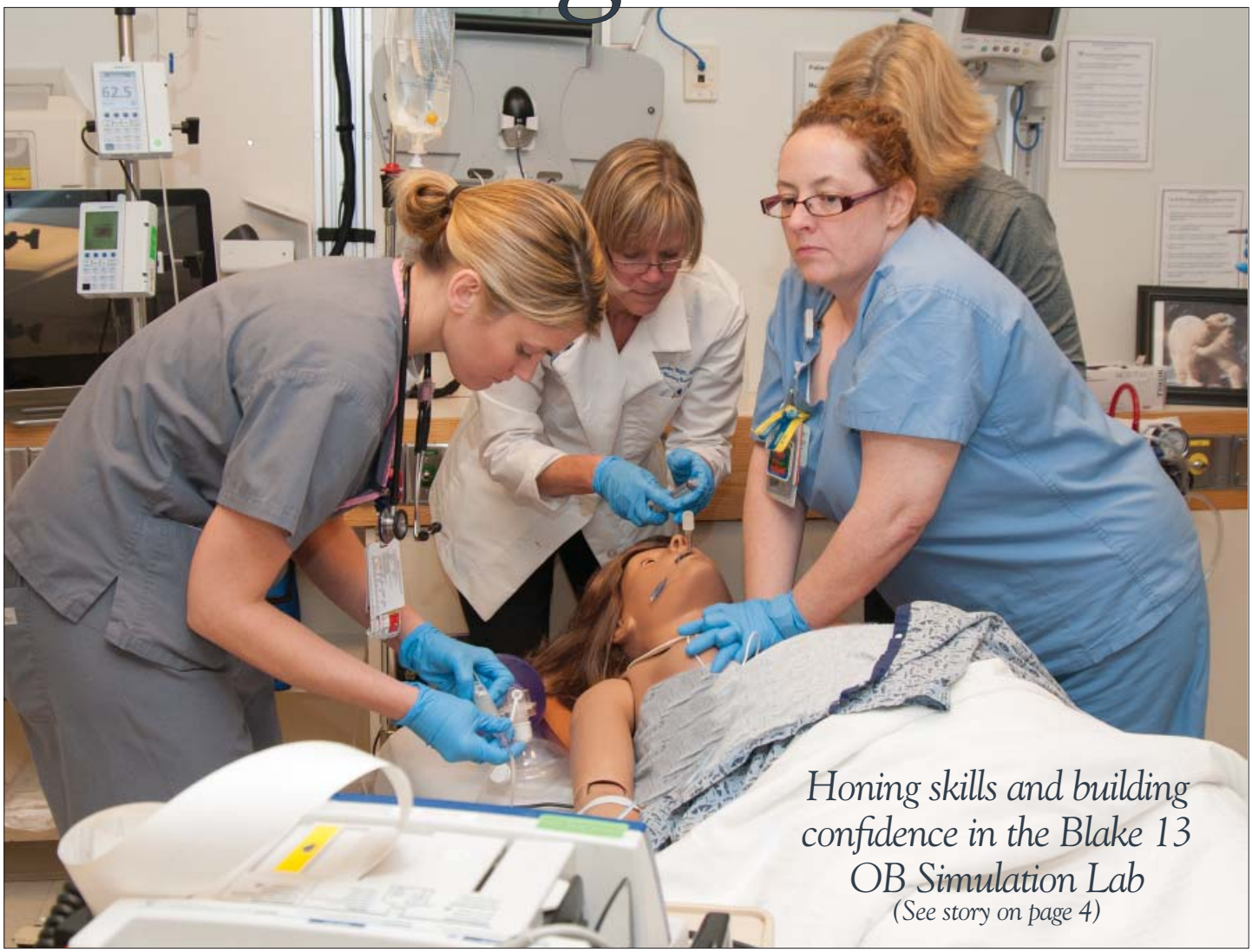
Caring Headlines
February 19, 2015

Simulating bedside emergencies



Honing skills and building confidence in the Blake 13 OB Simulation Lab
(See story on page 4)

Patient education and simulation professional-development specialist, Gail Alexander, RN (center back) leads staff nurses (l-r): Molly Ouellette, RN; Susan Goguen, RN; and Margie Stewart, RN (back), in simulated code call during recent OB simulation session.

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

Jeanette Ives Erickson

2015 PCS Strategic Plan
Goal #1

In the January 22, 2015, issue of *Caring Headlines*, I broadly shared the goals of the 2015 PCS Strategic Plan (see opposite page). In this issue, I'd like to start to take a closer look at the tactics for each goal, beginning with the first one.

Goal #1

- 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

Tactics:

- Prepare for and ensure a successful Joint Commission survey

2015 is a Joint Commission survey year. We will continue to work with collaborative governance committees and others to ensure understanding of, and compliance with, National Patient Safety Goals and other regulatory requirements. We are striving to improve performance in: blood-transfusion documentation; critical lab results: the RN-only model; PRN pain-medication guidelines; medication reconciliation and PAML completion; and controlled-substance administration practices. To ensure coordinated messaging, we're using a number of communication mechanisms, including: Tuesday Take Aways; *Caring Headlines*; the Excellence Every Day portal; *PCS News You Can Use*, EED booklets; National Patient Safety Goal badges; Exercise Your Excellence tips; and HealthStream modules. In the coming months, you can expect to see more inter-disciplinary tracers, unit-based audits, leadership training, town hall meetings, and a Joint Commission Fair.

