

Caring

Headlines

October 15, 2015

Case Management

celebrates 20 years of service at MGH



See
story on
page 4
and
clinical
narrative
on page 10

Case manager, Angela Wynder, RN (right), and nutrition support nurse, Michelle Picard, RN, review patient's nutritional needs in preparation for discharge.

In recognition of our incredible support staff

At MGH, we have some high-profile 'stars' on our roster; we're #1 in our field; and we're known far and wide for the world-class care we provide. As any knowledgeable healthcare provider or consumer will tell you, *none* of that would be possible without our world-class support staff.

Tom Brady may be the most recognizable name on the New England Patriots' roster—and he deserves all the accolades he receives. But every football fan knows that no quarter back is solely responsible for the success of the team. Every player, coach, trainer, and every other member of the team, on and off the field, makes a meaningful contribution to the team's performance. And so it is with health care, as well. At MGH, we have some high-profile 'stars' on our roster; we're #1 in our field; and we're known far and wide for the world-class care we provide. As any knowledgeable healthcare provider or consumer will tell you, *none* of that would be possible without our world-class support staff.

I'm talking about our unit service associates, operations associates, patient care associates, staff assistants, surgical technologists, physical and occupational therapy assistants, information associates, operating room assistants, practice access coordinators, managed care coordinators, IV technicians, respiratory therapy aides, operations coordinators, physical therapy aides, patient service coordinators, patient care information associates, sterile processing technicians, endoscopy technicians, OR equipment technicians, and all the other role groups that keep this organization operating smoothly and efficiently every single day. I can't imagine trying to run this hospital without them.

I've always known that patients, families, and professional staff value the work of our support staff—a day doesn't go by that someone doesn't



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

come up to me to tell me what a great job they're doing or share a personal story of how someone in a support role has made a difference in their hospital experience, or in their lives. But I had to chuckle when I started gathering information for this column and realized that every manager, supervisor, and director in Patient Care Services thinks that his or her support staff is the *best* in the hospital. They literally clamored to have their teams mentioned by name or highlighted in some way in recognition of their diligence, compassion, and service.

I wish I had room to mention everyone by name, but what I can do is share a few of the comments I heard and perhaps some of our support staff will recognize themselves in these words.

From one director: "Our support staff is indispensable. They're the face of our practice, they identify gaps in customer service and are the go-to people when we need questions answered. They're flexible and accommodating; multi-tasking is the norm. I can't imagine what life would be like without them. They are *amazing*."

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From a clinical staff member: “Our USA (unit service associate) takes pride in everything he does. He’s flexible, reliable, and sensitive to the needs of patients and the team. He takes initiative, always looking for ways to make a patient’s experience more enjoyable. You can count on him to get things done and to do it with a positive attitude.”

From a nursing director: “Our patient care associate (PCA) is deeply committed to providing every patient with exceptional care. She’s articulate and caring; her passion for her work and her patients is evident in her practice every day.”

From a member of the PCS Executive Team: “I had occasion to be in the Yawkey Infusion Unit the other day, and I was struck by the rapport that staff at the reception desk had with every patient who came in. You expect a cancer infusion unit to be a serious place, but patients approached the reception desk with smiles on their faces; they were greeted by support staff who obviously knew them; they shared stories and joked around. It felt more like a social club than a hospital waiting room. It was really something.”

From a nursing director: “I know operations associates are indispensable on all units, but on the pediatric units, they play a key role in preventing the abduction of children and infants. They monitor the comings and goings of staff, patients, and visitors, and they manage to do it without making anyone feel uncomfortable.”

From an associate chief nurse: “Many MGH support staff come to us from other roles or departments, so they have a great understanding of our culture, the larger organization, and how patients navigate the system. I hear so many people comment on the positive impact support staff make and how they look forward to seeing them—patients and professional staff alike.”

From a director: “In so many settings, support staff are the first impression patients and families have of MGH. They have great influence on hospital operations and the patient and family’s experience of care.”

From the OR: “Operating room assistants (ORAs) have an important role, preparing patients for transfer, ensuring they feel cared for, taking the time to explain what to expect as patients travel to the OR to meet other members of the surgical team. And ORAs play an integral part in preventing infection with a rigorous, standardized cleaning approach.”

From a nursing director: “Recently, a family member called looking for a six-hundred-dollar phone his wife had accidentally left behind when she was discharged. She thought she’d left it in the pocket of her johnny. I knew the soiled linen was still in our storage room. Our USA was fantastic! She knew exactly which laundry bag to look in. We opened the bag, and there was the phone in the johnny pocket. We have the best USAs.”

From Infection Control: “USAs make sure patient rooms are thoroughly cleaned and disinfected, keeping the environment safe and infection rates low.”

From MGH Back Bay: “Our administrative support team ensures patients have easy access to their PCPs when scheduling appointments. They coordinate follow-up care and close the loop on exams and referrals. Patients come to know them, which helps deepen the sense of trust they have with the whole practice.”

Clearly, our support staff are loved and appreciated. While I’m reminded of their good work and contributions on a daily basis, I hope *they* know what critical members of the team they are, and how much we rely on their knowledge, insights, actions, and countless acts of kindness. Tom Brady and the Patriots may be the reigning Super Bowl champs, but I’d choose our support team over theirs any day of the week!

In this Issue

Case Management.....	1
Jeanette Ives Erickson.....	2-3
• Our Incredible Support Staff	
Case Management Celebrates 20 Years.....	4-5
Bystander Awareness	6
Disabilities Awareness.....	7
PCS Scholarships	8-9
Clinical Narrative	10-11
• Angela Wynder, RN, and Michelle Picard, RN	

Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy	12
National Health Literacy Month.....	13
Patient-Education Materials on IVC Filter Removal.....	14
Patient-Education Materials on COPD	15
Unacceptable Abbreviations.....	16
Professional Achievements.....	17
Announcements.....	18
Policies, Products & Procedures	19
Partners eCare Update.....	20

Case Management celebrates 20 years at MGH

—by Janice LaMontagne, RN, ED case manager

No matter where case managers practice at MGH, their goal is to empower patients to manage the impact of their illness and enable them to function optimally in the community.

