

Caring

Headlines

September 3, 2015

Caring for Ebola patients in Sierra Leone



A typical day at an Ebola treatment center in Sierra Leone, employing strict infection-control practices



See story on page 4

Gearing up for Partners eCare

*MGH health professions
leading the way*



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

Ambulatory health professionals are already using the eCare scheduling tool as part of the revenue-cycle implementation that occurred in July, 2014. And they will precede the rest of the hospital in implementing the clinical component of eCare beginning in a few months.

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s we inch closer to April 2, 2016, the scheduled go-live date for our final transition to Partners eCare, much work is being done behind the scenes to ensure our readiness. And I think it's fair to say that our health-

profession colleagues are at the forefront of those preparations. Ambulatory health professionals are already using the eCare scheduling tool as part of the revenue-cycle implementation that occurred in July, 2014. And they will precede the rest of the hospital in implementing the clinical component of eCare beginning in a few months. Ambulatory Physical and Occupational Therapy, Social Work, Speech-Language Pathology, and Orthotics, along with Nutrition & Food Services, Intensive Case Management, and a number of integrative and complementary-therapy practices are among those who will be transitioning to eCare in the first wave.

MGH implementation of Partners eCare will occur in two waves. The first wave will roll out in three phases beginning December 10, 2015. At that time, most of our health-profession colleagues will begin enjoying the benefits of Partners eCare along with Dermatology and Psychiatry/Behavioral Health.

The second phase of wave one will go live on January 14, 2016. This will include the Allergy Clinic, Pediatrics, Physical Medicine and Rehabilitation, and some surgical clinics.

The final phase of wave one will roll out on January 28th and include Endocrine, Neurology, the primary care clinics, and the health centers in Chelsea, Charlestown, and Revere/Everett. So depending on their location, some health professionals will start using eCare in December; others will start when their health center goes live in January.

Wave two, which will complete our conversion to Partners eCare, will occur on April 2, 2016, with the remainder of the ambulatory practices and all inpatient clinical areas going live at that time.

The kick-off meeting for these final preparations was held a couple of weeks ago. But Michael

continued on next page

Everyone involved in these preparations has worked tirelessly to ensure optimal readiness by the go-live date... Though our health-profession colleagues may be the first to experience the thrill of working in the new system, by this time next year, all of MGH will be enjoying the benefits of a unified health information system—and no one more so than our patients.

Sullivan, our director of Physical and Occupational Therapy, says, “In my mind, we kicked off a long time ago. We’re on the thirty-yard line now.”

Don’t tell anyone, but I think we’re actually in the red zone with only a few more yards to go.

Leadership of the health professions have been meeting weekly throughout this process to discuss common questions, concerns, and ideas related to implementation. These meetings have been extremely useful in terms of sharing information, maintaining good communication, and helping leaders understand commonalities. Through these meetings, leaders were able to identify and come up with solutions to a number of shared problems.

Preparation has included a detailed review of how work is currently done versus how that work will be done once we convert to eCare. Physical Therapy alone identified more than 40 work flows that will be affected by eCare. Some tasks, such as writing notes, will have a similar work flow. Others, such as how they account for time spent at other institutions, may be different. The thing to remember is that we’re moving toward a common way of documenting and communicating information that will ultimately make our work more efficient and consistent.

A certain amount of training and indoctrination is already taking place in the health professions. Those who’ve been learning the finer points of eCare are showing others how it works, answering questions, and explaining how eCare will impact their documentation practices. They’ve assessed their hardware needs and had input into the train-

ing curriculum. The names of those who’ll serve as super-users during the transition have been identified, and a plan has been developed to ease the clinical load during transition to give staff time to acclimate to eCare.

All this is a precursor to the formal training and other preparations slated to begin in the fall. For those who go live in the first wave, classroom training will begin in October. Training will occur at locations near the main campus and at health centers. This training is intended to provide a good foundation for eCare and be followed by supplemental training within each department to address discipline-specific issues and impact. All clinicians will have ample time to practice in what we’re calling the eCare ‘playground.’ You’ll be able to see how information flows from one user to the next; how the scheduling process is seen by clinicians; how the billing team sees the charges entered by clinicians.

