Caring Headlines
May 4, 2017

Celebrating Speech Language Pathology

May is Better Speech & Hearing Month

See narrative by speech-language pathologist, Danny Nunn, CCC-SLP, on page 6

Speech-language pathologist, Erin Vuijk, CCC-SLP, works with patient, Dottie Runnals, on the Lunder 9 Oncology Unit, to ensure use of safe swallowing techniques.

Nursing & Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Continuous virtual monitoring

introducing electronic patient observer technology

With the ever-changing healthcare landscape, we are continuously challenged to ensure that the care we provide is safe, effective, and efficient. You may recall that as part of Partners 2.0, the Partners Chief Nurse Council created the Patient Observer Tiger Team to explore the feasibility of implementing a system-wide, electronic, patient observer program, or continuous virtual monitoring (CVM).

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

In the past, patient observation usually consisted of direct, physical observation by a designated staff member. The observer would intervene if the patient was perceived to be at risk in any way (such as pulling out tubes or lines). Direct observation is resource-intensive, and in light of recent technological advancements, may not be the most effective way to monitor patients at risk. At MGH, we have a history of leadership in finding innovative ways to keep patients safe. Over the past few years, despite increasing acuity and a decrease in restraint utilization, we've seen a significant reduction in the use of direct observers. This is partly due to the targeted interventions we've developed for patients with delirium and those at risk for falling. Many of the same nurses who worked to create those interventions are leading our efforts to implement a continuous virtual monitoring program.

I'm sure you're curious about how it works. With continuous virtual monitoring, patients requiring observation can be monitored remotely by specially trained staff using a live-feed camera and two-way audio equipment. As many as eight patients can be monitored at one time by two remote observers stationed at a central location. These specially trained observers have the ability to alert unit-based staff to immediately respond to patients if/when the need arises. Patient privacy is protected with the use of special screens (that block both audio and visual monitoring); these screens can be activated as needed for patient care or sensitive discussions. When continuous virtual monitoring is initiated, signs are posted in the patient's room to alert everyone that CVM is in use.

With continuous virtual monitoring, patients requiring observation can be monitored remotely by specially-trained staff using a live-feed camera and two-way audio equipment.

Continuous virtual monitoring was successfully piloted on four units at MGH (White 7, White 10, Ellison 7, and Ellison 16). The monitoring station is located on Bigelow 10 and is staffed by two trained observers at all times. The program is now available throughout the entire hospital and can be initiated by following the usual procedure for requesting a patient observer.

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Continuous virtual monitoring was successfully piloted on four units at MGH. The monitoring station is located on Bigelow 10 and is staffed by two trained observers at all times. The program is now available throughout the entire hospital and can be initiated by following the usual procedure for requesting a patient observer.

The Patient Observer Tiger Team has refined the criteria for determining whether patients would be better served by direct observation or CVM. The new criteria and re-assessment process will assist nurses in determining the need to initiate, continue, or discontinue observation, and facilitate deployment of observers when patients in need of monitoring are identified. The team has worked to streamline *e*Care documentation around patient observation and improve hand-off communication between nurses and observers.

The Staff Nurse Advisory Committee provided excellent feedback on many aspects of the program, which we've incorporated into the roll-out. As we move forward, we'll be interested in your comments and suggestions; please send ideas to Ann Marie Dwyer, RN, at 617-724-356, or Patti Shanteler, RN, at 617-643-2995.