This year, Case Management celebrates a milestone 20 years of service at MGH. In honor of the occasion, Nancy Sullivan, executive director of the department since its inception in 1995, shared some remembrances of her career and the development of case management over the past two decades. Recalls Sullivan, “My entire career has been spent at MGH. The first position I held was secretary/technician in the Pediatric Pulmonary Lab. It was as director of Utilization Management & Quality Assessment (UMQA) that I worked closely with Peter Slavin, then the director of the Clinical Care Management Unit [now MGH president], on shaping the case manager role. I recall long hours of planning with Joanne Wooldridge, associate director of UMQA and Dr. Slavin, working out the details of the role.”

Ten months later, with input from an interdisciplinary committee of physicians, nurses, and social workers, the role of nurse case manager was defined. The role called for a special combination of medical expertise, business acumen, and compassion. Case managers would help patients navigate the complicated landscape of healthcare delivery while helping to ensure cost-effective care.

Case management was introduced to the hospital very methodically. Sullivan and Slavin met with nurses, physicians, social workers, and physical therapists to explain the case-management concept and get their input on how to integrate it into care-delivery without interrupting or duplicating work. The decision was made to introduce case manage-



Nancy Sullivan,
director of Case Management

ment in three phases over six months to ensure that each area of the hospital had a smooth transition to case-management coverage.

From the very beginning, Case Management has enjoyed the crucial support of staff in the Case Management Support Unit (CMSU), who handle clerical responsibilities, referrals, communication, and so much more.

In 2003 the highly successful Clinical Documentation Improvement (CDI) program was created with CDI nurses reviewing documentation to improve the accuracy of Medicare reimbursement (and other DRG-based payers). More accurate documentation better reflects the severity of illness and mortality risk among our patient populations resulting in more accurate and favorable reimbursements.

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Case Management (continued)

In 2006, the Integrated Care Management (iCMP) program was created with care managers working out of Primary Care practices. These nurse care managers focus on a select group of medically complex patients, managing their care with primary care physicians and outpatient clinical teams. The iCMP team is a multi-disciplinary approach that includes social workers, community resource specialists, pharmacists, and a pharmacy technician. Patients are followed through all transitions of care. The goal is to enhance the patient experience, have a positive impact on clinical outcomes, and decrease overall utilization.

Since 1996 the scope and responsibilities of case managers has grown. Originally, there were 33 case managers at MGH, today there are more than 70.

Says Sullivan, "We're pleased to celebrate twenty years of exceptional case management at MGH. We have a number of events planned to commemorate the occasion." Between October 5th and 19th, Case Management posters will be on display in the Main Corridor. You can visit the Case Management information booth in the Main Corridor on Thursday, October 15th, from 8:00am–3:00pm. And on Tuesday, October 27th, from 12:00–1:00pm, Suzanne O'Connor, RN, will present "Winning with Changes and Changing to Win: Building Agility for a Faster-Moving Healthcare System," in O'Keefe Auditorium.

No matter where case managers practice at MGH, their goal is to empower patients to manage the impact of their illness and enable them to function optimally in the community. Case managers work with patients and families to help them derive maxi-

mum benefit from the healthcare services available throughout the continuum of care.

For more information about case management or the work of case managers on any specific unit, call 617-726-3665.



Above: case manager, Nora Arbeene, RN (right), meets with patient, Robin Gurlitz, to complete an assessment and craft an appropriate discharge plan together. **At left:** director, Nancy Sullivan (center front), with case managers and support staff on the steps of the Bulfinch Building.

(Photo by Michelle Rose)

Bystander Awareness Training

how to respond to situations of intimate-partner violence

—by Matthew Thomas, CNY day-shift operations supervisor, MGH Police & Security

Intimate partner violence (IPV) is a world-wide epidemic that touches everyone. Years ago, the MGH Domestic Violence Working Group (DVWG) was created to try to end intimate-partner violence. The group posited that the active participation of men in these efforts would be hugely beneficial, and so was born MGH Men Against Abuse (MMAA), a group comprised entirely of male employees from numerous departments throughout the hospital. The goal of MMAA is to end intimate-partner violence by raising men's awareness of the issue and providing educational tools to help men understand its causes and dire effects. The tag-line of the group is, "See it... Step up... Stop it." They pledge to never, "commit, condone, or remain silent about men's violence against women; to respect, listen to, and share power with the women" in their lives.



Actors, Nancy Capaccio (left) and Carol Feldman Bass, enact scenario of intimate-partner violence as part of a bystander awareness training session.

Imagine being a witness to, or learning about, a situation involving intimate-partner violence. Perhaps you've already witnessed a situation, wished you'd taken action, but didn't know what to do. On September 8, 2015, MMAA hosted an event to help educate staff about bystander awareness and ways to respond in these situations.

Guest, Alan O'Hare, and two actors from Life Story Theatre, Carol Feldman Bass and Nancy Capaccio, enacted a scenario that could happen in any real-life, work setting. Two women co-workers sat side-by-side, one troubled and distraught by what's going on in her home life, the other focused on work and frustrated by the other's lack of attention. Between scenes, O'Hare facilitated discussion about what attendees might do in a similar situation. Members of HAVEN, the Employee Assistance Program, and MGH Police & Security were on hand to answer questions about the many ways victims of intimate-partner violence can be supported at MGH.

