

Caring

Headlines

February 16, 2017

IV Academy

preparing staff nurses to serve as IV champions



See story on
page 4

Staff nurse IV champions enhance their knowledge and skills in order to share IV-therapy best practices with their nursing colleagues.

Diversity, inclusion, the federal immigration ban, and the world champion New England Patriots

Regardless of
what other people
are doing, regardless
of inflammatory
rhetoric we may
hear in the news,
and regardless of
executive orders,
Massachusetts
General Hospital
does not discriminate
against any individual
for any reason.
Period.

A

s I write this column, the day after Tom Brady and the incredible New England Patriots turned almost certain defeat into the greatest football comeback of all time to win their fifth Super Bowl title, I'm re-

minded of the importance of working together and never—*never*—abandoning the values that got us to the top of our game in the first place.

When this issue of *Caring* went to print, there was still a lot of confusion around President Trump's executive order banning entry to the United States from seven predominantly Muslim countries (Iraq, Syria, Iran, Libya, Somalia, Sudan and Yemen). The ban had been overturned by a US District Court, and the federal government was still appealing the ruling. As we gain greater clarity, we will keep this dialogue going.

But this column is not about the executive order. It's about our values and responsibilities as citizens, colleagues, and fair-minded members of a world-class, wonderfully diverse, healthcare community. Regardless of what other people are doing, regardless of inflammatory rhetoric we may hear in the news, and regardless of executive orders, Massachusetts General Hospital does not discriminate against any individual for any reason. Period.

As we try to find our equilibrium in an increasingly uncertain world, it's imperative that we keep the lines of communication open. I ask each of you



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

to make a special effort to extend yourselves to patients, families, and colleagues who may be feeling fearful or threatened. Put yourself in their place. Imagine what they might be thinking. Let them know this is a safe place, that we've got their backs, that we're glad they're here. I've been thrilled to see so many acts of kindness throughout the hospital; like the gift basket left by the Diabetes Unit for our Muslim colleagues as a gesture of good will. Every act of kindness reinforces our message of unity and inclusion.

On Wednesday, February 1, 2017, I invited members of the MGH community to a town hall in O'Keeffe Auditorium for an open dialogue on diversity in light of recent events. I was joined by: Steve Taranto, director of Human Resources; Bonnie Michelman, director of Police, Security & Outside Services; Carmen Vega-Barachowitz, director of Speech, Language, Swallowing & Reading Disabilities; Zeina Marshall, patient care information associate and co-chair of the PCS Diversity Committee; and Muslim chaplain, Imam Elsir Sanousi.

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Going forward,
it will be important
to acknowledge
political realities as
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can't let external
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values. We are
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Our practice is
rooted in love
and basic, human
kindness.

As always when thoughtful people come together for the greater good, the conversation was rich, impassioned, and uplifting. We spoke about religious freedom and the importance of respecting differences. We talked about taking the high road, not making assumptions, giving people the benefit of the doubt, and using phrases like, "Help me understand," to break down barriers and foster communication.

We talked about zero tolerance for discrimination and what that might look like if you encounter discriminatory behavior in your practice. Brian French, director of The Blum Patient & Family Learning Center, shared that an inter-disciplinary committee is currently working on a policy to articulate an appropriate response in that situation. That policy will be shared as soon as it's finalized.

Bonnie reminded us to speak up if we see something or hear something. Reporting even suspected incidents gives us an opportunity to follow up, educate, and support those involved.

Going forward, it will be important to acknowledge political realities as they unfold; but we can't let external forces dictate our values. We are a caring, healing organization, and we will always come to the aid of those in need. Our practice is rooted in love and basic, human kindness.

As *Boston Globe* columnist, Kevin Cullen, wrote about the Patriots' Super Bowl victory, "In the end, it wasn't about revenge. It was about per-

severance, about not panicking, about having a back-up plan when the original plan isn't working, and about believing in yourself, your ability, and one another... There's something much stronger, much sweeter, and much more satisfying than revenge. And it's called love."

If those aren't words to live by, I don't know what are.