- Develop and implement a plan to prevent catheter-associated urinary tract infections (CAUTIs) and central-line-associated bloodstream infections (CLABSIs)

CLABSI and CAUTI data show a positive trend in decreasing infection rates, but more work is needed to meet and exceed national benchmarks.

CLABSIs and CAUTIs are among the most common hospital-acquired infections. We know that both are positively impacted by nursing interventions. We will continue to employ best practices such as: utilizing approved indicators for catheter insertion; the Avoid-Reduce-Maintain bundle; daily assessment for removal of urinary catheters; exploring alternatives to urinary catheters; daily assessment for continued use of central lines; Bio-Patches; Scrub the Hub campaign; and chlorhexidine bathing in ICUs.

To further decrease CLABSI and CAUTI rates, we'll focus on evaluating a nurse-driven protocol for urinary-catheter insertion/removal and promoting a 'back to basics' approach for central-line management. And we will continue to evaluate new products.

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

- Begin the process of establishing a data warehouse

Improvement and innovation are driven by data. Patient Care Services compiles data from numerous sources within and outside of PCS (patient records, financial records, safety reports, staff surveys, Quadramed, staff scheduling, to name only a few). Currently, this data exists separately, making it challenging to compare, analyze, or discern relationships among data from disparate sources.

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This spring, we will establish a data warehouse for data collected by PCS departments. The data warehouse will be compatible with MGH and Partners data sources and provide a more direct way to link data from disparate sources and discern important relationships between quality and acuity measures.

- Enhance the culture of safety by implementing strategies to share errors and near misses

Since the introduction of our electronic Safety Reporting System in 2006, we've seen tremendous growth in the number of reports filed, with 19,817 reports submitted in 2014. The safety reporting upgrade that launches next month offers enhanced capabilities for synthesizing the data and communicating lessons learned from safety incidents and near misses. To make optimal use of these new capabilities, we'll begin incorporating safety reports into meeting agendas creating learning opportunities for staff and leadership. And we'll continue to encourage and share safety narratives as a means of preventing future events and fostering a culture of safety.

- Develop and implement a plan to enhance patient-satisfaction scores (such as quiet, pain-management, and responsiveness)

Informed by feedback from patients and families, the areas we've selected to focus on in 2015 to improve patient-satisfaction include pain-management, staff responsiveness (call-bell response), and quietness. Guided by the PCS Patient Experience Committee, some of the tactics we plan to employ include a hospital-wide campaign to engage all employees in our efforts to achieve these goals, training for newly hired staff on best practices in each of these areas, and other strategies as needed. To ensure success, our progress will be monitored by the Patient Experience and PCS Executive Committees.

- Increase awareness and utilization of the resources available through Interpreter Services to support the delivery of equitable care

Making professional medical interpreters accessible wherever and whenever care is delivered is critical to our ability to provide high-quality care to patients with limited English proficiency (LEP) and who are Deaf or Hard of Hearing (DHH). To increase awareness and utilization of interpreter services on inpatient units, a multi-pronged approach will be used to ensure staff are informed about available resources and know how to access them (in-person, by telephone, or by video). Education will include presentations, unit-based training and in-services, and a communication campaign utilizing MGH publications and other outlets.

These are the tactics we will employ in executing the first goal of our strategic plan. I welcome your comments and ideas and your help in enlisting the support of staff as we implement the plan.

In the next issue of *Caring Headlines*, I'll share the tactics we'll be employing to achieve our second goal, Partners *e*Care and optimizing the patient experience.

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

OB nurses use simulation to prepare for bedside emergencies

—by Patricia Connors, RN, OB clinical educator

In December, 2013, Noelle, the high-fidelity, birthing simulator, was relocated from the Simulation Lab on Cambridge Street to classroom space on the Blake 13 Obstetrics/Newborn Care Unit. The new space is an ideal location for the OB Simulation Lab as it allows staff to easily participate in unit-based educational programs complete with mannequin (Noelle), bedside monitors, and specialized equipment that enhance the reality of the simulations. In addition to being able to give birth, Noelle has a discernible heart rate, blood pressure, pulse, oxygen saturation rate, breath and heart sounds, and a palpable fundus. Assessment parameters can be programmed for each scenario, and Noelle's status can change idiopathically or in response to the interventions of the caregivers involved in the simulation. The new Simulation Lab has an adjacent classroom area for the all-important, post-simulation de-briefing session.

Over the past few years, the acuity of pregnant women coming to MGH for obstetrical care has increased. Many women are choosing to postpone giving birth until later in life, and many women develop co-morbidities that present challenges for routine delivery and put both the mother and the unborn child at risk. Historically, obstetrical nurses practicing in Antepartum, Labor & Delivery, and Postpartum, have had limited exposure to such rare

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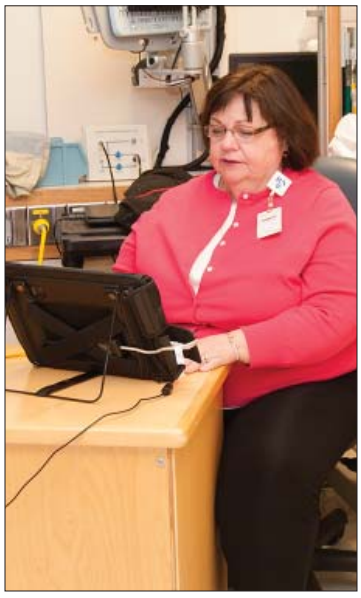

(L-r): OB clinical educator, Pat Connors, RN, provides background on growing number of OB emergencies; staff nurse, Lindsay Musgrave, RN, begins her assessment of Noelle; while professional development specialist, Jeanne McHale, RN, controls the simulation from behind the scenes.

and serious complications as spontaneous coronary artery dissection (SCAD), myocardial infarction (MI), or stroke, all of which can occur during pregnancy or during or after delivery. It is imperative that obstetrical nurses acquire the knowledge and skills necessary to respond to cardiac and respiratory emergencies. OB nurses need to be able to quickly identify signs and symptoms of a potentially worsening condition and respond appropriately in every changing situation.

