Caring Headlines
March 2, 2017

Black History Month event

reprises Lincoln's Gettysburg Address message, "a new birth of freedom"

See story on page 4

Dani Monroe, chief diversity and inclusion officer for Partners HealthCare

Mayor, Setti Warren of Newton, Massachusetts

"The world will little note, nor long remember what we say here, but it can never forget what they did here... It is rather for us to be here dedicated to the great task remaining before us — that from these honored dead we take increased devotion to that cause for which they gave the last full measure of devotion — that we here highly resolve that these dead shall not have died in vain — that this nation, under God, shall have a new birth of freedom — and that government of the people, by the people, for the people, shall not perish from the earth."

— Abraham Lincoln
Gettysburg Address
November 19, 1863

Nursing and Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Resting is healing

and quiet time enables rest

The Designated Quiet Times initiative encourages every inpatient unit to observe quiet time at specified hours of the day and night. Times may vary, but during quiet hours, noise, activity, and conversation should be kept to a minimum to allow patients to rest.

Florence Nightingale, whose theories on the environment of care became the underpinnings of professional nursing practice, wrote, "Unnecessary noise is the cruelest absence of care." It was true when Nightingale wrote it in 1859, and it's still true today. Evidence shows that quiet time in a hospital setting promotes healing, helps patients maintain circadian rhythms, decreases length of stay, minimizes stress and anxiety, and increases patient satisfaction.

Because maintaining a quiet, healing environment is so essential, Nursing and Patient Care Services, in partnership with the Service Excellence Department, launched the Designated Quiet Times initiative to encourage every inpatient unit to observe quiet time at specified hours of the day and night. Hours may vary by unit, but during quiet time, noise, activity, and conversation should be kept to a minimum to allow patients to rest.

Units that employ quiet times effectively adhere to some of the following practices:

- Designated lights are turned off in public areas
- Overhead paging is minimized
- Conversations at nursing stations and other public areas are minimized or conducted in hushed tones
- If possible, clinical interventions such as vital signs, blood draws, etc., are minimized, eliminated, or re-scheduled so as not to disrupt quiet time

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

- Visitors are encouraged to honor quiet times and take breaks to let their loved ones rest
- When possible, televisions are muted or turned down, and patients are encouraged to listen to music with headphones (earbuds and headphones are available on unit supply carts)
- Inter-disciplinary rounds are not scheduled during quiet time
- Room cleaning and other environmental tasks are not scheduled during quiet time
- Some units have designated quiet-time champions who provide gentle reminders if/when noise levels start to rise

Quiet time visual cue being piloted on Ellison 16

Thanks to the efforts of the NPCS Patient Experience Committee, a quiet time checklist has been developed and is being piloted this month. The

continued on next page

While some sounds, like biomedical alarms, are necessary, the majority of sounds that prevent patients from resting are within our control... I ask every employee in every role group to make noise-reduction a priority in your practice and an ongoing focus of your commitment to patient-centered care.

checklist contains reminders for staff on measures they can take to optimize the healing effects of quiet time (see below).

The Ellison 16 General Medical Unit has created hand-held 'reminders on a stick,' or visual cues, that staff can use to prompt one another when quiet time is in effect (see graphic on opposite page).

I know everyone in this organization is as committed to excellence as I am. I know there are competing demands on our time and talents. But we need look no further than the back page of this issue of *Caring* to see that we need to do better in keeping our environment of care quiet. Our HCAHPS scores for Quiet at Night are below 50% and fall into the 13th percentile nationwide. Colleagues, we can do better.

Quiet Time Check List: Reminders and To Do's:

- ☑ **Turn off designated light switches.**
- ☑ **Minimize conversations at front desk, outside patient rooms and in hallways.**
- ☑ **Promote use of headphones/earplugs to patients whose TV volume is loud.**
- ☑ **Encourage visitors to take breaks to let their loved one rest.**
- ☑ **Encourage colleagues to lower their voices during quiet times.**
- ☑ **Ensure telephone volume ringer is turned down low.**

To be clear—this is not a nursing problem; it's not a support-staff problem. Unnecessary noise on inpatient units is a *patient-care* problem. And that makes reducing noise a top priority for every employee of this hospital. Resting is healing, and quiet time enables rest.