Different versions of this bystander training have been held at MGH in the past. Like those, the September 8th event was well-received and a great opportunity to educate and empower staff. The DVWG and MMAA feel it's important that employees feel prepared to act appropriately should they ever encounter or become aware of instances of intimate-partner violence.

For more information about intimate-partner violence or MMAA, contact Debra Drumm, of HAVEN at MGH, at 617-726-7674; Matt Thomas, of Police, Security & Outside Services, at 617-643-0806; or Lenny Debenedictis, of the Employee Assistance Program, at 617-724-2206.

Think outside the call bell

improving accessibility for patients with disabilities

—by Zary Amirhosseini, disability program manager, and Stephanie Smith, OTR/L, clinical specialist

For many, using a call bell is easy—it's as simple as pushing a button. Call bells give patients a sense of security, knowing that someone is nearby and ready to help, whether they're feeling sick or need to use the bathroom. So access to call bells is an essential asset in terms of patients feeling safe and involved in their care.

Imagine having an injury or illness that makes it impossible to use the call bell, unable to contact the front desk or call for a nurse. For patients with amyotrophic lateral sclerosis (ALS), traumatic brain injury, spinal cord injuries, and many other disabling conditions, pushing a call bell can be a daily challenge. At MGH, in an effort to make call bells as universally accessible as possible, we've introduced adaptive call bells, an innovative solution

to ensure optimal patient safety and comfort, and make unit operations more efficient.

Last year, The Office of Patient Advocacy, Occupational Therapy, and Materials Management developed a program to pilot a variety of adaptive call bells on Lunder 7 (Neurology), Bigelow 9 (Respiratory Acute Care) and Ellison 14 (Burns and Plastic Surgery). Feedback was collected from each unit, and patients and staff agreed on two options, affectionately called, 'Big Red' and 'Jelly Bean.' Testimonials such as, "Jelly Bean is particularly useful for patients who have minimal movement of their extremities," and "Big Red is perfect for patients who are intubated," reinforced our decision to add these call bells to our already comprehensive inventory of adaptive devices.

The pilot also introduced a flexible hanging system called, Loc-Line, that allows various items, such as call bells, cell phones, or tablets to be attached to beds, wheelchairs, or recliners, allowing patients to access devices they might otherwise not be able to use. Loc-Line, Big Red, and Jelly Bean provide patients with more options for communicating with staff, hopefully giving them a greater sense of security, comfort, and control over their environment.

To request an adaptive call bell or a Loc-Line mounting system, call Customer Service at 6-9144. To ensure competency, make sure patients can activate call bells successfully three times in a row.

Go to the MGH Accessibility Resource Site under Partners Applications to see a list of all adaptive call bells, or e-mail: zamirhosseini@partners.org.

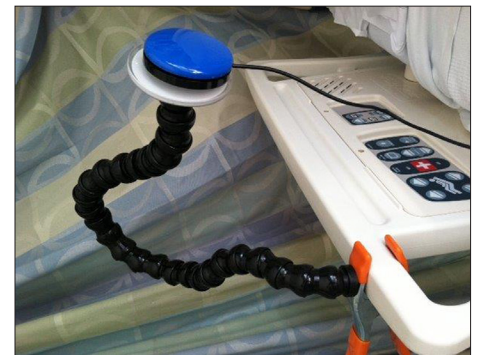
Big Red



Jelly Bean



Loc-Line hose



Presentation of the 2015 PCS Scholarships

—by Julie Goldman, RN, professional development manager

Below: senior vice president for Patient Care Jeanette Ives Erickson, RN, presides over PCS scholarship presentation ceremony.

On September 22, 2015, Jeanette Ives Erickson, RN, senior vice president for Patient Care, welcomed friends, family, and colleagues to this year's PCS scholarship presentations. Scholarships support MGH staff interested in earning a degree in Nursing or one of the health professions. Providing financial assistance to those wishing to further their education, and increasing the diversity of our workforce are basic tenets of our MGH philosophy and an important part of our mission and values.

Said Ives Erickson, "We're thankful to all our donors: Mr. Norman Knight; Mr. and Mrs. Gil Minor; the staff of Lunder 10 and Cox 1; and the Dowling family for funding these programs that help advance higher learning and increase the number of diverse nurses and healthcare professionals practicing at MGH."

The following scholarships were presented:

- The Norman Knight Doctoral Nursing Scholarship (Photo 1, l-r)
- Debra Burke, RN; Carol Casey, RN; Jennifer Clair, RN; and Julie Cronin, RN

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Education/Support (continued)

- The Charlotte and Gil Minor Nursing and Health Professions Scholarship to Advance Workforce Diversity in Patient Care (Photo 2)
 - Melissa Joseph, RN; Michael Grasso, RN; Rai Singh, RRT; and Jane Martell, RN
- The Cathy Gouzoule Oncology Scholarship (Photo 3)
 - Michele Golden, RN
- The Norman Knight Nursing Scholarship (Photo 4)
 - Alicia Shulman, RN; Jessica Robertson, RN; Charlene Badolato, RN; Jessie MacKinnon, RN;

Linda Caruso, RN; Alexa O'Toole, RN; Tara Belisle; Scott Farren, RN; Amira Hamzic, RN; and Karin Rallo, RN

- The Pat Olson, RN, Memorial Scholarship (Photo 5)
 - Michele Alvarez

Through the generosity of supporters, a record 25 scholarships were presented this year. For more information about the Patient Care Services Scholarships contact Julie Goldman, RN, professional development manager, at 617-724-2295.



(This photo by Autumn Aguilar)

Inter-disciplinary collaboration ensures safe progression for elderly couple

Mr. A was an elderly gentleman with advanced cancer who was non-responsive to chemotherapy... We soon discovered that in addition to dealing with his own health issues, Mr. A had been caring for his wife of many years.

