

Caring

Headlines

November 3, 2016

PeriOperative Nursing

*a highly specialized practice contributing
to optimal patient outcomes*

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Perioperative staff nurses, Natalie Bonvie, RN (left), and Rachel Eaton, RN, conduct pre-operative interview.

Nurses play key role in detecting and preventing *C. difficile*

CDIs are more likely to affect older individuals in hospitals and long-term care facilities, typically after the use of antibiotic medications; but more and more CDI is occurring among populations not typically considered high risk, such as younger, healthy individuals without a history of antibiotic use or inpatient hospitalization.

Preventing and controlling *Clostridium difficile* infection (CDI) is an ongoing challenge for hospitals and healthcare facilities across the country. CDI, also called *C. difficile* or *C. diff*, is a bacteria that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. CDIs are more likely to affect older individuals in hospitals and long-term care facilities, typically after the use of antibiotic medications; but more and more CDI is occurring among populations not typically considered high-risk, such as younger, healthy individuals with no history of antibiotic use or inpatient hospitalization.

The Centers for Disease Control and Prevention estimate that each year, 450,000 cases of *C. difficile* infection in the United States result in approximately 15,000 deaths. Research shows that CDIs are preventable with effective infection-control practices and the judicious use of antibiotics. Preventing *C. difficile* infection is a top priority of President Obama's National Action Plan to Combat Antibiotic Resistant Bacteria, launched in March of 2015.

In all hospitals, but especially those that practice relationship-based care, as we do, nurses play a critical role in detecting and preventing *C. difficile* infections. Nurses are instrumental in:



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

- **Detection:** *C. difficile* is highly transmissible in healthcare settings making early detection of new cases critical to preventing the spread of infection. The primary symptom of *C. difficile* is diarrhea; nurses at the bedside are likely to become aware of this symptom sooner than other clinicians. Detection is even more crucial in patients who are unable to communicate (due to mechanical ventilation, dementia, and other factors)
- **Initiating isolation:** Rapid initiation of Contact Isolation *Plus* is essential in preventing the spread of *C. difficile*. Delaying isolation increases the risk of transmission. In almost all instances, nurses are the ones who initiate Contact Isolation *Plus* for patients with known or suspected *C. difficile*, and they're most often the ones who notify other departments (such as Admitting and Infection Control)

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When it comes to protecting patients against aggressively transmissible infections such as *C. difficile* and Methicillin-resistant Staphylococcus aureus (MRSA), nurses are our first line of defense. Building trusting relationships with patients and employing the best infection-control practices go a long way toward detecting and preventing infection.

- **Monitoring:** Studies show that healthcare providers, support staff, visitors, and patients themselves frequently fail to follow proper hand-hygiene and contact-isolation protocols. The effectiveness of contact isolation is greatly enhanced when nurses work to promote compliance
- **Testing:** Collecting stool samples for testing is important in diagnosing *C. difficile*. Reliable, true-positive results can only be obtained from liquid stool. In most instances, nurses are called upon to collect diagnostic samples from patients who might have *C. difficile*, so it's vital that nurses know which specimens to collect and how to send them for testing
- **Environmental cleaning:** It's well known that *C. difficile* contaminates the rooms of patients infected with it. Nurses are familiar with the patient's care environment, so they're in a position to be able to identify surfaces that may be contaminated and need to be cleaned and disinfected. Environmental cleaning is more effective when nurses collaborate with Environmental Services staff to ensure all appropriate surfaces are cleaned and disinfected

- **Antibiotic exposure:** Exposure to antibiotics is the single most important risk factor for *C. difficile* infection. Improving antibiotic use through 'antibiotic stewardship' is key to reducing *C. difficile* infection. Even nurses who don't prescribe antibiotics play an important role when they collect specimens to ensure optimal utilization of antibiotics; ensure the correct administration of antibiotics; track antibiotic use; and re-visit the use of antibiotics as patients' clinical conditions change

We all play a role in keeping patients safe. But when it comes to protecting patients against aggressively transmissible infections such as *C. difficile* and Methicillin-resistant Staphylococcus aureus (MRSA), nurses are our first line of defense. Building trusting relationships with patients and employing the best practices of early detection, Contact Isolation *Plus*, monitoring, effective specimen-testing, maintaining a clean and disinfected environment, and strong antibiotic stewardship, go a long way toward detecting and preventing infection.

For more information, contact Dee Dee Suslak in the Infection Control Unit at 617-724-3076.