Guidelines for determining type and level of patient observation

Observation Level	Patient Behavior Clinical Criteria	Role of Nurse	Role of Observer	MD Ordered Required	Appropriate for Continuous Virtual Observation
LEVEL 1-Suicide Risk	The patient has demonstrated or stated **intent to harm him/herself** requiring close observation with interventions to maintain safety.	• Initiate Suicide Precautions, including a provider order for Observer • Communicate specific risk and plan of care to assigned observers • Document in patient record	• Remains at a distance that provides unimpeded view (including toileting) and keeps patient and observer safe per nursing assessment • Communicate patient behavior and interventions to nurse	**YES**	**NO**
LEVEL 1- All Others	The patient is demonstrating such severe impairment in judgment, high level of impulsivity, or has demonstrated **intent to harm others** requiring close observation with interventions to maintain safety.	• Assess safety of environment and continued need for Level 1 observation every shift • Communicate plan of care to assigned observers • Document in patient record	• Remains at a distance that provides unimpeded view (including toileting) and keeps patient and observer safe per nursing assessment • Communicate patient behavior and interventions to nurse • PCAs can perform ADL and VS (per facility)	**NO**	**NO**
LEVEL 2	The patient demonstrates severe impairment of judgment and some impulsivity or behavioral dyscontrol. Patient cannot be verbally re-directed.	• Attempt alternatives to observation prior to observer request • Assess safety of environment • Re-assess at a minimum every shift for continuation of observer or move to virtual observation (if available) • Communicate plan of care to observer • Document in patient record	• Maintains an unimpeded view of the patient (either in the room or outside the room based on nursing judgment) • May observe multiple patients if cohorted and nursing has assessed situation as safe • Communicate patient behavior and interventions to nurse • PCAs can perform ADLs and VS (per facility)	**NO**	**NO**
LEVEL 3	The patient demonstrates impairment in judgment. but is in good control Patient can be verbally re-directed. ***Use virtual observation where available**	• Attempt alternatives to observer prior to initiating referral • Assess for capacity for patient to respond to verbal direction • Assess safety of environment and continued need for Level 3 observation every shift • Communicate plan of care to observer • Document in patient record	• May observe more than one patient outside the rooms (with virtual observation where available) while maintaining impeded view of patient • Communicate patient behavior and interventions to nurse • PCAs can perform ADLs and VS (per facility)	**NO**	**YES**

In this Issue

MGH nurses serve in WWI before they have right to vote

—submitted by the MGH Nursing History Committee

Many MGH SON alumnae returned to practice at MGH to fill in for nurses who'd enlisted. MGH nursing staff at that time consisted almost entirely of students and SON graduates; the 'staff nurse' position wouldn't be created until 1925.

America had been preparing to enter the Great War for a year before war was actually declared by Congress in 1917. MGH was among the hospitals (coordinated through the American Red Cross) selected to organize and staff the equivalent of a 500-bed hospital in Europe if war was declared. The MGH Unit, Base Hospital No.6, would be located in Talence, France, near Bordeaux. MGH staffing initially consisted of 23 physicians selected by MGH general director, Frederic Washburn, MD; 65 nurses selected by chief nurse, Sara Parsons, RN; and 25 reserves. Shortly before departing from Boston, the entire staff of Base Hospital No. 6 met for the first time at a farewell service at Trinity Church. Bishop Lawrence presided along with the unit's chaplain, Reverend Henry Knox Sherrill, who described the event as, "the most moving service I ever attended." Over the course of the war, Base Hospital No.6 increased to 4,000 beds with more than 100 nurses.

All nurses who served were required to be single and between the ages of 25 and 35. They were given physical exams and immunizations against smallpox and typhoid. They were required to provide training-school and alumnae-association credentials prior to signing the muster-in roll (when a military unit is created, it is 'mustered in,' when it is disbanded, it is 'mustered out.') Signing the roll committed them to service for the duration of the war. Many of these nurses had never left their home towns before.

Initially enrolled as Red Cross nurses, upon taking the oath of allegiance they became part of the Nurse Corps of the US Army. In July, 1918, the Nurse Corps was re-designated the Army Nurse Corps by the Army Reorganization Act. By law, appointments were restricted to female nurses. Although part of the larger US Army, nurses were not given the benefit of military rank, had to provide their own uniforms, and were paid about $50 a month. At the outset of the war, the Army Nurse Corps was comprised of 403 nurses; by the end of the war, in 1918, more than 22,400 nurses had enrolled, 10,000 of them serving overseas.