Resources available to staff

- Partners Office for International Professionals and Students: pips@partners.org
- Employee Assistance Program: 866-724-4EAP or e-mail astidsen@partners.org
- Center for International Patients: 617-726-2787
- MGH Chaplaincy: 617-726-2220
- MGH Police & Security: 617-726-2121
- The Office of Patient Advocacy, located in WACC 018: 617-726-3370
- Human Resources: staranto@partners.org
- The MGH Diversity and Inclusion website: <http://www.massgeneral.org/diversity-and-inclusion.aspx>
- Partners TravelSafe; a travel information and emergency assistance program for employees that offers a single point of contact if you encounter trouble while traveling domestically or internationally. For information, e-mail travel-safe@partners.org

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(Cover photo by Paul Batista)

IV Academy

preparing staff nurses to serve as IV champions

—submitted by the IV Task Force

The IV Task Force developed the idea for an IV Academy to prepare staff nurses to serve as IV champions on their units. The IV Academy presented both didactic education and hands-on training with infusion experts.

On January 20, 2017, more than 80 staff nurses from throughout the hospital attended the IV Academy in the Thier Conference Room. The event marked the introduction of an IV champion model for staff nurses on patient care units (similar to the Magnet and collaborative governance champion model already in use). The model, intended to enhance nursing practice around the use of peripheral intravenous lines (PIVs), partners staff nurses with IV therapy nurses as front-line users of infusion devices.

Feedback from staff in a number of forums pointed to a need for additional education and skill-acquisition in PIV assessment, the identification and treatment of complications, and appropriate documentation. It's hoped that implementation of the IV champion model will improve patient outcomes and satisfaction.

The IV Task Force was created

in 2015 to identify and promote opportunities to improve infusion therapy across disciplines and departments. The Task Force has representation from: IV Therapy, Infection Control, PCS Quality & Safety, and Nursing in the Emergency Department, Medicine, Surgery, Oncology, and Pediatrics.

The IV Task Force developed the idea for an IV Academy to prepare staff nurses to serve as IV champions on their units. The IV Academy presented both didactic education and hands-on training with infusion experts

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IV Therapy (continued)

Nurses engage in interactive sessions with faculty and members of the IV Task Force to learn best practices in adult, pediatric, and neonatal IV therapy.

from the IV Team, Dialysis, Oncology, Pediatrics, Nursing Informatics, and neonatal experts. The day was designed to be a robust learning experience with evidence-based education in PIV assessment and recognizing and responding to complications. IV champions were charged with taking this knowledge back to their units and identifying opportunities for improvement in their respective areas of practice.

A plan is in place to support IV champions as they return to their units to share best practices and implement change. Champions will meet with the IV Task Force again in March to discuss opportunities for improvement on individual units and share ideas on how best to implement changes. As champions guide their peers to improve practice around PIV assessment and documentation, we should see a notable difference in patient outcomes and satisfaction.

For more information about the IV Academy or the IV champion model, contact Bessie Manley Szum, RN, nursing director, IV Therapy Team and Phillips House 22, at 617-724-6220.



(Photos by Paul Batista)

IDEA Grants

a formal vehicle for identifying and supporting innovative ideas to improve care

—by Amy Giuliano, senior project manager

Innovation

The American Nurses Credentialing Center defines Innovation in service delivery and organization as a novel set of behaviors, routines, and ways of working directed at improving health outcomes, administrative efficiency, cost-effectiveness, or user experience that are implemented by planned and coordinated actions. (Greenhalgh, 2004)

A call for IDEA grant proposals went out in August, 2016, seeking innovative ideas that were aligned with the four pillars of the MGH mission and would advance, enhance, or improve patient care.

The Yvonne L. Munn Center for Nursing Research and Innovation recently completed a grant application process to establish the Innovation Design Excellence Awards (IDEA). Funded with generous support from Norman Knight and Kathleen and Ralph Verni, the IDEA Awards were created to strengthen our spirit of innovation by encouraging the sharing of ideas among all disciplines within Nursing and Patient Care Services.

A call for IDEA grant proposals went out in August, 2016, seeking innovative ideas that were aligned with the four pillars of the MGH mission and would advance, enhance, or improve patient care. Eligibility was open to all employees in Nursing and Patient Care Services. Proposals were submitted on-line and included a description of the proposed innovation, a plan for implementation, an impact statement, and estimated budget. Selection was based on the idea's alignment with

the MGH mission, its feasibility, and likelihood of success. The Model for Innovation in Care Delivery (developed by Jeanette Ives Erickson, RN, senior vice president for Patient Care; Marianne Ditomassi, RN, executive director for NPC Operations; and Dorothy Jones, RN, director emerita and senior nurse scientist, Yvonne Munn Center for Nursing Research) provided a conceptual framework for the program.