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PeriOperative Nursing

*a highly specialized practice contributing
to optimal patient outcomes*

—by Maureen Hemingway RN, nursing practice specialist, Operating Rooms

Perioperative nursing at MGH is a dynamic, fast-paced, nursing specialty. As an integral part of the multi-disciplinary surgical team, perioperative nurses care for 35,000 patients per year.

According to the Association of PeriOperative Registered Nurses (AORN) “The practice of perioperative nursing requires specialized knowledge and skills that contribute to optimal patient outcomes.” This statement is a good starting point in understanding the scope of perioperative nursing at MGH where the specialty is a dynamic, fast-paced, nursing practice. As an integral part of the multi-disciplinary surgical team, perioperative nurses care for 35,000 patients per year. Many nurses who transition to the perioperative setting say it’s something they’ve always been interested in but didn’t really know what it was all about. That interest spurred the department to spotlight perioperative nursing practice and its contributions to positive patient outcomes.

Perioperative nursing conducts several orientation programs comprised of both hands-on practice and didactic education as prescribed by AORN. Nurses who complete the Perioperative Nursing 101 Orientation Program find they’re well prepared for independent practice. Recent graduates found the orientation model very supportive, describing staff development nurses and preceptors as caring and committed to the success of orientees.

With an eye toward continuous improvement, the program is revised based on feedback received after each program. Caitlin Yeaton, RN, a general medicine nurse with six years experience, observed that classroom experiences were so valuable, espe-

cially once she got into the OR environment. She recommended reversing the ratio of classroom time to hands-on experience.

Interviews with recent perioperative nursing graduates generated some common themes: patient care, safety, teamwork, and active engagement in daily learning. This OR environment is fast-paced and dynamic; no two days are ever alike. Caring for patients undergoing cutting-edge procedures is exciting and intriguing for perioperative nurses. Many nurses are surprised by the technical aspects of perioperative nursing, but the human side of caring for patients is the same no matter the setting. The busyness and technical components of surgery don’t distract perioperative nurses from their primary goal—delivering the highest quality, compassionate, patient-focused care.

Samantha Herwig, RN, says, “I like the time before cases begin; that’s when I can spend time with patients and comfort them before surgery.”

Interacting with patients, connecting with them, calming them, is the highest priority for perioperative nurses. Laura Clancy, RN, says, “I like the team effort, working together with techs, surgeons, residents, interns, and anesthesiologists.”

Says Bonnie Spencer, RN, “I like the one-to-one patient care.”

Though rooted in tradition, perioperative nursing at MGH is evidence-based. We have nurses who’ve worked in the OR setting for more than 40 years, and we have nurses who are new to the perioperative setting—some new graduates, some who are just new to MGH, and some who’ve transi-

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tioned to perioperative nursing from other specialties within the hospital.

OR nurses are members of multiple teams, coming together in various combinations to care for specific patients. These teams all share a mental model of patient care. Many OR nurses say they value teamwork above all else.

Tayla Hussey, RN, says, “It’s so nice to work as part of a multi-disciplinary team because physicians are right there whenever there’s a question.”

Katie Zager, RN, says, “I love delivering care in this model. Teamwork is huge.”

Says Jennifer Tavernelli, RN, “The nurse brings everyone together. The nurse is the one who makes sure that everyone is on the same page.”

Bonvie (left) and Eaton review patient’s chart post-procedure.



These sentiments are reflected in the care they deliver. Conducting universal protocols (often driven by nurses) enhances communication and allows the team to plan for individualized patient care. Coordination of care is a hallmark of patient safety.

Perhaps Natalie Bonvie, RN, described it best: “The nurse is a member of a well-orchestrated team. Everyone has a specific job, but it’s the nurse who coordinates everything. As an OR nurse, I’m responsible for reassuring my patients, preparing them for surgery, checking orders, and providing a safe environment. Every one of those steps is crucial.”

Providing a safe environment is a common theme in the OR setting, and working together is part of the culture.

Says Lisa Liu, RN, “Every day that I’m involved with good teamwork is a good day.”

Perioperative nurses are a vital part of patient care at MGH. Rachel Eaton, RN, says, “When I leave, I can honestly say I did a good job. I think about my patients when I get home, and I’m excited to come back each day. I feel like I have a positive work-life balance.”

The perioperative environment is supportive and encouraging. Says Kristen Kelly, RN, “I love my fellow nurses, my team leader, and my clinical nurse manager.”

The general public may not be 100% clear about what perioperative nurses do, but they can rest assured that our team is committed to providing the highest quality care to our patients by working closely together with our physician colleagues and one another.