Feedback from patients tells us that some of the most frequent complaints related to noise are:

- loud conversations at the nurses' station
- people congregating outside patient rooms
- cell-phone ring tones and conversations overheard in patient rooms and public areas
- loud televisions or music
- alarms from biomedical monitors

While some sounds, like biomedical alarms, are necessary, the majority of sounds that prevent patients from resting are within our control. And in most cases, eliminating them is a simple matter of awareness. I ask every employee in every role group to make noise-reduction a priority in your practice and an ongoing focus of your commitment to patient-centered care. Thank-you.

For more information, or to submit comments or suggestions, please send e-mail to: mghmission@partners.org.

In this Issue

Black History Month event

"A new birth of freedom"

—by Deborah Washington, RN, director, Nursing and Patient Care Services Diversity Program

Abraham Lincoln spoke of, "a new birth of freedom," in his memorable Gettysburg Address to stir unity of purpose in the hearts of Americans weary of a traumatizing civil war. Slavery had become a galvanizing issue that spurred national debate over the importance of equality and what slave ownership said about us as a country. The idea of freedom as a basic human right and a central part of our national identity has been the subject of oratory in this country for more than two centuries. And it is as relevant today as it was when Lincoln delivered his landmark address in November of 1863.

The idea of freedom as a basic human right and a central part of our national identity has been the subject of oratory in this country for more than two centuries. And it is as relevant today as it was when Lincoln delivered his landmark address in November of 1863.

On February 3, 2017, Nursing and Patient Care Services held its annual Black History Month event with keynote speakers, Dani Monroe, chief diversity and inclusion officer for Partners HealthCare, and Mayor Setti Warren of Newton, Massachusetts.

Monroe referenced the Oscar-nominated movie, *Hidden Figures*, that chronicles the contributions of an elite team of female African-American mathematicians at NASA in the early 1960s. Said Monroe, we have our own 'hidden figures' here in our organization—people with special gifts, talents, and skills who deserve to be recognized, supported and encouraged—but no one sees them because they're invisible. Diversity and inclusion means maximizing the contributions of *all* employees. That's my mission, to tap the special talents and skills of all the hidden figures among us."

Monroe shared Partners' broad vision for diversity and inclusion and touched on some of the strategies they hope to employ to achieve those goals, including focusing on leadership, resources, and community outreach.

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(L-r): Brink, Warren, Monroe, and Washington

"When it comes to politics, it's not about beating the other side. It's about getting to the greater good. If we truly want a diverse and inclusive organization, we need to be willing to stand up for it, work for it, try to understand every point of view, and check our biases at the door."

—Mayor Setti Warren

Warren acknowledged the 'toxic and divisive' environment of our current political landscape saying, "We're still grappling with how to welcome people of diverse backgrounds into our country and into our organizations. We're still trying to figure out this 'fabric' we call society."

He suggested that to guide us in this work, it would be helpful to ask ourselves three questions:

- Who are we as a society and who do we *want* to be?
- What kind of society do we want to leave for future generations?
- What constitutes success from a social and economic perspective?

Warren reminded attendees that this 'American experiment' began more than two centuries ago; that we've lived through slavery, women's suffrage, Brown vs. the Board of Education, the civil rights movement, and marriage equality. And we overcame those obstacles because everyday citizens stood up, came together, and resolved to make a difference.

In one compelling story, Warren recalled his time in the military and his deployment overseas. Said Warren, "My unit was very diverse. We were politically, culturally, and racially different. We didn't agree on much politically, but we had to depend on each other for survival. We had to have each other's backs. That experience taught me that listening to and understanding different points of view is a way to bring people together."

Said Warren, "One of the most important lessons I learned is that when it comes to politics, it's not about beating the other side. It's about getting to the greater good. If we truly want a diverse and inclusive country or organization, we need to be willing to stand up for it, work for it, try to understand every point of view, and check our biases at the door."

Warren and Monroe's messages of inclusion were reinforced by musical guests, vocalist, Zoe Krohne, and pianist, Austin Marks, in their rendition of Lizz Wright's civil-rights anthem, *Freedom*.

Monroe, Warren, and Deborah Washington, RN, director of NPCS Diversity Program, were joined by James Brink, MD, co-chair of the MGH Diversity Committee, for a group sing-along of the gospel protest song, *We Shall Overcome*. Said Washington, "It way not carry the same message it did in the 60s, but it's significant that we can still find common meaning in those words, today."

For more information about the NPCS Black History Month event, or our diversity and inclusion efforts, contact Washington at 617-724-7469.