In its inaugural offering, 22 applications were received and reviewed by the IDEA Steering Committee. Two grants of up to \$5,000 were awarded for proposals that scored highest against the criteria, including measurable outcomes and the likelihood of making a significant, sustainable difference in practice, now or in the future.

IDEA grants went to neuroscience staff nurse, Jared Jordan, RN, for his proposal to install bathroom safety harnesses, and the team of Lillian Ananian, RN; Jeanette Livelo, RN; Paul Currier, MD; and Dominic Breuer, for their pilot study, "Assessing the impact of a central-line-associated blood-stream infection (CLABSI) flip board on

continued on next page

staff engagement with the CLABSI-prevention process via qualitative analysis.”

The bathroom safety harness idea aims to keep patients safe while maintaining their dignity and privacy while toileting. The proposed safety harness alert staff if a patient gets up without calling for assistance. The intervention seeks to prevent unnecessary falls while helping to deliver quality, compassionate care.

Last year, the Medical Intensive Care Unit (MICU) worked with the Northeastern University School of Engineering to expand existing CLABSI-reduction strategies by posting a CLABSI flip chart with a visual display of the number of weeks since the last central-line infection. Anecdotal findings suggest that the chart has had a positive impact on staff engagement. The IDEA grant supports a study of the impact of the CLABSI-reduction strategy of applying human factors and systems-engineering approaches to patient-safety initiatives.

The inter-disciplinary IDEA Grant Steering Committee, co-led by Ditomassi and Gaurdia Banister, RN, executive director of The Institute for Patient Care, benchmarked programs at other organizations, reviewed applications, and guided the award process.

For more information about IDEA grants, contact Amy Giuliano at 617-643-9670 .

IDEA Grants Steering Committee

Co-leads:

- Gaurdia Banister, RN, executive director, The Institute for Patient Care
- Marianne Ditomassi, RN, executive director, Nursing and Patient Care Services Operations

Members:

- Allison Sandler, RN, Neonatal Intensive Care Unit
- Ann Chastain, PT, physical therapist
- Stephanie Smith, OTR/L, occupational therapist
- Peggy Settle, RN, nursing director, Neonatal Intensive Care Unit
- Mary Cramer, executive director, Organizational Effectiveness and chief experience officer
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- Hiyam Nadel, RN, nursing director, Obstetrics and Gynecology
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Project support:

- Amy Giuliano, senior project manager



(Photo by Michelle Howe)

IDEA grant recipients, (left) the team of (l-r): Jeanette Livelo, RN; Dominic Breuer; Paul Currier, MD; and Lillian Ananian, RN. Above: Jared Jordan, RN.

Wonderful nursing moments remind us why we're here...

My name is Suzanne Murphy, and I am a staff nurse on the Bigelow 13 Respiratory Acute Care Unit (RACU). As is true of any profession, there are certain aspects of being a nurse that become routine after a while. Giving meds, helping patients in and out of bed, documenting, writing notes—these are all part of our daily routine.

Sometimes you can get so immersed in the 'routine,' you forget to notice those incredible moments that made us want to become nurses in the first place. Recently, I found myself in such a situation. It just takes a moment with a patient to help you re-focus and remember why you're here—why we're all here.

I took care of 'Joan' for only a few days, but in that short amount of time, I learned lessons that will inform my practice for a long time to come. Joan had been living in a rehab setting for the past six years and was chronically ventilator-dependent. She was admitted to the RACU with a urinary-tract infection and pneumonia. When she arrived in the RACU from the Emergency Department, she was started on IV antibiotics. As she started to improve clinically, she returned to the same daily routine she'd been maintaining in the rehab facility as far as her diet and time out of bed during the day.

The first day I cared for Joan, I noticed that her routine seemed stagnant. I encouraged her to eat



Suzanne Murphy, RN, staff nurse,
Respiratory Acute Care Unit

and get out of bed, but she was passive and disinterested. She ate minimal amounts of her meals and even slept through one of her daughter's visits. I wasn't sure if this was just an off day for Joan or if something else was going on. Was she depressed? Was something clinically manifesting? Was she febrile?