Everyone involved in these preparations has worked tirelessly to ensure optimal readiness by the go-live date. Our mantra, “Never worry alone,” has never been more relevant than with this lead-up to Partners eCare. Though our health-profession colleagues may be the first to experience the thrill of working in the new system, by this time next year, all of MGH will be enjoying the benefits of a unified health information system—and no one more so than our patients. Thank-you for your diligence, commitment, and willingness to go the extra mile for those who will benefit most from this change.

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(Cover photos provided by staff)

One nurse's experience at an Ebola treatment center in Sierra Leone

—by Paige Fox, RN, staff nurse, Emergency Department

The day 'Abdul' came to the Ebola Treatment Center, he arrived with his brother looking young and strong and scared. Abdul was 4, 'Saidu' was 2. They were carried from the back of an ambulance by two nurses dressed in personal protective equipment. Only the eyes of the nurses were visible, but the children clung to them nonetheless. They had come from a nearby observational interim care center, one of many set up to care for children during the mandatory 21-day quarantine period after being exposed to the Ebola virus. The children's father, older brother, and grandparents had all died of Ebola, and their mother, with a 5-month-old infant at home, wasn't able to care for them. A fever the previous night had brought them to the Ebola Treatment Center.

Abdul and Saidu arrived by ambulance, a familiar sight for me as I've been a nurse in a pediatric emergency department for several years. But the similarity ended there. This treatment center, made up of large canvas tents in a small village in Sierra Leone, was worlds away from MGH.

To minimize risk, the intake process at an Ebola treatment center is rigidly routine. Ambulances back into a reception bay so patients can be delivered in isolation into the high-risk area, and drivers can remain in front in the low-risk area. The back of the ambulance is sprayed thoroughly with chlorine. Two nurses in full protective equipment greet patients and walk or carry them to the triage area. They check temperature, heart rate, breathing, and ask detailed questions about their illness. That information is relayed to nurses in the low-risk, triage area, separated from the high-risk area by a wall and glass window. Staff use the results of the assessment and the information gathered from the patients to determine if they need to stay for monitoring and testing or if they can be discharged home. If admitted, patients are sent to one of three treatment tents based on the likelihood of their testing positive for Ebola.

The day Abdul arrived, I was standing in the low-risk area, trying to smile reassuringly as the nurses completed their triage assessments. It's rare that children under 5 survive Ebola. We helped them shower and get changed and make their beds. We placed IV cannulas in both children so we could give them fluids and send blood work to the local lab. Placing an IV in a scared child is difficult under the best of conditions, but with two sets of gloves and fogged goggles, it's even more of a challenge. Once finished with

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Mother and child outside the Ebola treatment center.

Global Health (continued)

the intake process, one of our volunteer caregivers helped Abdul and Saidu get settled onto adjacent mattresses.

I can't imagine what we would have done without our amazing survivor caregivers. Each of these volunteers had survived Ebola and come back to the center to care for other Ebola patients, mostly children. Many of these volunteers had lost entire families to the virus and still had the strength and compassion to return. With no immunity to Ebola, I had to wear full protective gear to guard against exposure to contagious bodily fluids, and I could only stay in the high-risk area for a few hours at a time due to the extreme heat. No longer susceptible to the virus, however, survivor caregivers could enter the unit in paper scrubs and stay all day to help the children eat and drink, use the bathroom, or simply hold them.

Sadly, both Abdul and Saidu tested positive for the Ebola virus and were moved to the confirmed treatment tent. As they developed more symptoms, grew weaker, and spent less time awake, caregivers were constantly by their sides.

When the brothers became too weak to eat or drink, the care team gathered to discuss options, including the possibility of using nasogastric tubes (flexible tubes inserted through the nose to administer medication or fluids to patients who can't eat or drink). One of the symptoms of Ebola is massive bleeding; we were concerned that placing nasogastric tubes could irritate the nose or throat and cause more bleeding. With Abdul and his brother fading, the team decided that the benefits outweighed the risks.