Partnering with professional-development specialists in the Knight Simulation Program, a two-hour continuing-education offering was developed to help prepare OB nurses on Blake and Ellison 13. Simulations were crafted that provide two post-partum obstetrical emergencies involving cardiac and respiratory deterioration. Each program is designed to accommodate four to six staff nurses with the objective of learning: assessment and management of patients with worsening respiratory or cardiac conditions; identification of appropriate nursing roles, use of emergency equipment, and the importance of effective communication and documentation in an emergency situation.

Depending on the scenario, nurses have an opportunity to defibrillate the patient using the AED mode, perform cardiopulmonary resuscitation, assist with intubation, and administer medications. These interventions may be foreign to OB nurses who've never been exposed to such emergencies or who haven't experienced them recently. Simulation faculty act as physicians during the simulation to help advance the action.

The most important part of the simulation experience, a faculty-guided de-briefing follows each simulation. Simulation faculty lead nurses in a discussion that allows participants to reflect on their practice and share their thoughts and feelings about how the scenario unfolded and how the team functioned under pressure. Faculty use this time to answer questions and reinforce lessons learned. Participating in both the simulation and the de-briefing have a strong impact on nurses and help influence future practice.

To date, 46 staff nurses on Blake and Ellison 13 have attended the program. Response has been very positive. Once the initial apprehension passes, staff report feeling prepared and empowered to respond in an emergency.

For more information about the OB Simulation Program, call OB clinical educator, Pat Connors, RN, at 617-643-9694.

(Top-to-bottom): As Noelle develops complications, staff nurse, Molly Ouellette, RN, steps in to assist Musgrave with care. Soon, a full-blown code is called. Tanya Rosenbaum, RN (left), Alison Golden, RN (center back), and Gail Alexander, RN, acting as attending physician, join the effort. CPR is initiated. Following the simulation, McHale facilitates the all-important de-briefing. Note: Noelle and her baby are both doing fine!

Critical Care Nurse Residency Program

preparing the next generation of critical-care nurses

—by Sheila Burke, RN, professional development specialist

On January 22, 2015, family, friends, and colleagues celebrated the achievements of six critical-care nurse residents at the completion ceremony of the Critical Care Nurse Residency Program. Executive director of The Institute for Patient Care, Gaurdia Banister, RN, welcomed attendees and gave a brief history of the program, which was established in 2001 in response to an increasing demand for critical care nurses. The residency, supported by The Norman Knight Nursing Center for Clinical & Professional Development, provides an environment of support for new nurses to prepare them to meet the needs of patients and families and function as part of the inter-disciplinary team in a critical-care setting. Banister thanked ICU nursing leadership and interdisciplinary faculty for their invaluable contribution to the program and preceptors for their dedication, clinical wisdom, and guidance.

Sandra Muse, RN, nursing director for the Surgical ICU, congratulated residents for their perseverance and resiliency over the past five months and for successfully completing the program.

Nurse resident, Kristina Nyman, RN, shared a narrative chronicling her care of a complex patient in the Neuro ICU. She noted that caring for him not only improved her assessment skills but tested her emotionally and showed her the importance of knowing the patient. Nursing practice specialist, Mary McKenna Guanci, RN, engaged Nyman in a dialogue about lessons learned from the experience.

The Critical Care Nurse Residency Program has now been completed by 206 nurses since its inception in 2001. Banister and program coordinator, Sheila Burke, RN, presented certificates of completion to each graduate.

For more information about the Critical Care Nurse Residency Program, call Sheila Burke at 617-726-1651.

Below: professional development specialist, Sheila Burke, RN (right), with CCRN graduates (l-r): Kristina Nyman, RN, Neuroscience ICU; Melissa Pike, RN, Neuroscience ICU; Monica Doucette, RN, Cardiac ICU; Melissa Conklin, RN, Cardiac Surgical ICU; and Amanda Regan, RN, Surgical ICU. Not pictured: Bridget Bubar, RN, Surgical ICU. At right: Nyman shares her clinical narrative.

(Photos by Paul Batista)

Perianesthesia Nurse Awareness Week

—by Lori Rizzo, RN, perioperative staff specialist, and Lucy Milton, RN, OR clinical nurse specialist

In honor of Perianesthesia Nurse Awareness Week, February 2–8, 2015, MGH perioperative nurses hosted an informational table in the Main Corridor. Perianesthesia nurses specialize in pre-admission assessment and testing and pre- and post-anesthesia care. This year, the theme of Perianesthesia Nurse Awareness Week was the pre-admission process—providing patients and staff with information about planning and preparing for surgery, pain-management, and education about all-important health care proxies. The table featured a 'Wheel of Fortune' game where participants could test their knowledge on these topics and learn more about the role of perianesthesia nurses who deliver skilled, compassionate care to patients every day. The interactive game was a springboard for dialogue with patients, visitors, and other MGH colleagues.