While Joan slept, I took the opportunity to ask her daughter some questions about her life in the rehab facility. I mentioned to the daughter that Joan hadn't been eating much and barely wanted to get out of bed. Was this normal for her? The daughter responded that she'd been acting that way for the past six months or so. She'd had to move from her previous facility because it closed, and Joan was transferred to a facility nearby. Since that transition, the daughter felt Joan hadn't been herself. She wasn't eating or working with physical therapy like she used to, and much of her routine from before had declined.

After speaking with Joan's daughter, I reached out to our speech pathologist and physical thera-

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Joan had been living in a rehab setting for the past six years and was chronically ventilator-dependent. She was admitted to the RACU with a urinary-tract infection and pneumonia.

pist. I wondered if Joan's disinterest in food could be due to her change in diet; I asked the speech pathologist to re-evaluate Joan now that she was doing better clinically. Perhaps adding foods Joan liked would help improve her appetite.

At the same time, our physical therapist reported that Joan needed a lot of encouragement to work with her, which was consistent with what I had experienced. I arranged to be present when the physical therapist worked with Joan so we could provide encouragement together.

In the back of my mind, I wondered if there was something more. Perhaps Joan was depressed. During rounds, I mentioned Joan's passivity to the team, and after looking back at the medications she'd been taking prior to admission, we found that her anti-depressants had been held.

The team questioned something else I hadn't considered—could we possibly wean Joan's ventilator settings? After all, that's the standard in the RACU. Some members of the team felt it would be impossible as Joan had been on the same vent settings for the past six years. But Joan was mobile, she had no underlying neurological conditions, and prior to this admission she'd been eating a regular diet. On the other hand, she was on volume control.

The team made it a goal for the day to see if Joan could tolerate different vent settings. To our surprise, she was able to tolerate small changes. The next day, we decided to see if Joan could speak on the ventilator, but again Joan was indifferent. When we talked to her about vent-assisted speech, she patently refused. The team and I couldn't understand why. But as I sat with Joan to better understand, she let me know she was scared. It was fear of the unknown that kept her from trying.

In an attempt to demystify it for her, I explained how it would work. I assured her she wouldn't be alone when we tried it, and I'd stay with her and hold her hand the whole time.

Toward the end of the day, Joan's respiratory therapist, our attending nurse, and I went into Joan's room to try again. And again, Joan was resistant. I reminded her of our talk earlier. I held her hand, and a look of unspoken trust passed between us. She was going to give it a try.

When Joan let out her first, "Hello," her eyes grew wide; she couldn't believe she had done it.

Coincidentally, at that precise moment, Joan's son called for an update. I told Joan I had to leave the room to take a phone call. As I updated Joan's son, I was looking into her room and could see the pure joy on her face. When I told her son what we were doing, he didn't believe it. So I had his call transferred to Joan's room. I put him on hold and quickly ran into her room. I picked up the ringing phone and held it to Joan's ear. Again, she said, "Hello," not knowing who was on the other end.

The next thing I heard was Joan's son screaming on the other end of the phone. They spoke for a few minutes, but Joan soon grew tired and handed the phone back to me. Her son told me it was the first time he'd heard his mother's voice in six years.

It was one of those wonderful nursing moments. During that brief phone call, I was reminded of what we do for patients and families. Some of the interventions we employ are routine to us—getting patients out of bed, weaning their ventilator settings, attempting vent-assisted speech. But they're not routine to the patient. To the patient, that's what makes our practice special. What may seem like a simple gesture—holding a patient's hand or transferring a phone call—is actually what brings meaning to the patient. These small acts are just as much a part of the healing process as antibiotics and other treatments. Sometimes, those small gestures are what make the unbearable, bearable.

It's easy to get lost in the routine. Maybe Joan had become lost in her own routine. But in that moment, in that one short phone call, we brought Joan some joy. And isn't that why we got into nursing in the first place.

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

We clinicians are a curious bunch. We want to know what's happening. Why. And what we can do about it. When Suzanne probed into Joan's motivation, she set in motion a series of events that changed Joan's life for the better. When our interventions bring hope and joy to a patient, believe me, there's nothing routine about that.

Thank-you, Suzanne.

The next thing I heard was Joan's son screaming on the other end of the phone. They spoke for a few minutes, but Joan soon grew tired and handed the phone back to me. Her son told me it was the first time he'd heard his mother's voice in six years.