My name is Angela Wynder, and I've had the privilege of being an inpatient case manager for the Oncology, Leukemia, and Transplant services for the past three years. Mr. A was an elderly gentleman with advanced cancer who was non-responsive to chemotherapy. He was admitted for failure to thrive. We soon discovered that in addition to dealing with his own health issues, Mr. A had been caring for his wife of many years. Mrs. A had advancing dementia and refused to acknowledge her condition or allow family members to assist.

My name is Michelle Picard, and I have been a nutrition support nurse for many years. Upon initial consult, a colleague in my department met with Mr. A and his family. The following morning, my colleague shared her assessment of Mr. A. He was married; his wife had some signs of dementia that had become apparent over the past few months. They had five adult children, two of who were in the medical profession. I knew from experience that this wasn't going to be an easy home plan because of Mr. A's age, his advanced diagnosis and deconditioned state, the proposed plan of treatment, and the fact that Mr. A's primary caregiver was his wife.

I met with Mr. A's case manager, Angela Wynder. I filled her in on the information I had and shared my concerns with her. Mr. A was fragile and at high risk for complications on total parenteral nutrition, or TPN (a method of bypassing the diges-



Angela Wynder, RN, case manager (right), and Michelle Picard, RN, nutrition support nurse

tive system and supplying a nutritional solution directly into a vein). Mr. A's discharge plan would depend on Angela's assessment and the wishes of Mr. A and his family.

Wynder: I met with Mr. A, his wife, and two of their adult children. Mr. and Mrs. A lived together in a two-story home. They had family in the area but did their best to maintain their independence and not ask their children for assistance. Mrs. A was Mr. A's designated health care proxy. Mr. A retained capacity and was able to answer all my questions with short, direct answers. Mrs. A often asked why I was asking certain questions and what I planned to do with the information. Mrs. A initially came across as cold and withdrawn, perhaps even angry. But as our conversation progressed, I recognized the fear and suspicion in her eyes. My grandmother has dementia, and I'm very familiar with that tell-tale expression. Michelle had told me that Mrs. A was experiencing dementia, so I wasn't completely surprised by her behavior.

I could see that it was important for the family to allow Mrs. A to participate in decision-making and

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help direct the plan of care. I came out of that conversation with the acute understanding that Mr. and Mrs. A's primary goal was to maintain independence at home. I knew I'd need to convince them of the need for additional assistance in order to make their goal of returning home a realistic and safe possibility.

After meeting with the family, Mr. A's daughter caught up with me in the hallway and expressed great concern, not just for her father, but also for her mother. She explained that her father had been concealing the severity of her mother's dementia from everyone, including the family, for a long time. She went into great detail about her mother's paranoia at having anyone else in the home. And she talked about her father's hesitation at allowing anyone to see the degree of assistance Mrs. A now needed.

Over the next five days, I met with Mr. A and his family many times. I sat with Mr. and Mrs. A and reviewed the need for round-the-clock support. They had many questions about TPN and the need for a PICC line to be placed for easier administration. I answered all their questions and reviewed the criteria for inpatient rehab. For Mr. A, discharge to an inpatient rehab would have been the obvious choice. However, when taking into account his age and advanced cancer diagnosis, the better plan was clearly one that allowed him to stay with his wife and maintain the independent life style he valued for the short time he had left.

Two days prior to Mr. A's discharge, I coordinated an educational session with the vendor who would be providing the TPN for Mr. A at home. I've seen many fiercely independent patients who thought they could master TPN administration only to find that they weren't able to do it when asked to demonstrate the multi-step process. As suspected, neither Mr. nor Mrs. A was able to grasp or demonstrate the technique, and they ultimately requested an alternative.

I provided Mr. and Mrs. A with information about private-duty care. And I discussed the possibility of having one of their children assist with TPN administration. Both options called for someone to come to the home, which had the added advantage of someone being able to check on Mr. and Mrs. A to ensure they were both doing well.

Picard: When I met with Mr. A, he deferred the planning process to his family. His adult children were lovingly concerned for their parents; they knew they were failing but wanted to honor their wishes to try it their way. It came down to deciding on the safest plan possible even though it might not have been Mr. A or his family's first choice. I empathized with them because I had been through something similar recently, watching close family members hold onto their independence at the end of their lives. There's something to be said for dying with dignity and assisting patients in their ability to do that.

Wynder: Mr. and Mrs. A chose to allow their daughters to come to their home daily and administer TPN to Mr. A. As Michelle said, it wasn't the ideal plan. I had real concerns about this family's ability to influence Mrs. A's decision-making for the tough choices that would need to be made in the future. It may not have been a perfect plan, but it allowed Mr. A and his wife to return home together and maintain the dignity and independence they so desired.

Piccard: Mr. A was discharged home five days after starting TPN. Everything he needed was in place. In my department, we follow patients on home TPN with the primary team vendor. One evening when I was on-call, I got a page from Mr. A's daughter seeking advice. She knew what needed to be done; she was just looking for validation. She was letting herself be the daughter.

Mr. A continued treatment for another week before deciding to stop everything and transition to hospice. He passed away about two weeks later. We feel fortunate to have been able to help Mr. A achieve his goals with the support of his family and other caregivers.

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

Through this narrative, Angela and Michelle gave us a glimpse into the complex ethical issues and care planning that go into ensuring a safe discharge while at the same time respecting the patient's wishes. They role-modeled the need to listen to Mr. and Mrs. A and allow them to retain as much control as was safely possible. Together with the family, they crafted the optimal solution, ultimately allowing Mr. and Mrs. A to stay together during his final days.

Thank-you, Angela and Michelle.

Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy

—by Julie Goldman, RN, professional development manager

Award recipients, Denise Elias, RN (front left), and unit service associate, Carlos Henriquez (front right), with associate chief nurse, Debra Burke, RN (tan suit); nursing director, Barbara Cashavelly, RN (brown plaid jacket); and staff of Lunder 9.

On September 17, 2015, Lunder 9 staff nurse, Denise Elias, RN, and unit service associate, Carlos Henriquez, were honored as the 2014 and 2015 recipients of the Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy. The award was established in 1999 in memory of Cronin and Raphael and in recognition of the exemplary nursing care they received at MGH. The award recognizes a clinical and/or support-staff member who consistently demonstrates excellence in identifying and addressing the needs

of patients and families. Cronin and Raphael believed that empowering the people who care for patients allows them to grow and flourish and excel in the important work they do.

The award criteria are based on patient advocacy and empowerment. The selection committee looks for candidates who seek solutions to patient problems; partner with other disciplines to provide the highest quality care; and demonstrate flexibility in their practice.

In her remarks about Elias, Lunder 9 nursing director, Barbara Cashavelly, RN, said, “Denise was at the top of the list for this award. She is seen as one of the most flexible and positive forces on the unit. She’s always focused on finding a solution. She’s first to offer help to her colleagues. She individualizes the care she provides and always goes above and beyond to meet their needs.”

About Henriquez, Cashavelly said, “Carlos takes great pride in his work as out unit service associate; he’s committed to keeping our unit clean. Carlos does anything that’s asked of him with a smile. I’ve asked Carlos to find bed extenders, and he’s scoured the entire hospital to find them. Patients love his bright personality and willingness to help.”

Associate chief nurse, Debra Burke, RN, noted, “As I listened to Barbara speak, I saw everyone nodding their heads. That tells me that Denise and Carlos were excellent choices for this award. Thank-you for your advocacy for our patients and families.”

For more information about the Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy, call Julie Goldman, RN, at 617-724-2295.



October is National Health Literacy Month

—by Amber Leigh Blough, RD; Julie McCarthy, RN; and Vita Norton, RN
for the PCS Patient Education Committee

Even highly educated people are at risk for low health literacy, but the elderly, newly immigrated, and those with multiple, chronic, health conditions are especially vulnerable.

Health literacy, the ability to obtain, process, communicate, and understand health information, is a crucial part of patient-centered care and pivotal in terms of health-related decision-making. In an effort to empower patients and caregivers, the Patient Education Committee is observing National Health Literacy Month with an information booth in the Main Corridor on Wednesday, October 28, 2015.

Although health information is one of the top three most frequently searched topics on-line, only 10% of the adult population in the United States possess the skills needed to use the health information available. With increased access to medical knowledge via the Internet, it's more important than ever that healthcare providers educate and support patients and caregivers using the basic principles of health literacy.

Low literacy skills aren't the only barrier to comprehension. Technical jargon, the complexity of information, navigating an unfamiliar healthcare system, and the emotional stress of being confronted with their own or a loved one's diagnosis all impact a person's ability to process and understand health information. Even highly educated people are at risk for low health literacy, but the elderly, newly immigrated, and those with multiple, chronic, health conditions are especially vulnerable.

As the baby-boomer generation approaches retirement age, the effects of poor health literacy are compounded. In order to promote health literacy, it's essential that health information be provided clearly and simply. Providers should use plain language, ensure understanding by asking open-ended questions, and use techniques such as the "teach-back; show-back" method when providing patient education.

The Patient Education Committee's booth will have resources for clinical staff, patients, and visitors. Clinicians can learn about services available at the hospital such as the Blum Patient & Family Learning Center, interpreter services, and other tools and resources available to support patient education.

Patients can pick up helpful tips on topics such as, "How to Speak with your Child's Doctor," "How to Prepare for a Medical Appointment," and "How to be Medication Smart." Information will be available on Patient Gateway, iHealthSpace, and how these on-line programs can enhance communication between patients and healthcare providers.

Members of the Patient Education Committee will be on hand to answer questions. Stop by and test your own health literacy with the *Wheel of Knowledge*. Members of the MGH community are our greatest assets in championing health literacy.

For more information about the Patient Education Committee, health literacy, or the October 28th educational booth, contact Gail Alexander, RN, patient education and simulation professional development specialist, at 617-726-0359.

Patient-education material on IVC filter-removal now available

Data shows a low rate of filter-retrieval nationwide... Sometimes, filter-removal isn't scheduled because patients aren't aware that filters are intended to be temporary; so they don't follow up with providers to determine if and when the filter should be removed.

A new, multi-specialty, patient-education document has been developed by the Fireman Vascular Center to ensure that patients who've received retrievable inferior vena cava (IVC) filters have their filters removed when

clinically appropriate. Experts from Vascular Medicine, Vascular Surgery, the Department of Radiology, and the Knight Center for Interventional Cardiovascular Therapy contributed to the development of the document, called, *Caring for Yourself after Your IVC Filter Insertion*.

Data shows a low rate of filter-retrieval nationwide for a variety of reasons. Sometimes, filter-removal isn't scheduled because patients aren't aware that filters are intended to be temporary; so they don't follow up with providers to determine if and when the filter should be removed. The new document, *Caring for Yourself after Your IVC Filter Insertion*, strives to engage patients in their care, reinforce the message that filters are usually intended to be temporary, and encourage patients to follow up with the clinician who placed the filter as well as their primary care providers.