(Photo at left by Michelle Rose)

Above left: Deborah Washington, RN, director of NPCS Diversity Program. Right: Vocalist, Zoe Krohne, and pianist, Austin Marks, perform Lizz Wright's civil-rights anthem, *Freedom*.

What do social workers do?

clarifying mis-perceptions to encourage informed decision-making

—by Ellen W. Forman, LICSW, and Renee Bigaud-Young, LICSW, contributor

In recognition of National Social Work Month, this March the department of Social Work would like to provide some tools to help you successfully refer patients and families to an MGH social worker. Does this sound familiar? You think your patient would benefit from speaking with a social worker, but when you suggest a referral, you get a less than enthusiastic response. You know social-work interventions can make a difference, but patients seem reluctant when you bring it up.

MGH social workers are highly trained mental health professionals available to help patients and families through all manner of challenges. But some patients and families have mis-perceptions about what social workers do. The following is intended to help staff clarify those mis-perceptions and encourage informed decision-making.

What do MGH social workers do?

MGH social workers are integral members of the healthcare team. Social workers are available on all adult and pediatric inpatient units as well as the Emergency Department and many outpatient practices, including Dialysis, the Cancer Center, and pediatric specialty clinics. An outpatient Social Service practice provides individual, couples, family, and group therapy for adult patients.

The role of social workers across all practice areas is the same: to help people access care; address barriers to treatment and safe discharge; cope with mental or physical illness, injury, hospitalization, and end-of-life issues; manage the demands of caregiving; and come to grips with life after loss.

Social workers look at patients holistically within the context of their environment, taking into account their social situations, support systems, mental health, substance-use factors, finances, and safety. They address social determinants of health through patient education and by connecting patients and families to community resources and public benefits.

MGH social workers are highly trained mental health professionals available to help patients and families through all manner of challenges. But some patients and families have mis-perceptions about what social workers do.

What is the most common misconception?

A common misconception is that MGH social workers are employed by the sate. MGH social workers are employed by the hospital, not the Massachusetts Department of Children and Families (DCF). Social workers employed by DCF are responsible for child protection; they work to support and preserve families. While all MGH professionals are mandated reporters of suspected abuse, neglect, or financial exploitation, those investigations are conducted by state agencies.

How can I explain to patients what social workers do?

There are as many answers to that question as there are providers at MGH. However you decide to answer it, you might want to include:

- Social workers are available to listen, talk things through, and support you while you're going through this hospital experience
- Social workers can help you problem-solve
- Social workers can help you learn about and find public benefits and community resources that can make a difference in your life

However you phrase it, be assured that patients are in good hands, and that MGH social workers can help in dealing with the troubles of everyday living and life's most difficult challenges.

For more information, go to the Social Service website: MGHsocialwork.org, or call 617-726-2643.

Blake receives NERBNA's Excellence in Nursing Practice Award

—by Cheryl Tierno, RN, nursing director

On Friday, February 10, 2017, as the New England Regional Black Nurses Association (NERBNA) celebrated 45 years of service to nurses of color and the healthcare community, staff nurse, Jasmine Blake, RN, was recognized for Excellence in Nursing Practice. Blake began her career at MGH as part of the *e*Care Nurse Residency Program and was later hired to work in the Blood Transfusion/Apheresis Unit. She was one of 14 nurses honored by NERBNA for excellence in education and teaching, nursing practice, and leadership.

Cheryl Tierno, RN, nurse manager of the Blood Transfusion/Apheresis Unit, nominated Blake for the award, writing, "Jasmine is a compassionate and empathetic caregiver who tailors her nursing care to each patient based on their cultural, educational, and religious needs. Jasmine is the ultimate team player, offering support to her colleagues every time she walks through the door. She is a self-directed, highly motivated nurse who works effectively as part of a team or independently with patients and staff. She continuously strives to increase her knowledge to provide exceptional care for patients.

"Jasmine excelled in her *e*Care training and helped guide and educate her colleagues during our transition to Partners *e*Care. Her thought process is logical and inquisitive; she can do anything she sets her mind to.

"Jasmine became a certified buprenorphine waiver trainer on her own time without informing anyone. [Buprenorphine is an opioid medication used to treat opioid addiction.] She's completed Advanced Cardiac Life Support, Pediatric Advanced Life Support, and attended the Critical Care Consortium. And I know she's planning to earn a master's degree in Nursing."