The Perioperative Nursing Service would like to thank Pre-Admission Testing Area nurses, Sue Croteau, RN, Joan Braccio, RN, and Sharon Kelly-Sammon, RN, who volunteered to staff the table. And special thanks to Croteau and clinical nurse specialist, Lucy Milton, RN, for their efforts in making the display fun and informative.

Says associate chief nurse, Dawn Tenney, RN, "Congratulations to all our perianesthesia nurses who do such tremendous work for our surgical patients each and every day."

For more information about the role of perianesthesia nurses, call staff specialist, Lori Rizzo, RN, at 617-724-0150.

Pictured below staffing the Perianesthesia Nurse Awareness Week table are (l-r): Sharon Kelly-Sammon, RN; Susan Croteau, RN; Barbara Crawley, RN; Joan Braccio, RN; Lucy Milton, RN; and Croteau.

(Photos provided by staff)

RT's extensive knowledge of ECMO helps give patient more time with family

Ms. C, was a 61-year-old woman with idiopathic pulmonary fibrosis admitted to MGH from Spaulding Rehabilitation Hospital when her breathing difficulties worsened.

My name is Carolyn La Vita, and I am a senior respiratory therapist. One Sunday when I was the charge therapist for the day shift, I got report from the overnight charge therapist on all the patients currently receiving extracorporeal membrane oxygenation (ECMO). One of those patients, Ms. C, was a 61-year-old woman with idiopathic pulmonary fibrosis. Ms. C had been admitted to MGH from Spaulding Rehabilitation Hospital when her breathing difficulties worsened. She was put on venovenous ECMO in hopes of eventually receiving a double-lung transplant.

When I met Ms. C, she had one large cannula in her right atrium and one in her right internal jugular vein, through which deoxygenated blood was being drained. The blood was passed through an oxygenator and returned to her body via another large cannula to her pulmonary artery. Despite this complex technology, Ms. C was awake and alert. I was told of a large clot extending from one of the cannulas into the ECMO circuit tubing. Clot formation is not uncommon during ECMO. To prevent it, most patients are anticoagulated to some degree. Large clot formations can be dangerous, as pieces can break off and travel into the patient or obstruct the machine, preventing pump flow.

Overnight, this large clot had started to impede ECMO flow. The night ECMO and charge therapists alerted the covering physician, but Ms. C was stable, so nothing was done emergently. The night charge therapist told us we'd need to change Ms. C's circuit, most likely very soon. Shortly after report, I received a call

Carolyn La Vita, RRT, respiratory therapist

from the day ECMO therapist saying that Ms. C's flows were dropping. I immediately went to the Cardiac Surgical ICU. When I arrived, the surgical resident was at Ms. C's bedside. I knew the ECMO therapist and I had to act quickly to coordinate a plan clearly identifying who would be responsible for what.

Two other patients were on ECMO in the Cardiac Surgical ICU that day. Since the other therapist knew those patients well, his primary responsibility would be to care for them. My responsibility would be to care for Ms. C and change her ECMO circuit with help from the surgical residents. Changing the ECMO circuit would be a good learning opportunity, so I paged a less experienced therapist to observe and assist. When the other surgical resident arrived, we talked about the change in great detail to ensure everyone knew their specific role.

The residents clamped the tubing and cut the old one away, then re-attached the new tubing. On the new ECMO device, I turned up the RPMs to

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increase the pump flow. Unfortunately, I couldn't get the pump flow high enough to maintain sufficient flow. Due to Ms. C's poor lung function, she began to desaturate. The residents paused, hoping her vital signs would improve. I checked to make sure there were no kinks or clamps on the circuit restricting flow. There weren't.

I told the resident we had a problem. Since changing the circuit hadn't improved the flow, I surmised there had to be a clot in one of the cannulas or else something was happening internally. The residents stepped away from the bedside and called the attending surgeon, who recommended placing another drainage cannula in her right femoral vein. The resident placed the additional drainage cannula, but there was still no improvement.

With a new circuit and drainage cannula, the problem had to be in the other cannula or inside the patient. Ms. C's lungs couldn't compensate for the lack of ECMO support, and her oxygen saturation continued to fall. She began having cardiac arrhythmias and eventually went into full cardiac arrest. Chest compressions were performed, and medications were given. I suggested they convert her to venoarterial ECMO to support her heart by placing a cannula into her femoral artery. As basic life support was being administered, the resident again called the attending surgeon who also suggested placing an arterial cannula. I suggested to the resident that we wye all the cannulas together to increase the chance of improved flow. He relayed the idea to the attending surgeon who agreed.

As Ms. C received epinephrine in line with the PEA (pulseless electrical activity) arrest algorithm, her blood pressure became labile. She was hypotensive with a mean blood pressure in the 30s. Following administration of epinephrine, her blood pressure rose above 100. I was concerned about increased bleeding, but I knew the epinephrine was necessary to keep perfusion to her organs.

The arterial cannula was placed, and as we were about to re-connect to the ECMO circuit, it was time to administer epinephrine again. Knowing how Ms. C had responded to previous doses, and knowing that increased after-load (in the form of severe hypertension) could prohibit ECMO flow, I asked the nurse practitioner to wait before administering epinephrine. Being able to achieve good ECMO flow would restore her blood pressure, and I knew we would be on venoarterial ECMO shortly.