For more information or if you’re interested in becoming a perioperative nurse, come to the perioperative open house, November 18, 2016, from 9:00am–1:00pm in Lunder 234, or call Patrice Osgood, RN, nursing director, at 617-724-3604.

Focusing on nutrition

inter-disciplinary collaboration ensures patients' nutritional needs are met

—submitted by the PCS Patient Education Committee

Care is most effective when all members of the care team collaborate to ensure a patient's nutritional needs are met. Patients, family members, nurses, physicians, and dietitians all play an important role in developing the nutrition care plan.

Patients, family members, nurses, physicians, and dietitians all play an important role in developing the nutrition care plan. In their interactions with patients, clinicians can reinforce the importance of optimal nutrition in promoting healing and fostering a healthy lifestyle.

The initial nursing assessment (INA) helps identify patients at risk for poor nutrition. The Malnutrition Screening Tool (MST), implemented with the launch of eCare, prompts nurses to offer oral nutritional supplements and/or consult a dietitian based on the results of the MST screening. This initial assessment along with the patient's medical history helps determine the patient's nutritional needs and care plan.

Some information that helps identify patients at risk include: knowing if they were eating well prior to admission. Have they lost weight recently without trying? Do they have problems chewing or swallowing? Will their ability to eat be affected by their illness and/or treatment plan? Are there cultural preferences or food allergies to consider?

Other factors that can interfere with adequate food intake include nausea, vomiting, changes in taste, and poor appetite. The presence or absence of these factors can change over time. If you determine that a patient has any of these nutritional challenges, alert Nutrition & Food Services. It's helpful if clinicians inform patients that their diets may change due to restrictions, tests, procedures, or as medical issues arise.

Care is most effective when all members of the care team collaborate to ensure a patient's nutritional needs are met.

- Nutrition service coordinators (NSCs) provide menus for food selection and notify the care team about food allergies, preferences, and other accommodations the patient may need
- Registered dietitians (RDs) are food and nutrition experts who, when consulted, determine the appropriate nutritional care plan for patients given their medical history and reason for current admission. Registered dietitians advise patients and nurses around best practices to increase oral intake and arrange for supplements as necessary. In some cases, they may recommend alternative therapies (enteral feedings or parenteral nutrition). They also provide patient education
- Registered nurses (RNs) help plan, implement, monitor, and evaluate the nutrition care plan and educate patients about the rationale for diet restrictions or changes
- Physicians (MDs) place diet orders based on current medical diagnoses and physical exams. They make medically driven changes when necessary

Whenever possible, family members and caretakers should be included in teaching sessions. Their participation during discharge education is essential to ensuring patients' needs are met at home. Respecting culture and food preferences is important in dietary planning. All visitors should check with the nurse to confirm that food brought from home is in alignment with the patient's dietary plan.

Registered dietitians can answer any questions you may have regarding optimal nutrition. Outpatient services are available for follow-up and long-term management. For more information, consult your registered dietitian through the on-call directory or during multi-disciplinary rounds.

The MGH Council on Disabilities Awareness

On Tuesday, October 11, 2016, the MGH Council on Disabilities Awareness sponsored its annual Disabilities Awareness Booth in the Main Corridor to share information and educate the MGH community on how to make the hospital a more welcoming and accessible place for all. Staff were on hand to answer questions and disseminate information about the resources available at MGH for individuals with disabilities.

Patients and visitors:

- The MGH Accessibility website, www.massgeneral.org/accessibility, houses information on transportation, parking, entrances, escorts, adaptive equipment, communication, and amenities
- The MGH Disabilities Program supports patients with disabilities with visit planning, accommodations, and much more. Call 617-726-3370 or e-mail: MGHAccessibility@partners.org

Staff:

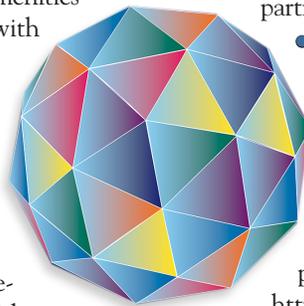
- Look for the FYI flag on the patient's chart in eCare to identify patients with disabilities who may need special accommodations
- The MGH Accessibility Resources (MARS) SharePoint site houses information on best practices, guide-

lines on caring for people with visual, hearing, and cognitive impairments, and people with autism spectrum disorders

- The PCS Excellence Every Day Portal contains communication and etiquette tips, our service animal policy, and information about assistive devices and other resources
- HealthStream modules are available to help educate staff around working and interacting with individuals with disabilities

Employees with disabilities:

- The Employees with Disabilities Resource Group (EDRG) provides networking opportunities, social connection, and collaboration to MGH employees with disabilities (<http://sharepoint.partners.org/mgh/mghedrg/SitePages/Home.aspx>)
- The Partners Employment Assistance Program offers support to employees with disabilities (or who may be caring for a family member with a disability) by finding internal specialists or community resources (<http://eap.partners.org/> or call 866-724-4EAP)
- Every MGH employee has an HR business partner (formerly 'generalist') who is available to answer all personnel questions. Find your HR business partner at <http://hr.partners.org/mgh/hr-contacts.aspx>



Above (l-r): Sheila Golden-Baker; RN, professional development specialist; Zary Amirhosseini, disabilities program manager; and Joe Crowley, senior manager for Police & Security, staff disabilities awareness booth in the Main Corridor.

New nurse learns valuable lesson about the essence of nursing

critical thinking can only be learned through hands-on experience

Two months after completing my orientation, I was assigned to an elderly woman who was experiencing respiratory distress. Over the course of her hospitalization, she had been intubated due to worsening respiratory failure, and she had become septic requiring high-dose pressors.

My name is Stephanie Neville, and I am a new graduate nurse in the Blake 7 Medical Intensive Care Unit (MICU). Earlier this year, just two months after completing orientation, I was assigned to care for an elderly woman who was experiencing respiratory distress. Over the course of her hospitalization, she had needed to be intubated due to worsening respiratory failure, and she had become septic requiring high-dose pressors. But Mrs. P had turned a corner by the time I met her, and at the start of my shift, she'd been off of pressors for more than 24 hours. When I met Mrs. P, she seemed like a 'typical' MICU patient; little did I know that later in my shift she would begin to rapidly decompensate.

After an uneventful morning, I was surprised to hear Mrs. P's vent alarm since it had been quiet all shift. When I went into her room, I was



Stephanie Neville, RN,
new graduate nurse

shocked to see her endotracheal tube filled with frank red blood. She was hypotensive and not ventilating. I alerted the nearest nurse and asked her to suction Mrs. P so I could urgently page the medical team and respiratory therapist. Everyone showed up quickly while I continued to suction blood from the endotracheal tube and start her back on pressors. I tried to remain calm while explaining to everyone in the room the events that had occurred prior to their arrival. I was quickly supported by fellow nurses who jumped in to help titrate pressors

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Someone once told me that as a new graduate nurse, you can be taught nursing skills. But the critical thinking, communication, and compassion that comes with being a nurse can only be learned through experience and caring for patients at the bedside. In the past year I've learned more than I ever thought possible—from my preceptors and my experiences.

and order more blood. The whole team worked together while discussing treatment options to stabilize Mrs. P.

I had learned in report that Mrs. P was DNR (do not resuscitate) and her family did not want to escalate care. No family members were present at the moment; so I knew I had to advocate for Mrs. P to make her wishes known.

As the medical team ordered an emergency bronchoscopy and massive transfusions, we were close to maxing out on three pressors. I asked the team to contact the family to let them know what was happening and see if they wanted us to proceed with these measures. I reminded them that the family did not want to escalate care.

After numerous phone calls to try to reach the family, we were able to speak with Mrs. P's health care proxy. We explained that Mrs. P's condition was unstable and made sure she understood that any efforts to keep her alive would involve invasive procedures and life support. Mrs. P's health care proxy felt sure that Mrs. P would not want any invasive procedures.

We immediately transitioned to comfort measures only, and I requested a Dilaudid drip. I did everything I could to help Mrs. P pass peacefully. We stopped pressors and removed her endotracheal tube. I stayed by her side until she passed away a few moments later.

Someone once told me that as a new graduate nurse, you can be taught nursing skills. But the critical thinking, communication, and compassion that comes with being a nurse can only be learned through experience and caring for patients at the bedside.

This past year I learned more than I ever thought possible—from my preceptors and from my experiences. But no amount of orientation could have prepared me for what to expect or how I would feel during my first unexpected death as a nurse.

I was overwhelmed. But as horrible as that experience was, I look back now and know I did everything in my power to help Mrs. P. Yes, the pressors, the blood, the labs, the bronchoscopy, and all the other interventions were important. But the *most* important thing I did that day was advocate for my patient and make her wishes known when no one was there to speak for her. As tragic as her passing was, Mrs. P passed peacefully, according to her wishes, and with dignity.

