "At first, you can't touch it, but in time, the edges soften, and it cools."

One parent spoke about how losing a child doesn't make sense, but she appreciated the service because, "It's a community of sorrow and support."

Staff members spoke eloquently about the loss of each child and how caring for them made them better, more empathic clinicians.

These are some of the sentiments shared at the memorial service, which is held for MGH families who've experienced the death of a child, from infancy through adolescence, including miscarriage or stillbirth. Many families and staff return year after year to participate in what is an extremely poignant and meaningful event.

Social worker, Nancy Leventhal, LICSW, moderated the service. Remarks and reflections were offered by Kevin Schwartz, MD, pediatrician; Mona Hemeon, RN, staff nurse, Labor & Delivery; and Lord, also a bereaved parent. Several family members shared stories and offered words of advice, encouragement, and healing. Pediatric chaplain, Kate Gerne, offered a spiritual reflection, and the musical lyrics, "Love can build a bridge from your heart to mine," helped set the tome.

Lorrie Kubicek, music therapist, and Kimberly Khare provided guitar music and vocals during the service, with Bette Midler's, *The Rose* and other selections. Parents, families, and friends were invited to participate in a naming ceremony and were given pewter hearts, red roses, and daffodil bulbs to plant in memory of their children. Each family held a candle, shared a moment of silence, and read together in prayer. Many families hung fabric memorials, which will be placed in a scrapbook. Child life specialists, Jamie Rossi and Melissa Tecci, compiled a pictorial slide show depicting years of precious memories. Fun activities were provided for younger children at the MGH Back-up Child Care Center.

Following the service, a reception was held in the East Garden Dining Room where families had an opportunity to re-connect with caregivers and mingle with families experiencing similar grief. Memorial quilts and scrapbooks from past years were on display.

Members of the Comfort and Support After Loss Committee include:

- Nancy Leventhal, LICSW, co-chair
- Clorinda Cottrell, LICSW, co-chair
- Kathryn Beauchamp, RN
- Kate Gerne, chaplain
- Leslie Kerzner, MD
- Jamie Lee Rossi, CCLS
- Kate Stakes, RN
- Melissa Tecci, CCLS

For more information about the annual Comfort and Support after Loss Memorial Service, call 617-724-9040.

The power of cell phones and medical interpreters

you have access to medical interpreter services in your pocket

I know it's tempting to want to use phone apps for quick interpretation, but the translations aren't always accurate; they can contain wrong words and erroneous information. And that can have a serious impact on patient safety.

Question: It's great that we have so many ways to access medical interpreters. When should we use the phone for interpretation versus requesting an interpreter at the bedside?

Jeanette: Phones are an effective and efficient way to access interpreters. They're particularly effective when the information you want interpreted is brief and routine. When the conversation is of a more sensitive nature, such as discussing DNR status or communicating a diagnosis, or the interaction warrants an in-depth dialogue between patient and provider, the presence of an interpreter is highly recommended.

Question: It seems like we need more I-POPs and V-POPs on our units. We only have one or two, and often they're both in use.

Jeanette: Many providers aren't aware that they can use their Voalte phones to access an interpreter. It's especially helpful when a hands-free device is preferred, such as when you are walking with the patient or performing bedside care. Just call 3-3344 from your Voalte phone, and you'll be connected to an interpreter.

Question: Can I use phone apps (applications) for interpretation?

Jeanette: I know it's tempting to want to use phone apps for quick interpretation, but the translations aren't always accurate; they can contain wrong words and erroneous information. And that can have a serious impact on patient safety. Research confirms that the use of phone apps is not a reliable form of medical interpretation.

Question: I work in two different units. One unit has one type of V-POP, and the other unit has a different type of V-POP. Why is that?

Jeanette: Medical Interpreter Services is in the process of upgrading all their remote-access interpreting devices to allow for better sound and image quality. The new V-POPs are mounted on an adjustable pole to allow for better positioning. To date, 50% of the devices have been replaced, and we anticipate that all devices will be switched out by the end of the year.

For more information about V-POPs, I-POPs, interpretation by phone, or any of the services offered by Medical Interpreter Services, call 6-6966.