Nurses were eager to acquire this new skill. We began the process of learning how to insert nasogastric tubes, checking to make sure they were placed correctly, and using them to provide food, fluids, and medication. We got a lot of practice as children often pulled them out, and they'd need to be replaced several times a day. We began giving IV fluids continuously, instead of the prior practice of three times a day during medication rounds.



Staff members wait for discharged patient to come through chlorine shower outside treatment center.



Staff nurse, Paige Fox, RN

Despite our best efforts and high hopes, 2-year-old, Saidu, continued to deteriorate and ultimately succumbed to the virus. It wasn't unexpected, but it was nonetheless heart-breaking. We took some time to mourn his loss then redoubled our efforts to care for Abdul. Slowly but surely, after enduring countless IV-cannula and nasogastric-tube placements, Abdul began to sit up on his own. Soon, he was able to go outside. He started to eat small amounts of food and request water. At one point, he actually smiled. After 19 days in the treatment center, Abdul finally walked out of the chlorine shower that separated the treatment zone from the outside world. To a celebratory flurry of singing and dancing, Abdul walked with his mother on shaky legs toward the vehicle that would take him home. He was the first child under 5 to make it to that shower. With tears in our eyes and smiles on our faces, we waved good-bye to Abdul and returned with renewed hope to our other patients.

The next morning, as I began my last shift before returning to Boston, a security guard told us that a mother and child were at the gate looking for medical attention. My heart sank. I knew before I saw them who it was. Abdul had had a number of seizures the night before, and they had continued until he returned to the treatment center. We knew this wasn't going to be good. We brought him into the unit and medicated him to make him more comfortable. As expected, Abdul passed away shortly thereafter.

I left Sierra Leone with a heavy heart for many reasons; one of them certainly this beautiful child who'd come so close to surviving, but who ultimately lost his battle with this merciless virus.

Since coming home, I've stayed in touch with some of the staff at the treatment center. I heard another child had been admitted, a 3-year old. I was told he was doing well, getting maintenance fluids through an IV, and he'd have a nasogastric tube if necessary. It reminded me of the amazing nurses, doctors, and survivor caregivers who are still there, who had eagerly learned new skills, and

are using them to give the best possible care to this child and so many others.

I also learned that the treatment center discharged its first survivor under the age of 5 a few weeks later.

Focused on the most vulnerable populations in dozens of countries, MGH offers global leadership in clinical care, research, education, and disaster response. For more information about MGH Global Health, go to: www.massgeneralcenterforglobal-health.org.

Knowing the patient informs crucial end-of-life decisions

'Tia' was a 51-year-old woman who had been diagnosed five months earlier with neuroendocrine cancer that had spread to her pelvis, femurs, ribs, lungs, and skull. I met her the day after she'd had palliative femur surgery.

My name is Kristen Nichols, and this patient-care experience took place when I was nurse on the Phillips 21 GYN-Oncology Unit. 'Tia' was a 51-year-old woman who had been diagnosed five months earlier with neuroendocrine cancer that had spread to her pelvis, femurs, ribs, lungs, and skull. I met her the day after she'd had palliative femur surgery.

Tia was in excruciating pain with her mother by her side. In assessing her, I attempted to touch her foot to get a pulse. She cried out. When I attempted to elevate her leg to help reduce the swelling, she cried out again. She rated her pain at 10 out of 10. She asked her mother to put a sign on her bed that said, "Don't touch my feet."

Tia reported that the surgical team had asked her to get up and walk that morning, but she couldn't comply because of the pain. I could see that her level of pain was affecting her attitude. I assured Tia and her mother that our priority was going to be to get her pain under control. Given the extent of her cancer and the fact that she was one day post-op, I knew there were two types of pain to address: chronic cancer pain and acute post-operative pain. I made it my business to advocate for Tia and get her pain under control.