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

Moving from the structure and security of the academic setting into clinical practice is a major transition, one every veteran clinician can vividly recall. Stephanie was thinking Mrs. P's recovery was progressing on track when without warning, everything changed. But Stephanie was well-trained, and she had good instincts. Despite the rapidly changing situation, she did what nurses do; she advocated for her patient; she worked with the team to give Mrs. P the best possible care; and she took advantage of the knowledge and experience of her more experienced colleagues. Every day, clinicians come to work not knowing what to expect, prepared to do whatever it takes for their patients and colleagues, just as Stephanie and her team did.

Thank-you, Stephanie

2016 Molly Catherine Tramontana Award

—by Michele O'Hara, RN, nursing director, Labor & Delivery

The Molly Catherine Tramontana Award for Outstanding Service and Patient Care recognizes labor and delivery nurses who provide exemplary care to grieving families. The award, established in 2007 by Mark and Jennifer Tramontana in memory of their daughter, Molly Catherine, provides funding that enables a labor and delivery nurse to attend an annual bereavement conference.

Each year, the Tramontana family, leadership of Vincent OB-GYN, labor and delivery nurses, and MGH Trustee, Gardner Jackson, celebrate Molly

Catherine's memory by honoring a nurse (or nurses) who provide exceptional care to a family that has experienced unexpected loss.

This year's recipient was Janet Palermo, RN, a labor and delivery nurse for more than 25 years. Palermo was nominated by fellow nurses, Lois Richards, RN, and Jen Bernard, RN, who were with Palermo when one of her patients experienced an unexpected loss.

Said Richards, "Janet stayed with her patient through the entire labor process, never leaving the family's side. With tears in her eyes, she continued to give loving care to this patient and her family. I have so much respect for Janet's nursing abilities.

She is the epitome of the art of nursing."

Said Bernard, "Janet was a wonderful example that day. Every day that Janet works she exemplifies the qualities of a Tramontana award recipient."

We're grateful to the Tramontana family for their continued support of excellence in obstetrical nursing care.

For more information about the Tramontana Award or to nominate a colleague for recognition, contact Michele O'Hara, RN, nursing director, at 617-724-1878.

(L-r): Michele O'Hara; Katherine Kruczinski; Susan Cahill; Jeff Ecker; Janet Palermo; Jenn and Mark Tramontana and their children; Beth West; and Lois Richards.



(Photo provided by staff)

Pre-Procedure Evaluation Phone Program

—by Donna Van Kleeck, RN, and Karen Parmenter, RN

Currently, more than 1,000 calls a month are made by PPE nurses. In 2015, more than 13,000 patients were pre-screened over the phone...With the closing of the Pre-Admission Testing Clinic in January, the program will expand to include those patients, as well.

“Hi, my name is Debbie. I’m a nurse in the Pre-Procedure Evaluation Phone Program at MGH. I’m calling to gather some health information for your upcoming procedure. No, you don’t have to come in; we can do it over the phone. When you come in on the day of your procedure, your anesthesia provider will have already reviewed the information we’re discussing.”

Every week, nurses in the Pre-Procedure Evaluation (PPE) Phone Program call hundreds of patients scheduled for procedures requiring anesthesia. Historically, patients had to come to the hospital to meet with an anesthesia provider, but today, more and more patients are completing their PPEs over the phone with a nurse.

The process for scheduling a PPE begins when the surgeon confirms a date for surgery. Patients are asked to complete an on-line questionnaire prior to the phone call so the nurse will have some background information in advance.

On the day of the phone call, the nurse reviews the patient’s responses to the questionnaire and adds relevant details for the anesthesia team. Home medications are updated, and instructions are given as to which medications the patient should take (or not take) on the morning of surgery. Patients are given information on how to prepare and what to expect on the day of the procedure.

Ideally, the pre-procedure interview is conducted two to four weeks prior to non-emergent procedures. Once the interview is completed, an attending anesthesiologist reviews the information. If the anes-

thesiologist requires more, he or she will contact the appropriate provider, patient, or facility to obtain the necessary information.

When the patient arrives at the hospital for their procedure, perioperative nurses and anesthesia providers review the PPE information. Having the information in advance allows providers to ‘know’ the patient and individualize their care accordingly.

In addition to being convenient, the PPE Phone Program has proven to be a reliable method for pre-screening patients. Surgical cancellations are greatly reduced because of the thorough screenings conducted by PPE nurses and attending anesthesiologists.