I-PASS

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

Question: I know many of my colleagues have started using the I-PASS format for hand-over report. What is that?

Jeanette: As an organization, we've adopted the I-PASS format for 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 enhances continuity across the continuum and increases patient safety. A recent Joint Commission report states that the most common cause of health-care-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 does 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,' that reinforces patient safety.

I-PASS hand-over checklist:

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

Question: Why did we choose I-PASS?

Jeanette: I-PASS incorporates two important elements that aren't included in some of the 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 here?

Jeanette: Yes, nurses and other clinicians helped pilot the I-PASS approach on White 9, White 10, and Ellison 19 last year, and they continue to use it as their hand-over format along with staff on many other units. The Norman Knight Nursing Center is coordinating education with a combination of unit-based learning and classes offered through the Center. More than 5,000 clinicians have been trained in I-PASS, to date. Some units are further enhancing hand-over communication by moving report closer to the patient and, when appropriate, to the bedside with the patient.

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

Announcements

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Blum Center Events

National Influenza Vaccination Week
"Spread holiday cheer, not the flu"
Monday, December 7–Wednesday, December 9, 2015
8:00am-4:00pm

Stop by the Blum Center to receive your flu vaccine if you have not already done so. And stop by the informational tables in the White Lobby for materials, games and giveaways!

"Promoting Play: the Greatest Gift of All"

Wednesday, December 9th
11:00am–12:00pm
Haber Conference Room
Join child life specialist, Danielle Surprenant, CCLS, for a presentation on the developmental stages of children's play.

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

For more information, call 4-3823.

ACLS Class

Certification:

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

Day one:
February 19, 2016
8:00am–3:00pm

Day two:
February 29th
8:00am–1:00pm

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

Location to be announced. For information, send e-mail to: acls@partners.org, or call 617-726-3905

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

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday, 7:30am – 5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday, Thursday, 7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

One-stop intranet site for strategic priorities

Want to know more about the Partners-MGH patient care re-design, patient affordability, and budget review initiatives? Wondering about the time line?

To read the latest articles about this work, or if you have a cost-reduction idea or better way to deliver patient care, visit the new MGH/MGPO intranet site:

http://priorities.massgeneral.org.

Brian A. McGovern, MD Award

Call for Nominations

The MGPO is now accepting nominations for the 2016 Brian A. McGovern Award for Clinical Excellence. Nominate a physician who's focused on patient care, a superb clinical role model, and considered an "unsung hero." Physicians in all clinical departments are eligible.

Anyone can submit a nomination. Nominations are due by Friday, January 22, 2016.

To submit a nomination, go to https://mgpo.massgeneral.org/mcgovern/, or e-mail letter of nomination to Jenna Berube at jeberube@partners.org.

For more information, call 617-643-4936.

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Next Publication
December 17, 2015

Inpatient HCAHPS

2015 calendar year to date

HCAHPS Measure	CY 2014	CY 2015 Year To Date *(as of 11/13/15)*	% Point Change
Nurse Communication Composite	82.1%	83.1%	↑ 1.0%
Doctor Communication Composite	81.6%	83.4%	↑ 1.8%
Room Clean	72.2%	72.6%	↑ 0.4%
Quiet at Night	49.7%	51.0%	↑ 1.3%
Cleanliness/Quiet Composite	60.9%	61.8%	↑ 0.9%
Staff Responsiveness Composite	63.8%	65.7%	↑ 1.9%
Pain Management Composite	71.7%	73.2%	↑ 1.5%
Communication about Meds Composite	65.8%	66.5%	↑ 0.7%
Care Transitions	59.9%	62.7%	↑ 2.8%
Discharge Information Composite	91.6%	91.2%	↓ -0.4%
Overall Hospital Rating	79.8%	81.2%	↑ 1.4%
Likelihood to Recommend Hospital	90.0%	90.5%	↑ 0.5%

MGH continues to perform well on patient experience measures this year as compared to last year. For our three areas of focus—Quiet at Night, Staff Responsiveness, and Pain Management—we are well-positioned to achieve our goals.

Data complete through August, 2015; data partial for September, October, and November, 2015
All results reflect Top-Box (or 'Always' response) percentages

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