There were a few moments of angst, as it is very difficult knowing your patient is hypotensive and not being able to treat it. Once we were on venoarterial ECMO, we achieved enough flow that Ms. C no longer needed CPR or epinephrine, but the flows were still less than optimal.

Caring for Ms. C was intellectually challenging and emotionally difficult. During this acute event, it was rewarding to be able to troubleshoot the ECMO circuitry quickly and narrow down the source of Ms. C's problem.

The attending surgeon arrived, so we took a moment to recap what had happened and formulate a plan. Ms. C had drainage cannulas in the right atrium, right internal jugular vein, pulmonary artery, and right femoral vein. The return cannula was in the left femoral artery. The attending surgeon was concerned that the drainage cannula in her femoral vein was too low, limiting the flow. He asked the residents to adjust the position.

Flow is monitored by an ultrasonic probe, so I suggested putting the probe on the femoral venous cannula to see if it affected the flow as they adjusted the insertion depth. No change was detected. Where we had changed the circuit and replaced two cannulas, I knew the issue had to be internal. The nurse practitioner called for a STAT bedside echocardiogram, which showed a large peri-cardial thrombus compressing Ms. C's right atrium. She was taken to the operating room for immediate evacuation.

Ms. C continued on ECMO for several months after this event. Unfortunately, she passed away before she was able to receive a transplant. Caring for Ms. C was intellectually challenging and emotionally difficult. During this acute event, it was rewarding to be able to troubleshoot the ECMO circuitry quickly and narrow down the source of Ms. C's problem. Having a thorough understanding of ECMO and how it interacts with hemodynamics allowed me to anticipate potential issues and avoid further problems. Working as a team with the nurses, nurse practitioners, physicians, and other respiratory therapists, we were able to avert what could have been a catastrophic event, and at the very least, give Ms. C a few more months with her family.

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

This narrative is an excellent example of the advanced technology, complex interventions, and specialized skills required more and more frequently to care for our sickest patients. Carolyn gave us great insight into her thinking as she responded in this rapidly changing situation. Teamwork, communication, and flexibility were all key as the team systematically honed in on the cause of Ms. C's poor flow. Thanks to the extensive knowledge and experience of Carolyn and the team, Ms. C was able to spend a few more months with her family.

Thank-you, Carolyn.

Hand hygiene

still the most effective strategy for preventing hospital-acquired infections

—by Patti Shanteler, RN, staff specialist, and Judy Tarselli, RN, staff nurse

According to the World Health Organization, "Each year, hundreds of millions of patients around the world are affected by healthcare-associated infections. Most healthcare-associated infections are preventable through good hand hygiene—cleaning hands at the right time, in the right way." Significant improvements have been made in hand hygiene since new guidelines were established by the Centers for Disease Control and Prevention and the World Health Organization, but healthcare-associated infections continue to occur in hospitals across the country.

At MGH, infection-prevention professionals routinely help educate staff, raise awareness, and monitor hand-hygiene compliance by observing caregivers interacting with patients and the patients' environment. As a result, MGH meets or exceeds expectations for hand-hygiene compliance and has seen historically low rates for some healthcare-associated infections. Despite that success, we remain vigilant about proper hand hygiene and invite patients and visitors to do the same.

Healthcare workers are required to use hand hygiene before and after contact with patients or the patients' environment and at other times during patient care as described by the World Health Organization's "Five Moments" for hand hygiene (see opposite page).

A frequently asked question is, "What is meant by, 'the patient's environment'?" A poster developed by MGH Infection Control (see insert at right) defines the patient's environment as everything contained within a, 'giant imaginary bubble' surrounding the patient. The goal is to keep staff and visitors' germs out of the bubble (to keep the patient safe), and keep the patient's germs inside the bubble (to keep everyone else safe). Since germs are easily transmitted by touch, it's imperative to use proper hand hygiene before touching anything inside the bubble and again after leaving it.

Other tips to remember include:

Mid-task activities

When a staff member needs to leave a patient's room in the midst of providing care, gloves should be removed (if worn) and hand hygiene should be performed upon exiting the room and before returning to the patient. Visitors should do the same if they step out of the room and return.