Currently, more than 1,000 calls a month are made by PPE nurses. In 2015, more than 13,000 patients were pre-screened over the phone. The program also encompasses patients in nursing homes, rehabilitation facilities, and group homes. In those cases, a PPE nurse contacts the nurse caring for the patient and gathers information, eliminating the need for an ambulance ride to the hospital. As of January 1, 2017, with the closing of the Pre-Admission Testing Clinic in the Jackson Building, the program will expand to include those patients, as well.

Staff of the Pre-Procedure Evaluation Phone Program say it’s been exciting to be part of a program that has grown and changed so significantly over the years, adapting to meet the needs of the patient and the perioperative team.

For more information, call 617-643 2555.

Why on-line translation programs and apps are a ‘no-no’ in the medical setting

Unfortunately, many inaccuracies have been associated with on-line translation programs, which poses a safety risk for patients. MGH Medical Interpreters Services provide translation of written materials.

Question: I recently discovered Google Translate on-line, and I’m thinking it would be great to use for translating documents for my patients. Is there any reason I shouldn’t use it?

Jeanette: Unfortunately, many inaccuracies have been associated with on-line translation programs, which poses a safety risk for patients. In a study published in the electronic journal, *BMJ*, Sumant Patil and Patrick Davies from Nottingham Children’s Hospital in the UK, concluded that Google Translate has only a 57.7% accuracy rate when used for medical translation. Serious errors have been found in translations. For example, “Your husband had a cardiac arrest,” was translated in one language as, “Your husband has an imprisonment of the heart.” In another language, “Your husband has the opportunity to donate his organs,” became, “Your husband can donate his tools.” Google Translate and other on-line translation programs should not be used to translate any medical materials, especially those involving consent, discharge instructions, medication instructions, and diagnosis information.

Question: What do you recommend for translating documents?

Jeanette: MGH Medical Interpreters Services provide translation of written materials. You can reach them at 617-726-6966 or by e-mail at MGHTranslations@partners.org.

Question: Can I use a smart-phone app to interpret for patients?

Jeanette: Once again, where we can’t ensure the accuracy of these programs, to protect our patients, they should not be used in the medical setting. On-line programs and apps don’t allow for two-way communication. Using a trained medical interpreter (in person, by video, or by phone) ensures effective communication and meets compliance standards set by The Joint Commission.

Question: Can my Spanish-speaking colleague serve as an interpreter for me?

Jeanette: We should only rely on qualified medical interpreters to communicate with patients and families. Though many of our bilingual colleagues are willing to help, asking individuals who haven’t been assessed for language fluency to interpret for us poses a safety risk. Studies show that encounters facilitated by untrained interpreters have a larger percentage of errors with clinical significance than those facilitated by professional interpreters. Relying on individuals whose primary role is not interpreting puts them in the difficult position of working outside their scope of practice. And working with qualified medical interpreters is also in accordance with the new Affordable Care Act requirement.

For more information, contact Medical Interpreter Services at 617-726-6966, or refer to your orange RACE card where it’s listed under Emergency phone numbers.



COLLABORATIVE GOVERNANCE PATIENT EDUCATION COMMITTEE TEACHABLE MOMENTS

ACUTE PAIN OPIOID GUIDELINE: IMPORTANT PATIENT TEACHING POINTS



Identifying and managing pain is an important part of patient-centered care. Patients experiencing acute pain may be prescribed opioids as a part of their treatment plan. In light of the public health concerns related to opioid misuse, advancing efforts to teach patients how to use opioids safely is important for all clinicians.

Patient Assessment

When opioids are being considered as a part of the treatment plan, patients should be screened for mental health or substance use disorders before prescribing. The nursing admission assessment directs the nurse to ask patients if they use alcohol or drugs. If yes, additional questions about quantity, frequency, and substances are posed. Bring concerns to the ordering clinician's attention if you discover unidentified risks for opioid misuse.

Important Patient/Family Teaching Points

- Reinforce realistic expectations about pain control. The goal is to reach a tolerable level of pain, not a zero level of pain.
- Explain that opioids are only one part of a pain treatment plan. Other options may include:
 - non-drug strategies such as:
 - physical methods like body positioning, use of heat and cold, pacing activities to allow for rest periods, or massage
 - mind-body methods such as distraction and relaxation
 - educating patients about pain control
 - maximizing the use of prescribed non-opioid medicines alone or in combination with opioids
- Explain that the dose and type of pain medicine will be adjusted based on the level of pain, the effects of the pain medicine, and how well a patient can participate in their treatment plan.
- Explain that the duration of opioid therapy is based on the etiology of the pain. Most acute pain resolves within a few days. The goal is to use the least amount of opioid for the shortest period of time.
- Advise patients to contact their provider if their pain is not lessening over time as expected post-discharge.
- Teach patients about the safe use of opioids to reduce risk of harm including addition, overdose, or physical dependence.
 - Take medicines only as prescribed.
 - Never share medicines.
 - Use medicines for the purpose intended, not for something other than pain.
- Explain that a patient is allowed to receive a "partial fill" of an opioid prescription. Patients must get a new prescription if additional medication is needed.
- Discuss practical methods to safely store medications and dispose of any extra pills.