I reviewed her medications, both what she was getting here in the hospital and what she was taking at home. I paged the responding clinician and asked that Tia's MS Contin be changed to the same dose as her home regimen to manage her chronic pain. I explained that her current PCA (patient-controlled analgesia) settings weren't covering her surgical pain. And I sug-



Kristen Nichols, RN, staff nurse

gested a Palliative Care consult. The clinician agreed. I paged Palliative Care and asked them to come right away. Within the hour, I had given Tia her full dose of MS Contin, a palliative care doctor was on the unit, and her morphine dose had been increased. After a few hours at the new dose, Tia still reported a high level of pain, preventing her from eating or participating in activities of daily living. Every 3-4 hours, I paged Palliative Care to let them know her pain continued to be an issue.

By the end of my shift, Tia rated her pain at 6 out of 10 on her new medication regimen. Before I left, she sat up and showed interest in her dinner. She actually smiled at me. Tia's mother thanked me for my 'relentless pursuit' of comfort for Tia and confided that pain was Tia's biggest fear as she faced the end of her life.

That evening, during report to the night nurse, I explained how I had worked with the doctors to titrate Tia's pain medication and advised her to call Palliative Care overnight for guidance should she need it.

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The next day, Tia was much more animated. I told her my goal for the day was to get her pain down to 4 and get her out of bed. She was skeptical, but her mother appeared to have hope and started to encourage Tia that she could do it. That's when I knew I had gained her mother's trust.

I paged the team and requested we add Toradol to her medication regimen to see if reducing the swelling would ease her pain. By the end of the day, Tia had been able to sit in the chair for an hour. That's when I knew I'd gained her trust, too.

The following week, I was the attending nurse for the unit and checked on Tia every day. Her pain was well controlled on her new regimen. Tia's disease was progressing quickly, so we had a candid conversation about her code status and end-of-life goals. Tia lived with her mother. She told me her mother had cared for Tia's father when he was dying, and she didn't want to burden her with having to care for her the same way. She also said she was hoping to get on a clinical trial.

I realized that Tia didn't understand how close she was to the end of her life. I asked her oncologist to speak with her, and he let her know she was no longer eligible for clinical trials. Tia took it in stride, but her mother didn't cope with the news as well.

Later that day, in individual conversations with Tia and her mother, Tia's mom told me she wasn't ready to lose Tia. And Tia re-affirmed her desire to go to a hospice house. She reiterated that her biggest fear was pain.

Tia expressed an interest in a specific hospice house. I offered to be in the room when they spoke with the hospice representative to make sure Tia and her mother's questions were answered and that they fully understood what this meant for Tia. They agreed. As I listened to the conversation between Tia, her mother, and the hospice representative, I realized there needed to be some clarity on how the hospice house was going to manage Tia's pain.

I asked the representative if they could accommodate a Dilaudid PCA, and she said they provided pain medications orally. I explained what Tia had been through and asked if an exception could be made. She checked with her supervisor, and they agreed to accommodate Tia's PCA. They said they'd be able to accept her later in the week. Tia and her mother were very thankful I was there to ensure Tia's concerns were addressed.

That night, Tia became confused, and her left side became paralyzed. A CT-scan showed new brain metastases. When I saw Tia the next day, she was somnolent most of the time and delirious when she was awake. She was no longer able to activate her PCA to receive her pain medication.

We spoke with the oncologist about various options, one of which was radiation. Tia's mother wanted Tia to have the radiation in hopes that it could give her more lucid time with her daughter. But she didn't want to put Tia through any more pain or distress. I suggested we try it once, and I would accompany her to provide pain medication, if needed. I knew Tia very well and would be able to discern if the process was too much for her.

Tia tolerated the procedure well. I let her mother know that I thought it was okay to proceed. She was grateful I'd taken the time to accompany Tia, and I knew she trusted me to tell her the truth.

When I came back to work a few days later, Tia had completed her week of radiation. She was still paralyzed on her left side, but she was awake, alert, and back to her old personality. Her mother gave me a huge hug and thanked me for my efforts.