Nursing and Patient Care Services and the entire MGH community congratulate Blake for receiving the prestigious Excellence in Nursing Practice Award from the New England Regional Black Nurses Association.

For more information, contact Gaurdia Banister, RN, executive director of the PCS Institute for Patient Care, at 617-724-1266.

Below: Jasmine Blake, RN, with her Excellence in Nursing Practice Award, and at right with Tarma Johnson, RN, president of the New England Regional Black Nurses Association.

(Photos by JB Studio)

Physical therapist helps complex CF patient return home

I was consulted to see Mr. N, a patient with cystic fibrosis (CF). During our first treatment session, I learned that Mr. N had been through several incomplete and/or unsuccessful clean-outs at an outside hospital and was now in significantly compromised condition.

My name is Audra Wallace, and I am a staff physical therapist. Recently, I was consulted to see Mr. N, a patient with cystic fibrosis (CF). During our first treatment session, I learned that Mr. N had been through several incomplete and/or unsuccessful clean-outs at an outside hospital and was now in significantly compromised condition. I had several conversations with Mr. N and my clinical specialist to determine what he'd been doing that was or wasn't working, what we could offer him here, and what our plan should be.

I started the conversation with Mr. N by asking him what had and hadn't worked for him in the past. Many patients with CF possess a high level of awareness about their body and what works for them. Unfortunately, that wasn't the case with Mr. N. But based on the information I gathered from several conversations about past unsuccessful admissions, we developed a plan for Mr. N that included a combination of medications, airway clearance, and exercise. Mr. N approved, and we moved forward with the plan.

Due to Mr. N's level of infection and the extended time since returning to his long-past baseline, I anticipated his stay would exceed the usual two-week admission time. The volume and thickness of Mr. N's secretions made it necessary to do airway clearance three times a day, reduced after a short period to twice a day. Mr. N was unable to

Audra Wallace, PT
physical therapist

mobilize due to coughing fits and fatigue. I referenced numerous medical journals and consulted with CF specialists and his medical team to determine if there were other treatment options that might provide Mr. N with some relief from coughing. By this time, his cough was impacting his sleep and ability to participate in exercise, which had led to a decrease in muscle mass and endurance. These discussions helped us come up with an effective combination of medications and patient-centered scheduling to assist with sleep and slightly improved energy.

When Mr. N's health improved enough to initiate exercise, he experienced light-headedness, oxygen desaturation, and a general lack of balance after walking only 100 feet with support. Realizing that a typical exercise program wasn't appropriate for Mr. N, I shifted my approach to a less intense program that allowed for longer duration of exercise time, increased aerobic conditioning, and greater participation. I started Mr. N on a station-

continued on next page

ary bike and exercises with a lightweight exercise band. Even still, Mr. N could only tolerate five-minute intervals on the bike with no resistance. I'd never seen a CF patient so deconditioned or sick, especially after more than a week of physical therapy and antibiotics.

It was incredibly beneficial to consult with colleagues who were also caring for Mr. N to see what they found helpful and compare that to my approach. I wanted to make sure I was doing everything within my scope of practice to help Mr. N while working collaboratively with both him and the rest of the team. By researching and regularly checking in with my colleagues, I received many helpful suggestions and was reassured that the plan I implemented and augmented for Mr. N was the best possible option for him at the time.

Throughout Mr. N's stay, I was constantly reminded of the role that morale and participation play in a patient's recovery. While Mr. N would frequently talk about the steps he'd taken or planned to take to improve his health, each day I found myself repeating the same words of encouragement as the day before — stressing the importance of adhering to the plan, participating fully in therapy, and reminding him how both contributed to maximum improvement.

However, Mr. N still refused to fully participate in the agreed-upon plan. He'd take medications late or sometimes not at all; he'd refuse to perform exercises, or only agree to airway-clearance sessions. His lack of adherence required us to re-visit and re-evaluate the plan so he could continue to have a say. During these discussions, I again stressed the importance of adhering to the entire plan (including exercise) not just the portions he found beneficial. When we spoke, he was very agreeable, but it didn't translate into action or greater participation.

I spoke with Mr. N's girlfriend and parents about ways to motivate him, and they provided some insights that were helpful in increasing his participation. Toward the end of Mr. N's admission, I provided them with extensive education to ensure that Mr. N's progress would continue after he returned home. I stressed that the goal was to prolong the time between hospitalizations. They were receptive to the information, and I expected them to continue to aid in his recovery.