Half of all nurses employed by MGH volunteered to serve at some point during World War I. In addition to Base Hospital No. 6, MGH personnel served at other base hospitals: Peter Bent Brigham, No.5; Harvard Surgical, No.22; and an Army-run hospital, No. 55. Many MGH School of Nursing alumnae returned to practice at MGH to fill in for nurses who'd enlisted. MGH nursing staff at that time consisted almost entirely of students and School of Nursing graduates; the

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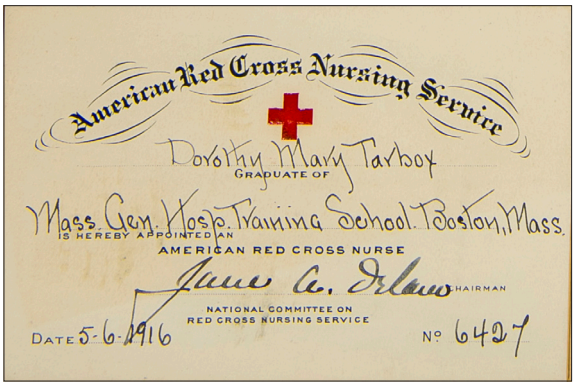


Opposite page: Red Cross Nursing card of Dorothy Tarbox, MGH School of Nursing, Class of 1915. Below: *Boston Globe* article about farewell service at Trinity Church, dated June 4, 1917. Below right: 1917 log book with May 23rd entry noting MGH Base Unit activated for duty.

'staff nurse' position wouldn't be created until 1925. And staffing levels were further taxed when a world-wide flu pandemic hit Boston in the fall of 1918.

Throughout the Great War, about 240 School of Nursing graduates served in various settings and capacities—base hospitals, clearing stations near the front lines, hospital trains crossing Europe, mobile surgical units, and hospitals in London and Paris. They filled administrative roles (13 were chief nurses at base hospitals), administered anesthesia, and organized and led educational programs at the newly-created US Army School of Nursing. They cared for soldiers, refugees, prisoners, and one another when they became ill. As prepared as they were by their MGH training, caring for sick and wounded soldiers presented an entirely different kind of challenge. But thanks to their competence and Parsons' leadership, it was a challenge they met and mastered.

It's interesting to note that at this time in US history, the women who served as nurses in The Great War had not yet gained the right to vote. In 1917, at the height of the suffrage movement, hundreds of women were arrested in protests in Washington, DC. Several leaders of the movement went on hunger strikes while in jail and endured force-feedings and beatings. It wasn't until 1920—two years after the war ended—that the 19th Amendment was passed, and women were granted the right to vote.

Even with that progress in the civilian sector, nurses were still denied official rank in the military. In 1920, Army nurses were given relative, or officer-equivalent rank, but not full rights and privileges—like base pay equal to that of officers of comparable grade. Sara Parsons became actively involved in the struggle to get full military rank for army nurses, taking her case all the way to the United States Senate. Read more about this in the July 6, 2017, issue of *Caring Headlines*.

This year marks the 100th anniversary of the United States entering World War I. Look for other installments from the MGH Nursing History Committee in future issues of *Caring Headlines*. For more information, contact Georgia Peirce, special projects manager, at 617-724-9865.

E BOSTON GLOBE—MONDAY, JUNE 4, 1917

FAREWELL SERVICE FOR BASE HOSPITAL NO 6

Trinity Church Crowded During Impressive Ceremonial For Doctors and Nurses of Massachusetts General Hospital, About to Leave For France

Upper Picture—Civilian Staff. Lower Left—Officers of the Unit, Left to Right—Maj Lincoln Davis, Surgical Director; Maj Frederic A. Washburn, Director; Maj Richard C. Cabot, Medical Director. Lower Right—Nurses Marching to the Church.

MASSACHUSETTS GENERAL HOSPITAL UNIT AT TRINITY CHURCH.