Tia's sister was there that day, and she told me she was going to take a leave of absence from work to bring Tia home for hospice. I confided in her that Tia didn't want to burden her mother with caring for her. She said she and her brother would be the primary caregivers; they wanted to do this for their younger sister and their mother. I provided a detailed picture of what that would mean, and they were still on board. I spoke with Tia and her mother alone to confirm this was okay. And it was.

This change in discharge plan was a hard-sell with the rest of the team, but I advocated fiercely for the plan the family wanted. Two days later, Tia went home with hospice.

A few days after that, I called to check on Tia, and she told me everything was going well. She thanked me for helping her get there. She died a month later at home, surrounded by her family.

I truly feel that the time I spent building a relationship with Tia and her family contributed to her having the best possible quality of life at the end of her life.

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

Title and credentials are not what instill trust. Trust is earned. Kristen earned Tia and her mother's trust with strong assessment skills, integrity, and fierce advocacy. When a mother acknowledges your 'relentless pursuit' of her child's comfort and well-being, you know you're doing something right. Kristen was present for this family from their very first meeting, throughout their hospitalization—even after they were discharged with the hospice care Kristen helped to arrange.

This family's trust in Kristen was well-placed.
Thank-you, Kristen.

Celebrating Accessible MGH

Question: What is the Celebrate Accessible MGH event all about?

Jeanette: On September 10th, from 2:30-4:00pm, under the Bulfinch tent, we'll be sharing the successes of the MGH Disabilities Initiatives with the MGH community. We've worked hard over the past six years to effect changes in our culture, policies, physical layout, equipment, and education to ensure that patients with disabilities have access to the highest quality of care.

Question: Who's involved in those efforts?

Jeanette: In 2004, the MGH Council on Disability Awareness was formed and charged with reviewing current reality, formulating recommendations, and raising awareness around ways to improve access and the overall experience for patients, family members, staff, volunteers, and visitors. Though the leadership and members have changed over the years, Council on Disability Awareness remains a large group of committed individuals (staff and patients) that meets quarterly. There is representation from almost every department in the hospital, including the MGH health centers. The Council is comprised of different work-groups, each with a specific focus, that report back to the larger group on their outcomes.

Question: Can you share some of their outcomes?

Jeanette: Absolutely. Lets look at the three main areas of focus:

Barrier removal:

- Installation of automatic doors in public and practice locations
- Renovated ADA-compliant public bathrooms
- Increase in handicap-accessible parking spaces in garages
- Curb cuts in pedestrian paths and widening of ramps leading to main entrance

- Lower counters at information desks, outpatient pharmacy, and newly renovated nursing stations

Equipment:

- Adjustable exam tables
- Wheelchair-accessible scales
- Adaptive exercise equipment at the Clubs at Charles River Park
- Specialized call bells
- Accessible podiums and assisted-listening systems in Thier and Yawkey conference rooms (in process)

Education and development:

- MARS (MGH Accessibility Resource Site) a one-stop intranet site with access to resources and equipment available for patients and families with disabilities
- Service Animal Policy
- HealthStream modules for physicians and other clinical staff, support staff, and transportation staff
- Employees with Disabilities Resource Group
- Autism Task Force
- Special patient flag to identify disability and services needed

Question: What's next?

Jeanette: The disability program has been a catalyst for improvements in access and care for individuals with disabilities and a model for hospitals across the country. Satisfaction surveys and an advisory group of patients, families, and community members will continue to inform our work.

We want MGH to be an employer of choice, so we continue to seek ways to ensure our workforce is inclusive and our workplace accessible for individuals with disabilities.

For more information about the September 10th event or any of the resources available at MGH, contact disability program manager, Zary Amirhosseini, at 617-643-7148.

Remembering colleague and friend, Barbara Carter, RN

The MGH community was saddened to learn of the passing of former MGH nurse, Barbara Carter, RN, on August 7, 2015... She enjoyed a nursing career at MGH that spanned 45 years.