Ultimately, his symptoms improved, and he was able to tolerate longer periods of exercise... I educated Mr. N and his family on how best to succeed outside of the hospital setting, including ways to increase his mobility, prolong time between hospitalizations, and work with the MGH outpatient CF team to accomplish those goals.

Throughout Mr. N's admission, I involved many members of the CF team in his care, most notably the social worker. The social worker helped address a number of social concerns and stressors. Initially, Mr. N wasn't entirely trusting or open with her regarding his needs or concerns, so I helped fill in some of the gaps. This was a recurring theme with Mr. N. On numerous occasions, I reminded him of the resources available and the role everyone on the care team played. In addition to relaying information to his nurses, doctors, and social worker, I stressed the importance of him sharing that information directly with the team.

I found myself advocating for Mr. N right up until the day of his discharge. His many setbacks and slow progress led to his discharge date being rescheduled several times. Ultimately, his symptoms improved, and he was able to tolerate longer periods of exercise. Though he wasn't in perfect condition, he had improved enough to continue treatment at home. I educated Mr. N and his family on how best to succeed outside of the hospital setting, including ways to increase his mobility, prolong time between hospitalizations, and work with the MGH outpatient CF team to accomplish those goals.

The time I spent working with Mr. N taught me the importance of the care team in treating patients and how I'm an integral part of that team. Serving as liaison, advocating for patients, and providing precisely the right type and level of care necessary, made me more confident in my abilities and in my knowledge of resources available to help.

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

Cystic fibrosis is a complex and challenging disease that impacts patients physically, emotionally, and spiritually. Audra approached Mr. N's treatment plan from every angle to meet his changing needs. She looked to the literature, she sought input from Mr. N's family, and she turned to her inter-disciplinary colleagues to ensure Mr. N got the individualized care and support he needed. When he was ready to continue his treatment at home, Audra educated Mr. N and his family to give him the greatest chance at succeeding with his regimen at home.

Thank-you, Audra.

NP student learns valuable lesson about culturally competent care

In the Maternal Child Health course taught by Mimi Pomerleau, RN, and Kristine Ruggiero, RN, at the MGH Institute of Health Professions, students were asked to reflect on how they link nursing theory to nursing practice and about the core virtues they're developing as a result of their clinical experiences. The following reflection was written by Evgeniya Larionova, RN.

"We may have different religions, different languages, different colored skin, but we all belong to one human race."
—Kofi Annan, Nobel Peace Prize recipient and former UN Secretary-General

My patient was accompanied by a traditional nurse midwife known as a comadrona. Comadronas are trusted women leaders in the community; they don't usually have any formal training but have years of experience delivering babies.

Some people say childbirth is a miracle, a heroic act, a surge of love accompanied by intense hours of labor. It's one of the most unique experiences a woman can have—a time when she is particularly vulnerable and in need of care and support. As a nurse practitioner student on the Labor & Delivery Unit at MGH, witnessing childbirth was something I will never forget. Thrown into the action on my first clinical day, I had feelings of joy, excitement, and nervousness. I felt privileged and grateful to witness a natural delivery, hoping to help a mom-to-be during the process.

In morning report, I learned that my patient was a recent immigrant from Guatemala, a member of the indigenous Mayan population. Mayan was her native language, but she also understood Spanish. Her husband had resided in the United States for five years, and they were reunited when she moved here a year ago.

Evgeniya Larionova, RN

My patient was accompanied by a traditional nurse midwife known as a comadrona. Comadronas are trusted women leaders in the community who accept a spiritual calling. They don't usually have any formal training but have years of experience delivering babies. Comadronas regard childbirth as a natural process and rely heavily on God and prayers. Nurses on the unit established a plan of care for my patient recognizing her spirituality and personal support system. They allowed the comadrona to be present during labor and assist with comfort measures. They also arranged for a qualified medical interpreter.

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The interplay between modern and traditional medicine contributed to a positive outcome. MGH nurses were not only culturally sensitive and able to appreciate the cultural values, beliefs, and attitudes of the patient, they were culturally competent with the knowledge, capacity, and skill to provide high-quality care.