New simulation gym on White 6



In November, with the support of Orthopaedic Surgery and the Orthopaedic Nursing Service, a new physical and occupational therapy simulation gym opened on White 6. The space provides a dedicated environment for exercise and functional training to enhance post-operative care and prepare patients for discharge. The room is equipped with specialized equipment to practice bathroom transfers, getting in and out of a car, and walking up and down stairs. Patients are enjoying the new space with individual and group therapy sessions. With the opening of the new gym, physical and occupational therapists now have greater opportunity to prepare patients for discharge home and greater ability to address their functional needs.



In the new simulation gym on White 6, patients, John Costanzo and Mary Colvario, work with physical and occupational therapists in preparation for discharge. Costanzo is pictured above with (l-r): White 6 staff nurses, Sherilyn Palmer, RN, and Genevieve De Los Reyes, RN; physical therapist, Maha Guirguis PT; occupational therapist, Rebecca Gingrich, OTR/L; and physical therapist, Jessica Wilson, PT.



(Photos by Jeffrey Andree)

Physical and occupational therapists 'Go Red' for women's health



The MGH department of Physical and Occupational Therapy, which includes ten physical therapists board-certified in Cardiovascular and Pulmonary Physical Therapy, support the American Heart Association's 'Go Red for Women' campaign.

The Partners in Helping you Quit Program

—by Stephanie Wilder, Jennifer Kulesa Kelley, and Patty Pizzano

The study tests which of two programs is more effective. Smokers are randomly assigned to one of the programs, both of which provide a personal tobacco coach and offer private, confidential help tailored to meet the employees' needs.

“I started smoking in my late teens,” says Patty Pizzano, Emergency Department operations coordinator at Brigham and Women’s Faulkner Hospital. Over the years, with the exception of when she was pregnant, Pizzano continued to smoke, sometimes as much as a pack a day. Now a grandmother in a world where smoking isn’t as socially acceptable, Pizzano says, “There’s a stigma attached to smoking today.” But she admits she was nervous about quitting. She worried the process would be difficult, that she’d become anxious or irritable, or that she’d pick up another bad habit to compensate for not smoking.

That is, until she found the Partners in Helping you Quit (PiHQ) research study. As a Partners employee, Pizzano was eligible to enroll in the free study designed to help smokers cut down and quit smoking. The study tests which of two programs is more effective. Smokers are randomly assigned to one of the programs, both of which provide a personal tobacco coach and offer private, confidential help tailored to meet the employees’ needs.

Through the PiHQ study, medication was recommended for Pizzano. She was hesitant to try it at first, but ultimately decided to go for it.

The medication worked, and Pizzano was surprised at how easy it was to quit with the help of her tobacco coach. She’s now a proud non-smoker. “It’s a burden lifted,” says Pizzano. “I can walk and run a little further. I even joined a gym.”

Pizzano credits the PiHQ research study and her tobacco coach for her success. The combination of medication and behavioral support worked for her. Says Pizzano, “The program is based on knowledge and research. It was great.”

Resources are available for all Partners employees (including MGH) and their adult dependents who may want to quit smoking. With a prescription from their physician or nurse practitioner, employees with Partners medical cov-



Patty Pizzano, Emergency Department operations coordinator at BWFH

erage (and their adult dependents) can receive FDA-approved medication to help quit smoking with no co-pay, no pre-authorization, and no coverage limits.

Partners HealthCare is now offering the Partners in Helping you Quit opportunity to all permanent employees and their adult dependents.

Primary care providers can place an ambulatory referral to the PiHQ Study through eCare. The search term ‘employee’ will bring you to the referral to Partners Employee Smoking Cessation. Select one screening question to confirm your patient is an employee or the adult dependent of an employee, associate the order with a tobacco use diagnosis, and submit the referral to the PiHQ team.

For more information, call 617-724-2205 or e-mail PiHQ@partners.org.

Want to make a world of difference?

Become an MGH volunteer

On the first Wednesday of every month, a link is placed on the MGH website at 12:30pm where potential volunteers can sign up for orientation. Many people want to become volunteers, so slots fill up quickly, often within minutes of the link being activated.

Question: How does one go about becoming an MGH volunteer?

Jeanette: On the first Wednesday of every month, a link is placed on the MGH website at 12:30pm where potential volunteers can sign up for orientation. Many people want to become volunteers, so slots fill up quickly, often within minutes of the link being activated.