The spirit of devotion to the National cause was conspicuous at the service in Trinity Church yesterday afternoon for Base Hospital No. 6, Massachusetts General Hospital, the officers, enlisted men and nurses of which, numbering 200, all in uniform, made an impressive appearance in the central section of the auditorium.

The church was crowded as it has rarely been before, the lower floor being filled by those who gained entrance only by ticket and the general public occupying the galleries, though hundreds, unable to gain entrance, waited around the doors on the sidewalk during the service. The chancel enclosure was crowded with spectators.

The entire service had a patriotic tone, the processional having been "The Son of God Goes Forth to War," and other hymns being "O, God, Our Help in Ages Past," "America," and "The Star Spangled Banner." The general tenor of the addresses was that with faith in Christianity and devotion to the work before it the Army of the United States will be a powerful force in settling the world war.

During the service the color bearers of the unit took their silk National flag and Red Cross standard within the chancel rail, their chaplain, Rev Henry K. Sherrill, hitherto curate at Trinity, dedicated them, and Bishop Lawrence offered a special prayer.

Bishop Lawrence's Advice

Rev Dr Alexander Mann, who led the service, said that Trinity Church, which existed before the Revolution, has spared neither men nor treasure in any of the wars the Nation has engaged in and that she sends the hospital corps forth on its errand of mercy with prayer and benediction.

Chaplain Sherrill, speaking to members of the unit personally, assured them that they may always command his service in any way they may ask it.

Bishop Lawrence likened the ceremonial to a gathering of knights of old, met to consecrate themselves before going forth to war. He declared that there is no fighting power equal to that based on sublime faith, as shown in the triumph of Cromwell's army.

He added: "If we put faith in God, what boots it what happens to us if we have done our duty. Soldiers possessed of faith will go serenely through all the horrors and chaos of war.

"I recommend that you carry four characteristics of America to the forces in Europe. Reverence for the truth and for the human body, no matter how badly mangled it may be by shells. Keep in mind that even the most shattered body is that of some mother's son that contained the Holy Spirit. Keep your respect for women also, that they may help you to be strong, pure and true. Respect the enemy, always remembering that we are fighting not a people but an unjust Government.

"And respect your job. No stretcher-bearer, soldier or even General knows where his work begins or ends. It is for him only to wait and obey orders. As you go forth 100,000,000 of Americans of all ages and conditions will gather to consecrate themselves to the cause of liberty."

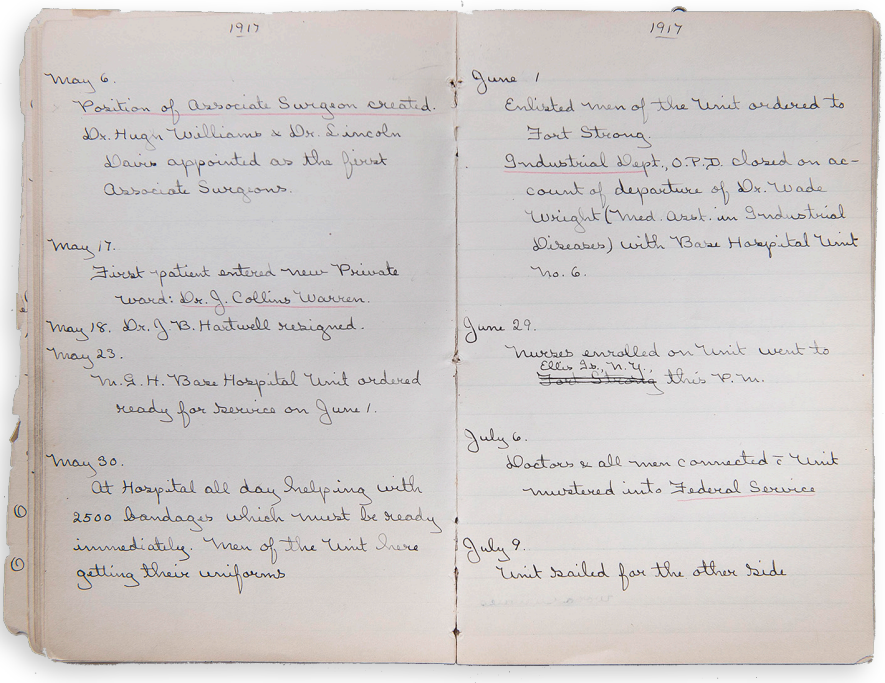
Expect to Start Within 10 Days

The date of the departure of the unit for France is not known yet, but they expect to start within 10 days.