When I entered the room, a nurse, a nurse midwife, and the comadrona surrounded the tiny woman. The nurse was checking her vital signs, the midwife encouraged the woman to take slow deep breaths. The comadrona, in a colorful, traditional dress, gently massaged her back. The room was dimly lit with the scent of lavender in the air. My patient's contractions steadily became more regular until she was in active labor and ready to give birth.

Something about the atmosphere struck me. The only language in that room was the language of trust, respect, and compassion between these women. I felt connected with what was happening, just by holding this woman's hand and talking to her.

Reflecting on this experience, I understand that nurses not only created an environment of comfort and respect, they had a significant impact on the process. Although birth is a unique and at the same time unifying biological event, providing therapeutic communication, physical, emotional, and spiritual care during labor is crucial.

Comadrona shared her knowledge and experience with MGH nurses. It was important for my patient to have a traditional midwife at the bedside to comfort and pray with her. The interplay between modern and traditional medicine contributed to a positive outcome. MGH nurses were not only culturally sensitive and able to appreciate the cultural values, beliefs, and attitudes of the patient, they were culturally competent with the knowledge, capacity, and skill to provide high-quality care.

It's essential for nurses in a heterogeneous country like the United States to be open-minded and cognizant of cultural differences and perspectives. I will take this amazing experience to my future nursing practice and always treat my patients with dignity, respect, and compassion. I hope to continue to integrate holistic and culturally sensitive care into our modern childbirth practices.

My patient gave birth to a beautiful baby daughter whom she named after the nurse who took care of her during delivery.

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Next Publication
March 16, 2017

Safety reporting

Patient Safety Awareness Week
March 13-17, 2017

Question: How do you file a safety report?

Jeanette: Safety reports are filed electronically via the Safety Reporting link in Partners Applications. Once in the safety reporting system, click on New File to open the Icon Wall showing all the categories available for reporting. The Icon Wall contains a wide range of safety-event forms; each one asks for specific information and allows the reporter to describe the event he or she experienced.

Question: When should you file a safety report?

Jeanette: You should file a report:

- when you're aware of events that result in injury, illness, or property or environmental damage
- when you see something that could have resulted in harm (a near miss)
- when you're not sure what happened and would like help reviewing or processing the event
- when you think something could be learned by reviewing the event
- when you see unprofessional behavior that could result in an unsafe environment
- when you're in doubt. When in doubt, file a report

Question: Why is it important to file a safety report?

Jeanette: Submitting safety reports is a critical step in identifying and prioritizing areas of concern so we can remedy potentially hazardous situations. A strong reporting culture is the foundation of a strong safety culture.

The MGH Credo and Boundary statements promote the use of safety reporting in the following passages. As a member of the MGH community and in service of our mission:

- I will share my successes and errors with my colleagues so we can all learn from one another
- I will never criticize or take action against any member of the MGH community for raising or reporting a safety concern

Question: Is the safety reporting system exclusively for patient-safety issues, or can you use it to report staff-safety issues, as well?

Jeanette: The safety reporting system is not restricted to patient-specific events; it encompasses issues related to the physical and psychological safety of staff, as well. Staff-safety categories that warrant a safety report include:

- general events where physical injury was experienced while performing one's job
- safety, security, or conduct issues that cause staff to feel their safety is threatened. This could include a wide range of events from attempted abduction, to disorderly conduct, to breach of confidentiality, to lost property, or vandalism
- breaches of professional conduct including aggressive behavior, lack of respect, or failure to collaborate or communicate

Question: What happens once a safety report is filed?

Jeanette: Once a safety report is submitted, it is seen by patient safety staff specialists in the MGH Center for Quality & Safety. Every report is reviewed and triaged by a staff specialist. The Patient Safety Team relays the report to the appropriate department leader or quality chair, provides guidance and support for an investigation into the event, and conducts a root-cause analysis of the situation. The report is automatically sent to the manager of the location where the event occurred (except in the case of professional-conduct reports.) Depending on the severity of the event, the team may also facilitate external reporting to

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the Department of Public Health, the Department of Mental Health, the FDA, or the Board of Registration in Medicine.

Safety reports generate a collection of data in order to gain full understanding of the event from all parties involved. Factors staff specialists consider include:

- How serious was the event; was there actual harm versus potential harm?
- What was the level of severity and does this event meet the criteria for external reporting?
- What other information is needed to conduct a thorough investigation of the event?
- Who needs to be involved in the investigation and follow-up of the event?
- How many services or departments were involved?
- Is there a policy and was it followed? If no policy or guidelines exist, should there be a policy?
- Were there other contributing factors?
- What are the most effective communication processes for involving the participating services?
- What kind of follow-up is needed; local investigation, root-cause analysis, continued tracking of event patterns?
- What needs to be done to improve the situation and ensure it doesn't happen again in the future?