Environmental contact only

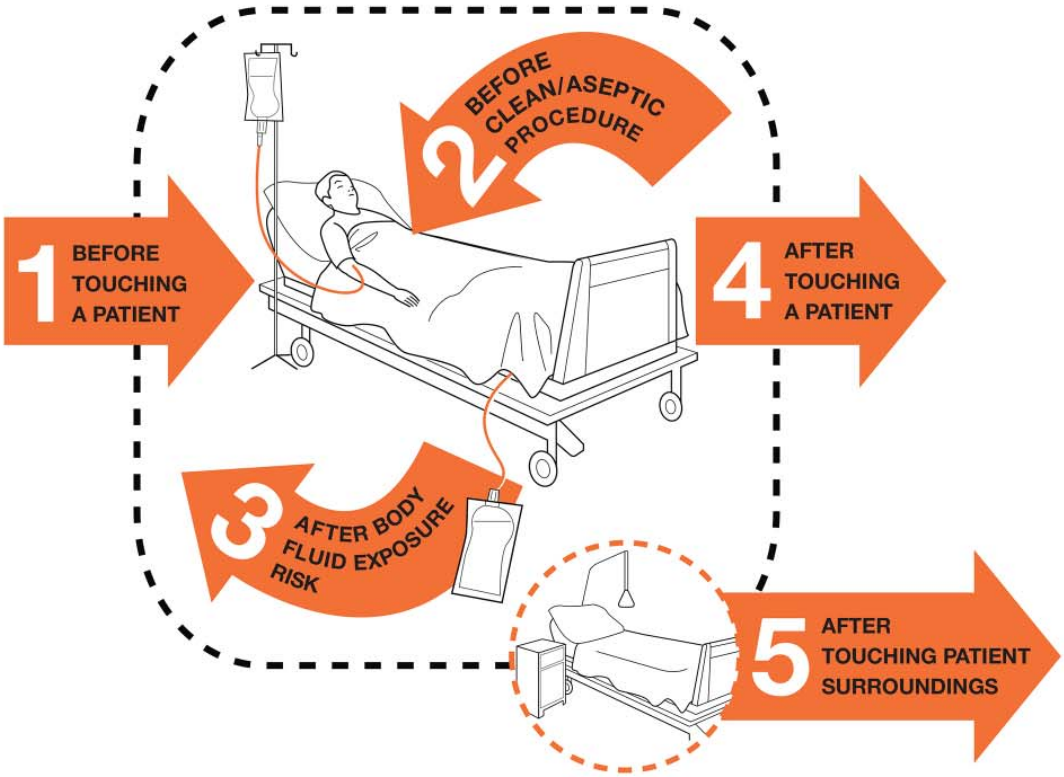
If a staff member enters the room to use a bedside computer, adjust a monitor, or change an IV and doesn't touch the patient, hand hygiene must still be performed before and after those tasks as they're all located within the patient's environment. The same applies to adjusting the bed, assisting with food trays, handling the TV remote control, or touching any other surfaces in the patient's room.

Communication Devices

Electronic devices, such as cell phones, smart phones, pagers, and hand-held computers, can also become contaminated and transmit germs. If these devices need to be used during an episode of patient care, staff should clean the device and disinfect their hands after using the device before resuming care of the patient.

For more information about hand hygiene or its impact on infection control, contact staff nurse, Judy Tarselli, RN, at 617-726-6330.

Your 5 Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

The poster above is part of the World Health Organization's effort to create a unified message about the risk of infection in the hospital environment. MGH will be adopting this poster as part of our campaign to sustain awareness of the importance of hand hygiene before, during, and after care.

Professional Achievements

Burke certified

Hematology/Oncology/BMT nurse, Christina Burke, RN, became certified as an oncology nurse by the Oncology Nursing Certification Corporation, in January, 2015.

Ehrlich certified

James Ehrlich, RN, staff nurse, Burns, Plastic and Reconstructive Surgery, became certified as a plastic surgical nurse by the Plastic Surgical Nursing Certification Board, in November, 2014.

Grosslein certified

Anna Grosslein, PT, physical therapist, received the CAPP-OB certification from the Women's Health division of the America Physical Therapy Association on January 27, 2015.

Penzias publishes

Alexandria Penzias, RN, clinical nurse specialist, Imaging/Radiology, authored the article, "Magnet Recognition and the Radiology Setting: Part Two – The Massachusetts General Hospital Experience," in the December, 2014, *Journal of Radiology Nursing*.

Roche publishes

Constance Roche, RN, nurse practitioner, Surgical Oncology/Cancer Center, authored the chapter, "Genetic Testing for Breast and Ovarian Cancer," in *Advanced Health Assessment of Women*, 3rd edition, Spring Publishing Company, 2015.

Whitney appointed

Kevin Whitney, RN, associate chief nurse, Surgical, Orthopaedics and Neurosciences, was appointed a member of the 2015 Bylaws Committee of the American Organization of Nurse Executives in January, 2015.

Mulgrew presents

Jackie Mulgrew, PT, physical therapist, presented, "Management of the Acute Care Medical and Surgical Cardiac Patient," at the Christus Spohn Hospital System, January 24, 2015.

Hemingway presents poster

Maureen Hemingway, RN, perioperative clinical nurse specialist, presented her poster, "Perceptions of Perioperative Nursing Staff toward Simulation and Team Training: Exploratory Safety Culture Survey Results," at the International Meeting on Simulation in Health Care in New Orleans, January 10–14, 2015.

Whitney and Gale publish

Kevin Whitney, RN, associate chief nurse, Surgical, Orthopaedics and Neurosciences, and Sharon Gale, RN, director of Outpatient Rehabilitation, Spaulding Rehabilitation Hospital, Cape Cod, authored the article, "Positioning Professional Membership Organizations for Success: Achieving Sustainability," in the February, 2015, *Nurse Leader*.

Kwortnik promoted

Stephanie Kwortnik, RN, clinical nurse specialist, was promoted to lieutenant colonel in the United States Army Reserve in January, 2015.

Kwortnik certified

Stephanie Kwortnik, RN, clinical nurse specialist, became certified as an adult clinical nurse specialist by the State Board of Massachusetts, in January, 2015.

Carlson publishes

Heather Carlson, RN, nurse practitioner, Palliative Care Clinic, authored the narrative, "12-Minute Journey," in the December, 2014, *Narrative Inquiry in Bioethics*.

Nurses publish

Annette McDonough, RN, nurse scientist; Kevin Callans, RN, case manager; and Diane Carroll, RN, nurse researcher, authored the article, "Understanding the Challenges During Transitions of Care for Children with Critical Airway Conditions," in a recent, *ORL-Head and Neck Nursing*.