Caring for Yourself after Your IVC Filter Insertion was developed in tandem with a broader patient-education initiative in collaboration with the Corrigan Minehan Heart Center. Both centers, in partnership with the Maxwell & Eleanor Blum Patient and Family Learning Center are working to standardize their patient-education materials. A key part of that standardization is creating materials using the principles of plain language. *Caring for Yourself after Your IVC Filter Insertion* was designed to be accessible to all patients, regardless of their

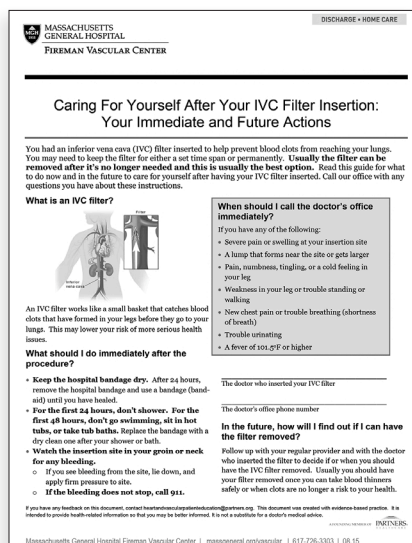
health-literacy level. It is the first of many improved patient-education materials to be developed by the Fireman Vascular Center and the Corrigan Minehan Heart Center.

The centers are working to establish production guidelines for all print, on-line, and audiovisual materials in the hope of reducing duplication of efforts and improving patient care.

Caring for Yourself after Your IVC Filter Insertion can be found in the Partners Handbook, located in Partners Applications > Clinical References. For standardized use across specialties, the document is listed as: *IVC filter form placement* and can be found under the

Cardiac, Procedure/Device, and Vascular folders of the MGH Patient Education Documents page.

For more information, contact Kalyn Horst, health education project manager at 617-643-0062.



New COPD care instructions and patient-education materials now available

On Tuesday, September 29, 2015, Provider Order Entry (POE) began prompting discharging clinicians to access COPD-management and patient-education materials. The prompt is diagnosis-dependent, similar to the Stroke and Pneumonia prompts. A COPD tab appears in the Core Measure folder, asking the provider if an adult patient (18 years old or older) has COPD. If the answer yes, additional questions are triggered. These are required questions for adult COPD patients and support optimal care for this patient population.






The discharging nurse will be asked if the patient has received educational documents and can access the documents directly from the Post Hospital Care Plan folder.

The folder contains three patient-education documents:

- *COPD Symptom Tracker*, containing tips for early recognition of COPD exacerbation
- *Living well with COPD*, containing information on what COPD is, how to manage it, and the benefits of pulmonary rehabilitation
- *Energy Conservation Techniques*, containing tips on how to modify daily activities to be able to do more with less physical exertion

To see the new COPD patient-education documents, go to: Partners Handbook > COPD patient education. Or go to: Partners Applications > Clinical References > Partners Handbook, and follow the prompts to MGH Patient Education Documents, Respiratory.

For more information, contact: Susan Morash, RN, at 617-726-3130; Nancy Davis, RRT, at 617-724-4496; or Alison Squadrito, PT, at 617-724-7488.

 MASSACHUSETTS GENERAL HOSPITAL  MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION	
COPD Symptom Tracker	
COPD (chronic obstructive pulmonary disease) is a chronic lung disease that makes breathing more difficult. It is important that you learn the symptoms of worsening disease , and know when to call your doctor .	
Get help now 	Call 911 if: <ul style="list-style-type: none">• Your breathing has gotten much worse even though you took your medications and you need immediate assistance• You have chest pain that does not go away
COPD getting worse 	Call your doctor if: <ul style="list-style-type: none">• You get more short of breath when doing your normal activities• You need more oxygen than usual to breathe comfortably• You have a fever• You are coughing or wheezing more than usual• Your mucus has increased or changed in color• You have trouble taking your medications• You have gained weight quickly or your legs swell
Doing well 	Continue with your treatment plan if: <ul style="list-style-type: none">• You have no trouble breathing• Your mucus is clear or white and easy to cough up• You can do your normal activities and exercise routine• You have no changes in your symptoms
July 2015 - MGH COPD Educational Committee	

Unacceptable abbreviations

revisiting an important, patient-care concern

— by Patti Shanteler RN, staff specialist

(Re-printed from the September 17, 2015, issue of *Caring*)

Abbreviations are a useful, time-saving tool for clinicians when documenting patient care. But like any tool, they must be used accurately and correctly in order to be effective. In 2001, the Institute for Safe Medication Practices (ISMP) issued a warning about certain abbreviations that contribute to confusion and increase potential for patient harm. That same year, The Joint Commission joined the ISMP in voicing its concern, issuing Sentinel Event Alert # 23: Medication errors related to potentially dangerous abbreviations.

In 2004, The Joint Commission elevated attention to the matter by addressing abbreviations in National Patient Safety Goal #2 related to effective communication. All hospitals were required to adopt the list of abbreviations recommended by The Joint Commission and to identify any additional abbreviations within their institutions that could be considered problematic. Today, the requirement for maintaining a list of unacceptable abbreviations is Standard IM.02.02.01. Compliance with this standard is evaluated by Joint Commission survey teams, as the use of unacceptable abbreviations is considered a practice that could result in direct harm to patients.

The danger was initially attributed to hand-written abbreviations. It was thought that a combination of illegible handwriting and certain ambiguous or misleading abbreviations could create confusion and the potential for error. However, the risk of harm has carried over into the electronic age.

While the electronic medical record has decreased the potential for error by eliminating the ability to use certain abbreviations in templates and drop-down boxes, when it comes to inputting free text, the potential for confusion and misinterpretation still exists. And when there's potential for misunderstanding in the medical record, there is potential for errors that lead to patient harm.

The list on this page comes from the MGH Patient Health Record Policy. In addition to eliminating these potentially dangerous abbreviations in all patient-care documentation, staff are encouraged to limit the use of abbreviations specific to certain practice areas or disciplines. Using abbreviations that are known only to a select few can lead to confusion and the need to 'guess' the intended meaning. One of the goals of an integrated record is to provide complete and accurate information to all caregivers who come in contact with the patient.