Mayor Curley and Maj Henry L. Higginson had seats near the chancel. Other invited guests were Gen Clarence L. Edwards, Commandant Rush of the Navy Yard, Pres Lowell and Pres-Emeritus Eliot of Harvard.

The unit officers, who sat in the front pews, were Maj Frederic Augustus Washburn, commander; Maj Richard Clarke Cabot and Maj Lincoln Davis, Capts Henry Chase Marble, Beth Vincent, Zabdiel Boylston Adams, Richard Frothingham O'Neil, William Jason Mixter, Roger Kinnicutt, Albert S. Morrill, Oscar Teague, Frederick Carpenter Irving and Augustus Goves Reynolds; Lieuts Ralph Augustus Hatch, DeWitt Somerville Clark, George Adams Leland Jr, Harold Grant Tobey, James Howard Means, George Climer, Paul Dudley White, Wade Stanley Wright, Joseph Charles Aub, William H. Guilfiler, William Haven Sherburne, Everard Lawrence Oliver, Carl Binger.

(Graphics provided by MGH Nursing History Committee)



1917

May 6.
Position of Associate Surgeon created. Dr. Hugh Williams & Dr. Lincoln Davis appointed as the first Associate Surgeons.

May 17.
First patient entered new Private ward: Dr. J. Collins Warren.

May 18. Dr. J. B. Hartwell resigned.

May 23.
M.G.H. Base Hospital Unit ordered ready for service on June 1.

May 30.
At Hospital all day helping with 2500 bandages which must be ready immediately. Men of the Unit there getting their uniforms

1917

June 1
Enlisted men of the Unit ordered to Fort Strong.
Industrial Dept., O.P.D. closed on account of departure of Dr. Wade Wright (Med. Asst. in Industrial Diseases) with Base Hospital Unit No. 6.

June 29.
Nurses enrolled on Unit went to Ellis Is., N.Y., ~~Fort Strong~~ this P.M.

July 6.
Doctors & all men connected w Unit mustered into Federal Service

July 9.
Unit sailed for the other side

From daughter to caretaker; from speech pathologist to healthcare decision-maker

I learned my mom had had a stroke and was completely hemiplegic (paralyzed) on the left side. She was conscious, recognized my dad and brother, and was breathing spontaneously. While she'd had an ischemic stroke, by the time she got to the hospital, she was no longer eligible for tPA.

My name is Danny Nunn, and I am a speech-language pathologist. Last year, I got the phone call I'd always dreaded. "Danny, Mom is in the intensive care unit." My 74-year-old mom has never enjoyed physical activity, has high blood pressure, and doesn't eat well. She's a lawyer, fiercely independent, and prides herself on taking care of everyone else. You can't share a problem with her without her tirelessly looking for a solution. My mom lives on a small island in Brasil, where she was now hospitalized, too unstable to be transferred to the mainland. It could not have felt worse to be in the best hospital in the world and unable to do anything for her.

I have been practicing in the acute care setting for more than 20 years. Neurology is not my specialty, but I've been doing a fellowship at the Neuromodulation Center at Spaulding, so I've been exposed to a lot of neuroplasticity and stroke research recently.

Neither my dad nor my brother have any clinical knowledge, but they were able to answer my immediate questions. I learned my mom had had a stroke and was completely hemiplegic (paralyzed) on the left side. She was conscious, recognized them, and was breathing spontaneously. While she'd had an ischemic stroke, by the time she got to the hospital, she was no longer eligible for tPA (the treatment, which when administered early, can reduce the long-term effects of stroke).