For More Information: See the MGH Policy Guidance Document: Use of Opioid Therapy for Acute, Non-malignant Pain in Adults



Professional Achievements

McAdams appointed

Eileen McAdams, RN, nurse practitioner, Charlestown HealthCare Center, was appointed a global health scholar by the MGH Center for Global Health, in September, 2016.

McKenna Guanci appointed

Mary McKenna Guanci, RN, clinical nurse specialist, Neurology, was appointed a member of the Board of Directors for the Boston chapter of the American Association of Neuroscience Nurses.

Staples presents poster

Monica Staples, RN, clinical nurse specialist, MGH Center for Disaster Medicine, presented her poster, "Team Training in High-Risk Environments," at the Disaster Health Education Symposium at the Uniformed Services University in Bethesda, Maryland, September 8, 2016.

Inter-professional team presents

Leslie Portney, PT; Gaurdia Banister, RN; Carmen Vega-Barachowitz, CCC-SLP; Mary Knab, PT; and Maureen Schneider, RN, presented, "Strengthening the Academic Practice Partnership to Support Inter-Professional Clinical Education," at the eighth international conference, All Together Better Health, in Oxford, England, September 7, 2016.

Nurses present

Amanda Bulette Coakley, RN, staff specialist; Jane Flanagan, RN, nurse scientist; and Christine Annese, RN, staff specialist, presented, "Exploring the Experience of Pet Therapy on Patients and Staff in the Acute Care Setting," at the ninth European Congress on Integrative Medicine in Budapest, Hungary, September 10, 2016.

Bernhardt appointed

Jean Bernhardt, director of the Charlestown HealthCare Center, was appointed a global health scholar by the MGH Center for Global Health, in September, 2016.

McLaughlin appointed

Sharon McLaughlin, RN, nurse practitioner, Charlestown HealthCare Center, was appointed a global health scholar by the MGH Center for Global Health, in September, 2016.

Algeri certified

Suzanne Algeri, RN, nursing director, Neuroscience Unit, became certified as a nurse executive by the American Nurses Credentialing Center, in September, 2016.

Algeri presents

Suzanne Algeri, RN, nursing director, Neuroscience Unit, presented, "Nursing Care of the Stroke Patient at Massachusetts General Hospital," at the seventh annual Nursing Symposium at Fudan University Huashan Hospital in Shanghai, China, September 21, 2016.

Nurses present prize-winning poster

Virginia Capasso, RN, nurse practitioner; Amanda Bulette Coakley, RN, staff specialist; Vivian Donahue, RN, nursing director; Susan Stengrevics, RN, clinical nurse specialist; Katie Feins, RN, staff nurse; Theresa Gallivan, RN, associate chief nurse; and Gaurdia Banister, RN, executive director of The Institute for Patient Care; presented their poster, "Effect of Fluid Immersion Simulation Mattress on Prevention of Hospital-Acquired Pressure Ulcers in Highest Risk Cardiac Surgical Patients," at the World Union of Wound Healing Societies in Florence, Italy, September 25-29, 2016. Their entry won Best Poster.

O'Connell presents

Denise O'Connell, LCSW, senior program manager, Lunder-Dineen Health Education Alliance of Maine, presented, "The Lunder-Dineen MOTIVATE Program," to the Maine Dental Hygienists' Association in Auburn and Brewer, Maine, September 9 and 16, 2016.

Golden-Baker presents

Sheila Golden-Baker, RN, clinical educator, presented, "Peer Review: Incorporating Innovative Concepts of Professional Development into Practice," at the seventh annual Nursing Symposium at Fudan University Huashan Hospital in Shanghai, China, September 21, 2016.

Inter-professional team publishes

Chris Laux, RN; Mary McKenna Guanci, RN; Stephen Figueroa, MD; Kerry Francis, RPh; Sarah Livesay, RN; and Charlene Mathiesen, RN, authored the article, "Clinical Q&A: Translating Therapeutic Temperature Management from Theory to Practice," in the August, 2016, *Therapeutic Hypothermia and Temperature Management*.