For more information about unacceptable abbreviations, contact Patti Shanteler, RN, staff specialist, PCS Office of Quality and Safety, at 6-2657.

Unacceptable Abbreviations and Symbol Dose Expressions

(the following abbreviations should not be used)

- Q.D. and Q.O.D.
- MS, MSO4, MgSO4
- H.S. (for half-strength or bedtime)
- ss
- ug for microgram
- U or u
- IU
- Per os (for oral)
- qn (for nightly)
- BT (for bedtime)
- Zero after a decimal point (1.0mg); may be mis-read as 10mg if decimal point is not seen (correct dose expression is 1mg)
- No zero before a decimal point (.5mg); may be mis-read as 5mg if decimal point is not seen (correct dose expression is 0.5mg)

Professional Achievements

Blanchard appointed

Howard Blanchard, RN, clinical nurse specialist, Knight Center for Interventional Cardiovascular Therapy, was appointed co-chairperson of the Membership Committee for the National Association of Clinical Nurse Specialists, August 25, 2015.

Larrivee certified

Kathleen Larrivee, RN, professional development specialist, The Norman Knight Nursing Center for Clinical & Professional Development, became certified as a professional development nurse by the American Nurses Credentialing Center, on August 14, 2015.

Beauchamp 'co-stars'

Pediatric ICU clinical nurse specialist, Kathryn Beauchamp, RN, is now appearing in the critically acclaimed movie, *Black Mass*, with Johnny Depp, about the life of Boston mob boss, Whitey Bulger. Not surprisingly, Beauchamp plays a nurse, and early speculation is that she'll clinch the Oscar for Best Performance by a Nurse in a Supporting Role!

Tighe Ventola certified

Ellen Tighe Ventola, PT, physical therapist, became certified in Pregnancy and Postpartum Physical Therapy by the American Physical Therapy Association's Section on Women's Health, on August 31, 2015.

Guevara certified

Ellison 12 staff nurse, Anna Maria Guevara, RN, has become certified in Medical-Surgical Nursing by the American Nurses Credentialing Center.

Mulgrew presents

Jackie Mulgrew, PT, physical therapy clinical specialist, presented, "Physical Therapy Management of Patients with Heart Failure," at the Allied Health Education forum in Raleigh, North Carolina, on August 13, 2015.

LaSala presents

Cynthia Ann LaSala, RN, Phillips 22 nursing practice specialist, presented, "Advance Care Planning, Communication, and Shared Decision-Making," as part of the American Nurses Association webinar, September 10, 2015.

Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, presented, "Tapentadol Therapy to Manage Moderate-to-Severe Pain: Key Considerations for Nursing," at the national conference of Pain Management Nursing in Atlanta, September 18, 2015.

Folger appointed

Abby Folger, PT, physical therapist, was appointed chair of the Patient Advocacy Day Scope of Practice Fair Committee for the American Physical Therapy Association of Massachusetts, in August, 2015.

Folger was also appointed a member of the Specialization Academy of Content Experts, Cardiovascular and Pulmonary, for the American Board of Physical Therapy Specialties, through 2016.

Stacy certified

Medical oncology staff nurse Kendra Stacy, RN, became certified in Oncology Nursing by the American Nurses Credentialing Center in July 2015.

Scott publishes

Katrina Scott, MDiv, chaplain, published the article, "Being Bipolar in Boston," in Harvard Divinity School's *Cosmologies* magazine, August 25, 2015.

Stacy certified

Staff nurse, Mary Stacy, RN, became certified in Oncology Nursing by the American Nurses Credentialing Center in July, 2015.

Salon appointed

Heather Salon, PT, physical therapist, was appointed a member of the Neurology Section Programming Committee for the American Physical Therapy Association, in June, 2015.

Whitney honored

Kevin Whitney, RN, associate chief nurse, received the 2015 Mary B. Conceison Award for Excellence in Nursing Leadership, from the Organization of Nurse Leaders of Massachusetts, Rhode Island, and New Hampshire, at the ONL quarterly meeting, in Norwood, on September 11, 2015.

Clinical Recognition Program

Clinicians recognized May–September, 2015

Advanced Clinicians:

- Christina Alexander, RN, Oncology
- Jason Beal, PT, Physical Therapy
- Mallia Bourque, RN, Cardiac Surgical ICU
- Sarah Brooks, RN, General Medicine
- Sarah Callahan, RN, General Medicine
- Elizabeth Daley, RN, Newborn ICU
- Elizabeth DeBruin, RRT, Respiratory Therapy
- Ashley Fowler, RN, Neurosciences
- Judy Gullage, RN, General Medicine
- Kaitlin Hudson, RN, Neurosciences
- Sara Hunter, RN, Yawkey Infusion Center
- Jeana Kaplan, SLP, Speech-Language Pathology
- Meredith Kweskin, RN, General Medicine
- Jennifer Mantia, RN, Medical ICU
- J. Naomi Martel, RN, General Medicine
- Kristin Merli, RN, Yawkey Infusion Center
- John Opolski, RN, Yawkey Infusion Center
- Joy Orpin, PT, Physical Therapy
- Allison Pinsince, OTR/L, Occupational Therapy
- Lisa Rattner, RN, General Surgery
- Justine Romano, LICSW, Social Work
- Kim Smith Sheppard, RN, CRC
- Stacey Sullivan, SLP, Speech-Language Pathology
- Stephanie Smith, OTR/L, Occupational Therapy
- Donna Tito, RN, Psychiatry
- Danielle Van Eron, RN, Cardiology
- Georgette Young, RN, Pediatrics

Clinical Scholars:

- Adam Barrett, RN, Surgical ICU
- Lyndsey Farrow, RN, Peri-Operative Services
- Abby Folger, PT, Physical Therapy
- Christine Joyce, RN, Cardiac Catheterization Lab
- Saheeda Mohammed-Kelly, RN, Labor & Delivery
- Kristen Nichols, RN, GYN-Oncology
- Richard Soria, RN, Medical ICU

Announcements

Apply for an Yvonne L. Munn Nursing Research Award

Eligible MGH nurses are invited to apply for a Munn Nursing Research Award to pursue a clinical investigation. Proposals should focus on: original research; advancing evidence-based practice; or performance improvement. Research teams must include a PhD-prepared nurse mentor.