Nurses publish

Paula Restrepo, RN; Deborah Jameson, RN; and Diane Carroll, RN, authored the article, "An Evidence-Based Quality Improvement Project to Improve Deep Vein Thrombosis Prophylaxis with Mechanical Modalities in the Surgical Intensive Care Unit, in a recent *Journal of Nursing Care Quality*.

Townsend publishes

Elise Townsend, PT, physical therapist, authored the article, "Effects of AFO Use on Walking in Boys With Duchenne Muscular Dystrophy: a Pilot Study," in the spring, 2015, *Pediatric Physical Therapy*.

Nurses publish

Felicity Astin, RN; Diane Carroll, RN; Sabina DeGeest, RN; and Jan Martensson, RN, authored the article, "Cardiovascular Nurse Education Programs for Registered Nurses: a European Survey," in a recent issue of *European Journal of Cardiovascular Nursing*.

Callahan publishes

Janet Callahan, PT, physical therapist, authored the article, "Non-Surgical, Non-Pharmacological Interventions for Cervical and Extremity Dystonia: a Systematic Review," in the January, 2015, *Physiotherapy Practice Research*.

Nurses publish

Donna Furlong, RN, staff nurse; Diane Carroll, RN, nurse researcher; Cynthia Finn, RN, staff nurse; Diane Gay, RN, staff nurse; Christine Gryglik, RN, staff nurse; and, Vivian Donahue, RN, nursing director, authored the article, "Comparison of Temporal to Pulmonary Temperature in Febrile Patients," in a recent, *Dimensions in Critical Care Nursing*.

Helping LEP patients get beyond 'provider knows best'

working with medical interpreters to ensure patients understand their options

Question: One of my patients who was limited in English proficiency (LEP) was reluctant to make a choice about her care. I wasn't sure what to do. Can interpreters assist in these situations?

Jeannette: Depending on the culture, education, and depth of understanding the patient has about her condition, some patients may default to a 'provider knows best' position when presented with a choice about their care. Medical interpreters are more than just 'translators,' they can serve as 'culture brokers,' sensing when there might be a cultural disconnect between patient and provider. Requesting a medical interpreter to help bridge this gap is the first and most important step.

But even with excellent interpreter services, LEP patients might still look to their provider for the 'right answer.' When explaining options to LEP patients, it's important to be *more explicit than usual* in stressing that the choice is up to them. Don't be afraid to say that you don't know what the best option is. It's helpful to interpreters when simple, direct language is used with patients.

Some patients may default to a 'provider knows best' position when presented with a choice about their care... When explaining options to LEP patients, it's important to be ***more explicit than usual*** in stressing that the choice is up to them.

Question: I want to include LEP patients in a research study I'm conducting. What's the best way to ensure that consent is truly 'informed'?

Jeannette: Medical interpreters work with researchers all the time to enroll patients in their studies. The provider-knows-best factor is just as important here. Some interpreters find that even after an explanation of the research study and a clear statement that participation is optional, the patient still thinks he or she has to participate or that it's related to their specific case, when it isn't. Researchers working with interpreters need to make this explicit, often repeating it more than once, so the meaning isn't lost in translation.

Question: Can an interpreter sign a consent form for a research study?

Jeannette: An interpreter cannot sign a consent form as a witness; he or she can only sign as a medical interpreter, a person trained in interpreting and medical terminology. If you need a witness, you should ask another qualified person to sign. Medical Interpreter Services has worked with Partners Research Management to develop forms that explicitly state the interpreter's role in this process.

Question: How can I best utilize the services of an interpreter in end-of-life discussions?

Jeanette: Medical interpreters are not only technically skilled linguistic conduits, they're compassionate, caring individuals. They can assist in walking LEP patients and their families through end-of-life care. Keep in mind that the tactful subtleties often employed in such situations may not be understood by LEP patients and families. Don't rely on well-meaning euphemisms or platitudes; be literal and direct in explaining the situation. The best practice is to huddle with the interpreter prior to the encounter to discuss whether the cultural context calls for a more direct approach. The interpreter will be better able to get your meaning across after such a discussion.

For more information about the services provided by MGH medical interpreters, call 617-726-6966.

Announcements

Save the Dates

Local NENIC educational events

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.

Master of Science in Health Professions Education

Applications Due March 1st

The MGH Institute of Health Professions Master of Science in Health Professions Education program was created to help solve a growing need for innovative educational reform and collaborative leadership across the health professions. This flexible part-time program is designed for working health professionals who wish to improve their teaching methods and skills in curriculum-design, program-evaluation, leadership, and scholarship.

Concentrations in simulation-based learning and educational research are available. Applications for the fall, 2015, cohort are due March 1st.

Vouchers may be used, and a discount is available for Partners employees.

For more information, contact program director, Deborah Navedo, at 617-643-4899, or go to: www.mghihp.edu/hped.

Blum Center Events

Shared Decision Making:
"Coronary Heart Disease"
Monday, February 23, 2015
12:00–1:00pm

If you
- have ever had a heart attack
- have been told you have a build-up of plaque in your arteries
- have any questions about keeping a heart-healthy lifestyle

Join us for a short video and a discussion with cardiologist, Rory Weiner, MD, about coronary heart disease.

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 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):
March 11th
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.

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.