McKenna Guanci presents

Mary McKenna Guanci, RN, clinical nurse specialist, Neurology, presented, "Neurologic Decline, Cortical Spreading Depression, and The Role of Electroencephalography in the Management of the Neuroscience Patient," at the annual meeting of the American Association of Neuroscience Nurses, in New Orleans, on April 10, 2016.

Guanci also presented, "Multidisciplinary Care and Family Rounding in the Neuro Intensive Care Unit, at the 14th annual meeting of the Neurocritical Care Society in National Harbor, Maryland, September 15, 2016.

Arnstein appointed

Paul Arnstein, RN, clinical nurse specialist, was appointed a representative to the Governor's Pain Treatment Education Special Commission in September, 2016.

Stieb presents

Elisabeth Stieb, RN, staff nurse, Food Allergy Center, Newton Wellesley Hospital, presented, "Daily Management of Food Allergies," at the west coast conference of the American Society of Allergy Nurses, in Seaside, Oregon, September 25, 2016.

McKenna Guanci, appointed

Mary McKenna Guanci, RN, clinical nurse specialist, Neurology, was appointed chair of the Nursing Awards Committee for the American Association of Neuroscience Nurses, earlier this year.

Nurse practitioners publish

Barbara Wuertner, RN, nurse practitioner; and Maria Avila-Wallace, RN, nurse practitioner, authored the article, "Cervical Cancer: Screening, Management, and Prevention," in the September, 2016, *The Nurse Practitioner*.

Inter-professional team publishes

Mary McKenna Guanci, RN; Herbert Fried, MD; Nathan Bart, MD; Shaun Rowe, RPh; Joseph Zabanski, MD; Andaluz Nomberto, MD; Bhimra Adarsh, MD; David Seder, MD; and Jeff Singh, MD, authored the article, "The Insertion and Management of External Ventricular Drains: an Evidence-Based Consensus Statement—a Statement for Healthcare Professionals from the Neurocritical Care Society," in the February, 2016, *Neurocritical Care*.

Announcements

Blum Center Events

"Weight Bias in the Medical Setting"

Thursday, November 10, 2016
12:00–1:00pm

Lisa Du Breuil, LICSW, and Anne Emmerich, MD, will discuss weight bias and its impact on patient health outcomes.

Shared Decision Making:
"Living with Diabetes: Making Lifestyle Changes to Last a Lifetime"

Monday, November 14th
12:00–1:00pm

Enrico Cagliero, MD, will lead a discussion about diabetes care.

"Understanding Lupus"

Friday, November 18th
12:00–1:00pm

Join April Jorge, MD, to learn about the symptoms, causes, and treatments for lupus.

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:

November 10, 2016
8:00am–3:00pm

Day two:

November 11th
8:00am–1:00pm

Re-certification (one-day class):

January 11, 2017
5:30–10:30pm

ACLS Instructor Class

December 2, 2016
7:00am–3:00pm

Location to be announced.

For information, send e-mail to:

acls@partners.org, or call
617-726-3905

To register, go to:

http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf.

The MGH Blood Donor Center

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

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

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday,
Thursday,

7:30am–5:00pm

Friday, 8:30am–3:00pm

Appointments are available

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

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Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services.

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For more information,
call 4-1746.

Published by

Caring Headlines is published twice each month by the department of Nursing & 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 17, 2016

Inpatient HCAHPS

Current data

HCAHPS Measure	CY 2015	CY 2016 Year-to-date (as of 10/11/16)	% Point Change
Nurse Communication Composite	83.0%	83.0%	→ 0.0%
Doctor Communication Composite	83.5%	82.6%	↓ -0.9%
Room Clean	72.9%	71.2%	↓ -1.7%
Quiet at Night	50.8%	50.5%	↓ -0.3%
Cleanliness/Quiet Composite	61.8%	60.8%	↓ -1.0%
Staff Responsiveness Composite	65.8%	64.7%	↓ -1.1%
Pain Management Composite	73.1%	72.3%	↓ -0.8%
Communication about Meds Composite	66.6%	65.9%	↓ -0.7%
Care Transitions	62.4%	60.0%	↓ -2.4%
Discharge Information Composite	91.1%	91.4%	↑ 0.3%
Overall Hospital Rating	81.2%	81.4%	↑ 0.2%
Likelihood to Recommend Hospital	90.9%	89.3%	↓ -1.6%

Data is complete through July, 2016, with partial data through October. MGH is performing well in Overall Rating and Discharge Information.

All results reflect Top-Box (or 'Always' response) percentages



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