To learn more about the award, e-mail: Kim Francis, RN, at KFrancis2@partners.org or Mary Larkin, RN, at MLarkin1@partners.org.

Letters of intent due:
October 16, 2015
Proposals due:
December 11th

For more information, go to the Munn Center website: at http://www.mghpcs.org/munncenter/Munn_Center_Research_Award.asp.

Blum Center Events

Please note the different times for each program.

"Infection Prevention is Everyone's Business"

Tuesday, October 20, 2015
1:00pm–2:00pm
presented by Dolores Suslak

"Talking to Your Doctor about Pain"

Wednesday, October 21st
12:00pm–1:00pm
presented by Paul Arnstein, RN

National Physical Therapy Month
"We've Got Your Back!"

Thursday, October 29th
1:00pm–2:00pm
Learn how to arrange your work environment to best fit you and your body and reduce stress and injury.
presented by Tara Pai, PT

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.

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.

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.

Patient Care Associates

Work Environment Survey

As part of our overall evaluation of staff perceptions of their work environment, the Patient Care Associates – Work Environment Survey (PCA -WES) was distributed the last week of September.

The survey is being conducted on-line; PCAs can complete the survey in one session or return to it as many times as necessary; all responses are anonymous.

PCAs will have one month to complete the survey, which will be used to promote a positive work environment.

For more information, call Gaurdia Banister, RN, executive director of The Institute for Patient Care, at 617-724-1266, or the Munn Center for Nursing Research at 617-643-0431.

ACLS Classes

Certification:

(Two-day program)

Day one: lecture and review
Day two: stations and testing)

Day one:
November 2, 2015
8:00am–3:00pm

Day two:
November 3rd
7:00–11:30am
(Note early start time)

Instructor class:
December 2nd
7:00am–3:00pm

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.

Recently updated policies, products & procedures

The following were reviewed by Patient Care Service's Policies, Products & Procedures Committee during August and September and have been updated in ellucid.

New:

- Remedy Z-Guard
Indicated for the relief of discomfort associated with diaper rash caused by wetness, urine and/or stool, and other macerated skin conditions

Reviewed with changes:

- Cooling Blanket/Warming Blanket
Revision: Use of the bear hugger is the preferred method of warming for patients with non-clinically-induced low body temperatures
- Nx Stage CVVH Circuit Blood Prime for Patients Weighing Less than 25 Kg.
Revision: reflects the use of a new product—See-Leur caps
- Oral Care for the Patient Undergoing Cancer Treatment
Update: For patients with dentures, soak the dentures in sterile water when not being used
- Subcutaneous Administration of Medication for Pain- and Symptom-Management (Continuous-PCA-Intermittent Infusion)
Updates:
 - 1) If therapy is suspended for more than 6 hours, remove the needle. Insert new subcutaneous needle in a different location when and if therapy is resumed
 - 2) Remove ketamine as it can be associated with painful skin lesions when administered subcutaneously

Reviewed with no changes:

- Aerosolized Ribavirin—Patient Care
- Blood Culture
- Drain Care: Abscess, Percutaneous Drainage Catheter
- Lumbar Drain External Cerebral Spinal Fluid- Drain Management
- Oxygen Therapy
- Percutaneous Transhepatic Biliary Catheter Drain Irrigation
- Ventricular Catheter- Dressing Change

Retired:

- CitricAid Clear
- Baza Protect

Ensure your practice is current by reviewing changes to policies and procedures in ellucid: (<https://hospitalpolicies.ellucid.com>).
For more information, contact Mary Ellin Smith, RN, professional development manager, at 4-5801.

Published by

Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital

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Submissions

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

Next Publication

November 5, 2015

Important eCare go-live dates approaching

—by Demet Donnell, project specialist

Important Partners eCare go-live dates are approaching:

- Wave 1A, December 10, 2015
- Wave 1B, January 14, 2016
- Wave 1C, January 28, 2016

Readiness efforts throughout the hospital are ramping up as we get closer to implementing the clinical portion of Partners eCare. Currently, efforts are focused on ensuring that work-flows are aligned with the new system. Numerous work groups with representation from all clinical departments are actively working to identify potential issues and recommended solutions. All issues are being tracked and reported to ensure they're resolved before going live.

The MGH eCare project team has been meeting with Wave 1 practices in preparation for go-live. Efforts include identifying super users, peer educators, and credentialed trainers; mapping hardware; and conducting de-

ployment dress-rehearsals. A large part of preparing for implementation is the work being done at the divisional level. Those efforts are spearheaded by clinical champions working closely with the project team.

The next few months leading up to the go-live dates for Wave 1 will require increased involvement of staff. The MGH eCare project team is always available to answer questions and provide guidance throughout the transition. They stress the importance of completing all readiness activities in your areas in a timely manner to ensure successful transition.

For more information about Partners eCare activities, go to the MGH Partners eCare website (<https://partnersecare.partners.org/hospital-networks/mgh/>), or seek out an eCare clinical champion in your area.

Partners eCare go-live dates:

- Wave 1A, December 10, 2015
- Wave 1B, January 14, 2016
- Wave 1C, January 28, 2016



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