Safety reports are used to identify trends in systems that impact safe patient-care delivery. Safety reports facilitate identification, implementation, and evaluation of improvement efforts.

Question: Is the person who files the safety report informed of the outcome of the investigation?

Jeanette: Upon submission of a safety report, the person who filed the report receives an immediate acknowledgment e-mail. Within 24 hours, the system generates another e-mail letting the person who filed the report know who has received the report. Managers may use different methods for sharing the results of safety reports with staff (one-to-one discussions, staff meetings, e-mail, educational forums, etc.) Check with your manager to see how that information is shared on your unit.

Question: What types of improvements have been made as the result of safety reporting?

Jeanette: In 2016, more than 21,000 safety reports were filed, up from 19,539 in 2015. Safety reports are often used as the basis of practice alerts, the impetus for new policies or procedures, and other educational communications. Safety-reporting data has helped inform our work around safe patient transport, medication safety, disruptive behavior, blood-product administration, and enhancements to *e*Care. The Safety Reporting Steering Committee is reviewing the process of communicating feedback to reporters to determine how to develop a more consistent and comprehensive follow-up process.

For more information about the MGH Safety Reporting System, call 617-726-9282.

Patient Safety Awareness Week

Speak Up for Safety educational booth
Monday, March 13, 2017
10:00am–2:00pm
Main Corridor

"Patient Safety: it's not Rocket Science,"
presented by James Bagian, MD
sponsored by MGH*f*C
Tuesday, March 14th
8:00–9:00am
O'Keeffe Auditorium

Keynote address
"Root-Cause Analysis:
Opportunities and Challenges,"
presented by James Bagian, MD,
Tuesday, March 14th
2:00–3:00pm
O'Keeffe Auditorium

Patient Safety Star Award Ceremony
Wednesday, March 15th
8:00–10:00am

"PCS Speak up for Safety: the Anatomy of a Safety Event"
Wednesday, March 15th
2:00–3:00pm
O'Keeffe Auditorium

Webinar
National Patient Safety Foundation
"How to engage the public in patient safety"
Wednesday, March 15th
2:00-3:00pm
Trustees Room
Patient Family Advisory Council members welcome

"Building Resilience to Improve Patient Safety"
Thursday, March 16th
12:00–1:00pm
O'Keeffe Auditorium
Michelle Dossett, MD, Benson-Henry Institute

Speak Up for Safety educational booth
Friday, March 17th
10:00am–2:00pm
Main Corridor

"Why does she need a medical interpreter?"

—by Andy Beggs, medical interpreter

As a medical interpreter, I find it indispensable to 'huddle' with providers before every encounter. It may only take a few seconds, but it's so much better than going in cold, and it truly does aid in communication during the encounter. But this case was a little different.

Upon arrival at an intake area of the hospital, the provider took me aside and said, "I don't know what's going on here. The patient is a 16-year-old girl who speaks perfect English. She goes to high school here. She's here with her mother, and I've heard them speak English. I'm not sure why they need an interpreter. Maybe the patient just doesn't like me."

I told the provider that I'd do what I could, and reminded her that the patient had the right to request a medical interpreter."

"I understand," said the provider.

When we got into the room, after introductions were made, the patient explained in English that she really just wanted her mother to be able to understand what was being said.

Hearing that put the provider's mind at ease.

The encounter continued with the daughter and provider speaking English, and me as the medical interpreter, letting the mother know what they were saying via simultaneous interpretation. In this way, the mother was able to provide valuable input into the conversation, since she now had a voice.

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The mother thanked me for my assistance. As they moved in to the treatment area, I explained that once they were ready to be seen by a clinician, a medical interpreter should be called to interpret for that encounter, as well.

There are a couple of key points about this story. By law, patients have the right to a medical interpreter at no cost. Also, family members should never be used as interpreters. In this case, the patient happened to speak English, but she wasn't equipped to interpret medical information for her mother, and she knew it. The fact that the mother and daughter spoke English to each other may have been an indication that the daughter grew up here and was more comfortable speaking English than her mother was. That's often the case when children are raised here and the parents still speak the language of their homeland. In this case, the mother faces the ongoing challenge of trying to communicate in English, essentially a foreign language for her. With just a passing understanding of English, it's not a good idea to engage in conversations about her daughter's health care without the aid of a medical interpreter.