Senior HealthWISE events

All events are free for seniors 60 and older

"Heartburn/Gastroesophageal Reflux Disease (GERD)"

Thursday, February 19th
11:00am–12:00pm
Haber Conference Room
Speaker: Sarah Emami, MD, geriatric fellow
Discussion will focus on causes, symptoms, treatments, the physiology of heartburn, and behavioral modifications that can help to alleviate the discomfort of GERD.

"A Tisket, a Tasket, What's in Your Medication Basket? A Discussion of Polypharmacy Issues"

Thursday, March 5,
11:00am–12:00pm
Haber Conference Room
Presented by Joanne Petrongolo Doyle, PharmD, and Laura Carr, PharmD, discussion will focus on polypharmacy, taking multiple medications at the same time.

For more information, call 4-6756.

MGH Safety Reporting

Same system, new look

It's an exciting time for MGH safety reporting. In 2006, an electronic safety reporting system was introduced. This year, it's getting a new look and feel.

Using the MGH Safety Reporting System, safety events, concerns, and near-misses are entered into the system and immediately sent to the Center for Quality & Safety (CQS). Reports are triaged with the most serious events investigated by CQS and unit-based quality staff (and/or reported to external agencies if necessary). Less acute events are sent to department representatives for follow-up. All reports help identify safety concerns and set the agenda for quality and safety improvements.

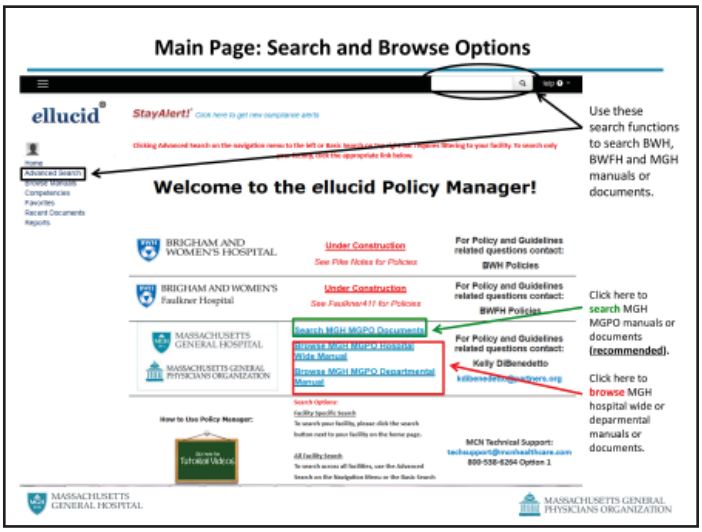
The new system offers:
- access for all MGH employees
- improved ease of use
- same questions, better design
- training
- resources available on how to use the system

For more information, call the Center For Quality & Safety at 617-726-9282 or email: mghsafetyreporting@partners.org

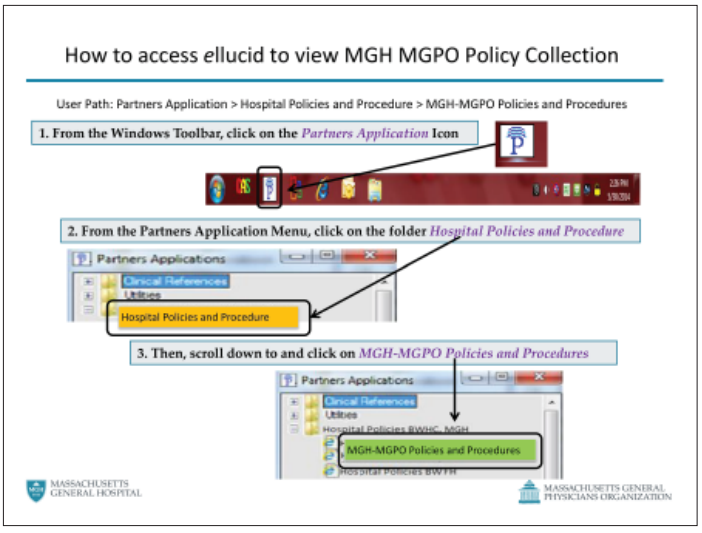
ellucid®is coming!

ellucid®, the hospital's new policy-management system, is slated to go live in the next few weeks. ellucid® offers many advantages over our current system. ellucid®:

- is easier to access from the Partners main menu (see image on this page)
- is easy to use and has a robust search function
- offers many ways to refine your search so you can find what you need more efficiently
- allows you to create an account where you can 'save' frequently used policies and procedures to your Favorites page



- produces copies that are clearer and easier to read
- enables access to the most recent versions of policies and procedures at all times



- offers tutorials on how to use ellucid® features

TROVE will remain active for one month after ellucid® is activated; staff may use either system to access policies and procedures during that time. This will give staff time to learn the new system and still be able to access documents through TROVE. After the first month, anyone logging into TROVE will be automatically re-directed to ellucid®.

As of press time, ellucid® was scheduled to go live on Monday, February 23, 2015. For more information, call Brian French, director of the Blum Patient & Family Learning Center, at 617-724-7843.

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For more information, call: 617-724-1746

Next Publication
March 5, 2015

Physical Therapy goes RED (with a splash of MGH blue) for women's health

MGH Physical and Occupational Therapy departments, including nine cardiovascular and pulmonary PT board-certified specialists, support the American Heart Association's Go Red for Women campaign.

For information on heart health, prevention, and living with heart disease, call the MGH Heart Center at 617-726-1843.

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