The MGH community was saddened to learn of the passing of former MGH nurse, Barbara Carter, RN, on August 7, 2015. A graduate of the MGH School of Nursing, Carter earned her bachelor's degree at Emmanuel College. She enjoyed a nursing career at MGH that spanned 45 years and included roles as a staff nurse, nursing supervisor, and administrative positions.

Though Carter was retired at the time of her death, many in the MGH community still remember her warm presence and passion for nursing. Says chief compliance officer, John Belknap, "I knew Barbara for more than eighteen years. She was a close friend and someone I could count on for straight-forward advice or a heartfelt laugh at the curves life threw us. Barbara and I were colleagues in the Compliance Office. One of the first things I noticed about her was how hard she worked. I cautioned her that it would take some time to get up to speed, but she wasn't one to sit back and let things happen. Very soon, she became the expert and was training others.

"Barbara never stopped being an MGH nurse. The patient was always at the forefront of her thinking. She was an invaluable asset to the Compliance Office."

Former MGH Compliance director, Maryanne Spicer, recalls, "I first met Barbara in the early days of intensive care units at MGH. She was a surgical nurse and a perfect choice to serve as a pioneer in these new specialized units. She was highly skilled, incredibly organized, and a hard worker; but most important, she loved being a nurse and supporting patients and families during frightening life experiences.



Barbara Carter, RN,
former MGH nurse

"As she took on more teaching and supervisory roles later on, those early skills stayed with her. She continued to care for and about those she knew. Her kindness of spirit is a loss to us all."

Barbara Dunderdale, RN, senior major gifts officer in the Development Office, says, "It was a true privilege to work with Barbara. A dedicated nurse, her primary concern was always the patient and family. A nursing supervisor for decades, Barbara served on many committees helping to design the Code Call Team, our Disaster Plan, and integrating nursing practice into the Transplant and Burn programs. Barbara was devoted to staff. She could always be seen listening to their stories and helping them solve countless problems, both personal and professional. Her loss is our loss."

Says Belknap, "All of us at MGH who knew Barbara will miss her greatly; she was one of a kind, a very special person. It was my pleasure to know her, to count her among my friends, and to be a small part of a life well-lived."

Announcements

Blum Center Events

(Note varying start times)

"Caring for a Family Member with Alzheimer's Disease"

Thursday, September 3, 2015
1:00–2:00pm

Join social worker, Barbara Moscovitz, LICSW, to learn about the challenges of Alzheimer's disease.

Book Talk: *Thinfluence*
Wednesday, September 9th
12:00–1:00pm

Join Malissa Wood, MD, for a candid discussion about factors affecting weight and the steps you can employ to overcome them.

"The Impact and Treatment of Atrial Fibrillation"

Thursday, September 10th
11:00–12:00pm

Join Monique Machado, RN, to learn about the causes, symptoms, and treatment for atrial fibrillation and ways to lower your risk for stroke.

"Treatment Options for Opioid Use Disorders"

Thursday, September 24th
12:00–1:00pm

Join Nalan Ward, MD, for a discussion on opioid use disorders, addiction, overdose, and recovery.

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.

MGH Nurses Alumnae Association fall reunion and educational program

This year's theme:
"Historical Reflections and Nursing Innovations"

Friday, September 25, 2015
O'Keeffe Auditorium
8:00am–4:30pm

Sessions will include: "MGH Graduate Nurses Who Served in the Military During the Vietnam War"; "Veterans, Post-Traumatic Stress Disorder and the Role of Equine Therapy"; "Nurses as Innovators," and others.

For more information or to register, call the MGH Nurses Alumnae Association at 617-726-3144.

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.

ACLS Classes

Certification:

(Two-day program)

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

Day one:

September 11, 2015
8:00am–3:00pm

Day two:

September 21st
8:00am–1:00pm

Re-certification (one-day class):

October 14th
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.

Submit abstracts for MGH Clinical Research Day

Thursday, October 8, 2015, is Clinical Research Day. The Division of Clinical Research invites investigators to submit abstracts by September 8th.