Question: What happens after orientation?

Jeanette: Volunteers are interviewed by a member of the Volunteer Department. If candidates are accepted, medical and criminal screenings are conducted. Volunteers are then placed in an appropriate area based on the hospital's needs and the interests of the volunteer. Then they receive the necessary training for that area.

Question: What area supports the most volunteers?

Jeanette: The Patient Escort Program is the largest volunteer area. It provides escort and discharge services to patients, families, and visitors. With more than 200 shifts per week, volunteers provide approximately 48,000 inpatient and outpatient escorts and discharges each year.

Question: What other volunteer opportunities are available?

Jeanette: There are many opportunities for individuals to volunteer at MGH. Volunteers are always needed in the Cancer Center, the Gray Family Waiting Area, Pediatrics, the Flower Shop, the Volunteer Office, the Pet Therapy Program, as baby cuddlers, rounding with the book cart, and many other settings.

Question: How many volunteers does the Volunteer Department have?

Jeanette: In 2016, more than 1,200 volunteers donated their time and service to patients and families. Every week, approximately 800 volunteers serve in some capacity throughout the hospital. In 2016, volunteers contributed more than 90,000 hours of service.

Question: Where can I get more information about volunteering at MGH?

Jeanette: Call the Volunteer Department at 617-726-8540 or e-mail: mghvolunteer@partners.org.

Volunteers make a world of difference in the lives of patients and families and many others who pass through the doors of MGH.

To interpret or not to interpret

the answer may fall in that ‘gray area’

— by Jonathan Fitzgerald, certified medical interpreter

“In the Emergency Department, a medical interpreter is with a patient and her medical provider. A police officer arrives and asks the interpreter to assist in speaking with the patient. What should the interpreter do?”

This past April a number of MGH medical interpreters attended the annual, three-day conference of the International Medical Interpreters Association (IMIA) here in Boston. The theme of the conference was, “Medical Interpreters: a Vital Part of Coordinated Health Care Delivery.” Sessions focused on topics such as, ethical dilemmas in medical interpreting, lack of established guidelines or gray areas, and the evolving role of medical interpreters in health care. I was particularly interested in the session on ‘gray areas’ within the established guidelines of medical interpreting.

The panel of experts addressing this topic was comprised of four seasoned interpreters with distinguished careers in medical and legal interpreting. They were presented with the following scenario and asked how they would handle it:

“In the Emergency Department, a medical interpreter is with a patient and her medical provider. A police officer arrives and asks the interpreter to assist in speaking with the patient. What should the interpreter do?”

Though there are medical interpreting guidelines and ethical standards to help interpreters decide on best practices in the field, sometimes there are gray areas where the appropriate course of action isn’t clear. In the above scenario, which can happen in any healthcare institution, it helps to have a hospital policy in place to address this type of situation.

Fortunately, that particular scenario does not represent a gray area at MGH. MGH has a clear policy stating that medical interpreters interpret solely for MGH staff and patients (with the exception of some medical suppliers who come to the hospital to teach patients how to use medical devices at home). When individuals come into the hospital from other organizations, —policemen, firemen, lawyers etc.— we politely decline our services. So when my colleagues and I heard two expert panel members respond that the interpreter *should* interpret for the police officer in the above scenario, we were surprised.

The first argument of the panelists in favor of interpreting for law enforcement was that one does not need to be a legal interpreter to adequately interpret for the police, provided their questions don’t amount to an interrogation of the patient. If

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It is good policy, best practice, and in the interest of public safety to have each entity utilize its own professional interpreting resources when coming into a hospital to communicate with persons of limited-English-proficiency... This policy protects everyone involved and empowers each individual to operate within their appropriate role.

questions are intended to attain identifying information or demographics, the panelists felt it would be appropriate for any trained interpreter to interpret for the police.

The challenge to this argument is that no one can predict whether the encounter is going to evolve from data-collection into an interrogation of the patient thereby requiring the services of a legal interpreter. And if it did, who would draw the line, law enforcement, the nurse, or the interpreter? Also of note, if a medical interpreter employed by the hospital interprets for law enforcement and the patient says something incriminating, the interpreter could then be subpoenaed to testify with regard to those statements.