Providers should always make use of medical interpreters when working with patients or family members with limited English proficiency, especially when the patient requests it.

For more information or to contact an MGH medical interpreter, call Interpreter Services at 617-726-6966.

Announcements

Global Health Service Awards

Do you know a colleague dedicated to solving health inequities locally or abroad? Nominate him/her for a Global Health Service Award. Global Health Service Awards were established to honor innovation, dedication, and commitment in the field of Global Health. The three areas of recognition are:

- Teaching and Mentoring: awarded to an employee who has demonstrated exemplary leadership through education and mentorship of local or foreign faculty and students
- Excellence in Research: awarded to a researcher whose work improves care for vulnerable populations through the creation and sharing of new knowledge
- Humanitarian Care: awarded to an employee whose actions and commitment demonstrated extraordinary compassionate care for a local, national, or international community in dire circumstances

All MGH employees with projects benefiting local, national, or international communities are eligible. Re-nomination of prior nominees is encouraged. Recipients will be announced at the Global Health Expo on May 10, 2017.

For more information or to submit an application, go to: http://www.globalhealthmgh.org or e-mail globalhealth@partners.org. Applications are due by March 31st.

Advance Care Planning Booth

The PCS Ethics in Clinical Practice Committee is holding its 17th annual Advance Care Planning Booth for patients, visitors, and staff.

Tuesday, April 11, 2017
8:00am–3:00pm
Main Corridor

The booth presented in conjunction with National Healthcare Decisions Day, whose theme this year is, "It always seems too early, until it's too late." Information will be available, including copies of the Massachusetts Health Care Proxy form.

For more information, contact Cindy Lasala, RN, at 617-643-0481.

Blum Center Events

"What it Means to Maintain Brain Health"
Thursday, March 9, 2017
12:00–1:00pm
Join Jonathan Rosand, MD, to learn how you can boost your brain health and prevent brain diseases.

"Understanding Lymphedema"
Wednesday, March 15th
12:00–1:00pm
Join Catherine Holley, RN, to learn about primary and secondary lymphedema and how best to manage this condition.

"Top 10 Sleep Questions"
Friday, March 31st
12:00–1:00pm
Join Kenneth Sassower, MD, to learn more about sleep health.
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.

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%20form.pdf.

2017 Staff Perceptions of the Professional Practice Environment Survey

The 2017 Staff Perceptions of the Professional Practice Environment Survey (SPPPE) will be e-mailed to staff in Nursing and Patient Care Services by the end of March, 2017. It will remain in the field for one month.

The survey takes approximately 45 minutes to complete and provides leadership with an assessment of organizational characteristics influencing staffs' perceptions of and satisfaction with the MGH professional practice environment.

Survey results are examined by leadership across NPCS, used to guide strategic planning, and help monitor the impact of changes made to improve professional practice across the work environment.

All survey responses are important. Every voice counts.

All answers are confidential; no individual data will be reported unless agreed to by the participant at the start of the survey. Data from the survey are reported at three organizational levels: NPCS; discipline-specific; and unit-level. Information shared with leadership will also be discussed with staff in unit and department meetings.

For more information, contact Dorothy Jones, RN, director emerita and senior nurse scientist, Yvonne Munn Center for Nursing Research, at 617-724-9340.

Inpatient HCAHPS

Current data

HCAHPS Measure	CY 2015	CY 2016 Year-to-date (as of 2/13/17)	% 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%	49.9%	-0.9%
Cleanliness/Quiet Composite	61.8%	60.5%	-1.3%
Staff Responsiveness Composite	65.8%	64.9%	-0.9%
Pain Management Composite	73.1%	72.8%	-0.3%
Communication about Meds Composite	66.6%	65.8%	-0.8%
Care Transitions	62.4%	61.0%	-1.4%
Discharge Information Composite	91.1%	91.9%	0.8%
Overall Hospital Rating	81.2%	81.9%	0.7%
Likelihood to Recommend Hospital	90.9%	89.8%	-1.1%

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

The data are complete through November, 2016, with partial data for December. While there is only a slight change in scores in general, MGH continues to perform well in Overall Rating and Discharge Information.

Caring Headlines
March 2, 2017

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