Submissions must be about clinical research conducted at MGH and may include manuscripts published after September 1, 2014.

Cash awards for best abstracts:

- \$5,000 Team Award
- \$1,500 Translational Research Award
- \$1,000 Individual Award
- Departmental Awards
- Raffle sponsored by the MGH Research Institute

Clinical Research Day begins at 8:00am with keynote address by Mark Fishman, MD, president, Novartis Institutes for BioMedical Research.

For more information, contact Jillian Tonelli at 617-724-2900.

On-line prerequisite courses at the IHP

If you're preparing for graduate school in Nursing, Occupational Therapy, Physical Therapy, or Physician Assistant Studies and need to take science or other prerequisite courses, the MGH Institute of Health Professions offers a full range of on-line courses and labs.

Classes begin
September 14, 2015.

Employer's vouchers may be used to take one or more courses for free. Register or view full list of course offerings at mghihp.edu/science. For more information, call 617-724-6362 or e-mail: cipsi@mghihp.edu.

Celebrate Accessible MGH

Come celebrate the success of the MGH Disabilities Initiatives

September 10, 2015
2:30-4:00

Under the Bulfinch tent

For the past six years the MGH community has worked to embrace a change in culture, ensuring that all patients have access to the same high-quality care at MGH.

Try a wheelchair scale or adaptive exercise machine. Learn about specialized call bells. See what resources are available to patients and employees with disabilities. Arrive early for door prizes.

ASL interpreter will be present.

For more information, call Zary Amirhosseini at 3-7148.

Selfless act of kindness warms hearts... and heads

—by Katrina Scott, staff chaplain

Recently, the MGH Chaplaincy became the unwitting ‘middleman’ for a transaction of kindness between a departing MGH resident and our population of cancer patients. On the last day of her residency, Peggy Kim, MD, delivered more than 150 hand-knitted hats and other items to the Chaplaincy in the hope that they would be given to cancer patients undergoing chemotherapy.

Says oncology chaplain, Katrina Scott, “We are constantly amazed by the generosity of spirit and these incredible acts of kindness at MGH, especially those acts that have a positive effect on so many patients.”

Kim made the hats during all her ‘free time’ as a resident. Said Kim, “I hope the hats provide some small measure of comfort to patients going through cancer treatment. I tagged each one



with a label specifying the yarn content and care instructions in case anyone suffers from allergies.”

Says pediatric chaplain, Kate Gerne, “We’re so grateful for this expression of kindness that comes straight from Peggy’s heart and hands; it’s an honor for us to be able to deliver these beautiful hats to our patients. I know they’ll be a source of great comfort.”

For more information or to receive

a hat, contact Katrina Scott at 617-726-4225 or Kate Gerne at 617-724-3613.



Staff chaplains, Katrina Scott (left) and Kate Gerne, show off just a few of the hats donated by resident, Peggy Kim, MD, to be given to cancer patients undergoing chemotherapy.

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Next Publication

September 17, 2015

Inpatient HCAHPS

2015 calendar year, to date

Measure	2014	2015 Year to Date	2014- 2015 Change
Nurse Communication Composite	82.1	83.2	1.1
Doctor Communication Composite	81.6	83.6	2
Room Clean	72.2	73	0.8
Quiet at Night	49.7	52.3	2.6
Cleanliness/Quiet Composite	60.9	62.6	1.7
Staff Responsiveness Composite	63.8	66.5	2.7
Pain Management Composite	71.7	73.6	1.9
Communication about Meds Composite	65.8	66.3	0.5
Discharge Information Composite	91.6	91.4	-0.2
Overall Rating	79.8	81.3	1.5
Likelihood to Recommend	90	90.8	0.8

Patient-experience metrics for 2015 continue to reflect a positive performance by MGH staff. We remain at or above all targets for the year; though some indicators dipped slightly in July.

Data complete through June, 2015
 All results reflect Top-Box (or 'Always' response) percentages
 Pull date: August 17, 2015



Returns only to:
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