The other argument in favor of interpreting for law enforcement was that by *not* interpreting, you could be putting the patient's life in danger. If, for example, the police were trying to get critical information from a victim to help apprehend a criminal who posed a threat to the patient or the community, then interpreting would be in his or her best interest.

In this scenario, the onus is on law enforcement because as a city, state, or federally funded entity, they're under the same obligation as any other institution to provide equal access to communica-

tion for limited-English-proficient individuals in their own language using an interpreter. If a police officer is unable to access an in-person interpreter, they should have the ability to contact an interpreter by phone wherever they go. This ensures that they're able to get any information they may need at any time to keep victims and the community safe. It also preserves the medical interpreter's role of acting solely in their capacity as a hospital medical interpreter and not outside their scope of practice.

It is good policy, best practice, and in the interest of public safety to have each entity utilize its own professional interpreting resources when coming into a hospital to communicate with persons of limited-English-proficiency. MGH and other hospitals have adopted policies prohibiting interpreters from interpreting for law enforcement — not to make life difficult for them, but to ensure that misinterpretations do not occur.

This policy protects everyone involved and empowers each individual to operate within their appropriate role, and most importantly allows medical interpreters to continue serving the communication needs of patients and staff throughout the rest of the hospital.

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Next Publication

March 2, 2017

Announcements

Jean Ridgway Tienken Certification Scholarship

MGH School of Nursing
class of 1945

The Norman Knight Nursing Center for Clinical & Professional Development is pleased to announce the launch of the Jean Ridgway Tienken MGH School of Nursing Class of 1945 Certification Scholarship. The scholarship will support several nurses each year with funding to attend a certification review course in their specialty area as they prepare for their certification exam.

This scholarship is created in honor of Jean Ridgway Tienken, a graduate of the MGH School of Nursing, class of 1945, who believed that the power of nursing is in how each nurse continually strives for excellence in patient care. The scholarship is made possible through the generosity of the Tienken family and will allow Ridgway Tienken's legacy to live on.

Scholarships will be awarded in March as part of the MGH celebration of Certified Nurses Day.

All MGH nurses are welcome to apply. For more information, contact Gino Chisari, RN, director of the Norman Knight Nursing Center at 617-643-6530.

Office Ergonomic Champion Program

Interested in learning how to make yourself or your co-workers more comfortable at the computer? Ever wonder whether a sit-stand workstation might be a good option?

Join us for the Ergonomics
Champion Program

Friday, February 24, 2017
9:00am–12:00pm
Yawkey 2-230

Presented by Aaron R.
Ross, ergonomics specialist,
Occupational Health Ergonomics
Program

Register on HealthStream

For more information, call
617-726-2217.

APRN/PA credentialing website

Visit the new APRN/PA
credentialing website at
[http://intranet.massgeneral.org/
pcs/](http://intranet.massgeneral.org/pcs/)

The site is located under the
Credentialing tab in the PCS
Resources Portal in Partners
Applications.

The website contains information
on APRN/PA credentialing,
guidelines for new hires and
managers, necessary forms, and
much more.

New materials will be added to
the site in the coming months.
For more information, call
Julie Goldman, RN, at
617-724-2295.

Name change for collaborative governance committee

To better reflect the work of this
important committee, the Policy,
Procedure & Products Committee
will be now be known as the
Clinical Practice Committee.
The committee will continue
to vet new and existing nursing
procedures and collaborate
with other committees and
departments to ensure practices
and procedures are evidence-
based and add value to patient
care delivery.

For more information,
contact committee co-chairs,
James Bradley, RN, or Kristen
Kingsley, RN.

ACLS classes

Two-day certification program

Day one:
June 12, 2017
8:00am–3:00pm

Day two:
June 13, 2017
8:00am–1:00pm

Re-certification (one-day class):
April 12, 2017
5:30–10:30pm

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

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

Blum Center Events

Shared Decision Making:
"Coronary Heart Disease"
Friday, February 24th
12:00–1:00pm

Join Rory Weiner, MD, for a
discussion about coronary heart
disease.

"Improving Communication and
Quality of Life: Cognitive Therapy
After Brain Injury"
Tuesday, February 28th
12:00–1:00pm

Join speech pathologist, Magdalen
Balz, CCC-SLP, to learn about
the evaluation and treatment of
cognitive deficits after brain injury.

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.



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Boston, MA 02114-2696



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