I was by my mom's side 72 hours later. By then, staff there knew I was a speech pathologist and, interestingly, began treating me more as a member of the medical team than a family member.

My mom's head CT had been saved to the intensivist's cell phone as a screen saver, which immediately told me her case was severe. I thought they were showing me a picture from a book; my heart sank when I saw my mom's name beside the image. There was a complete white-out of the right hemisphere. She didn't recognize me. I knew the next few days would be critical for her survival.

This was the first of many challenges on our journey. How much should I disclose to my bother and dad; how did I tap into my faith and ask for her to survive when science and experience told me that survival could be worse? I was shaken to the core, professionally and personally. This wasn't one of my patients, this was my mom.

A few days later she started to decline with worsening arousal and inability to clear her secretions due to suspected cerebral edema. I was fully capable and trained to help manage her secretions, but I couldn't do anything due to a lack of equipment and because at that moment, my role was to be her daughter not her healthcare professional.

I couldn't eat, sleep, or pray even though staff kept reminding me to. My internal conflict persisted: what do I wish for; do I allow my family to remain hopeful, or do I prepare them for the worst?

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(Photo provided by Danny Nunn)

Thanks to a fluke of timing, I was spared the discussion on the potential need for a craniectomy, which would have been unbearable to me. With the guidance of the physician, my dad and brother agreed it was best to wait and see what would happen. It took countless medications and a short intubation to start to see some improvement. It was so difficult to see her struggle with her secretions and not have the tools to help. How many times did I see someone use less than optimal technique and have to suppress my urge to step in.

After two long weeks, we were able to move my mom back to the infirmary and into a single room. I spent hours in a chair at her bedside, recognizing her extensive deficits and mourning the loss of her independence. I tried to discuss her preference for code status but she didn't have the capacity to verbalize her wishes, nor was it appropriate to discuss it at this time given our culture and faith.


Danny and mom

Because there was no speech therapist at the hospital, I was allowed to practice as one. But this was worrisome, because to test someone's ability to swallow, you have to feed them and see if they 'tolerate' it. Staff had no understanding of the complexities involved with swallow tests. Gradually, I showed them ways to recognize when it was reasonable for a patient to attempt a swallow test, and when it wasn't. Within a week, I was seeing other patients in the hospital and training staff on evidence-based, MGH, swallow-screening techniques while still attending to my mom.

Next came discharge. There were no rehabilitation hospitals in the area, no case managers, no information on how to find support services, just a promise that she'd have home care when she got home. There was no patient education, just an ambulance waiting to take us home. (Did I mention my mom lives on an island?)

Home care consisted of a nurse who marked the end of a nasogastric tube in relation to the entrance to my mom's nostrils, and a physician who wrote down a list of her deficits, based not on a physical exam, but on what I told him they were. My mom was completely dependent on my 76-year-old dad and me to turn her every two hours and tend to all her personal hygiene and toileting needs. After much fighting with the insurance company, we were able to get a physical therapist to come to the house three times a week.

This journey taught me so many things. I realized I knew nothing about the deficits I diagnose every day. Truly understanding what families experience is humbling. I've had a skewed perspective of what's important in terms of making progress. We need to be more attentive to the multi-faceted needs of patients and family members. While effective swallowing is vital, it might not be the highest priority of the day. The entire team, including the patient and family, needs to work together to establish realistic goals and expectations.

One of the biggest lessons I learned is that it's not just the patient's life that's affected but an entire community of family and friends. Fear, frustration, sleep-deprivation, and grief can make even the most rational family behave irrationally. We need to recognize that that behavior may be a cry for help.

I'm blessed to work in health care, I have access to the best professionals, I have extensive clinical experience, and I can still find it overwhelming to prioritize the day's goals and activities. Imagine what it's like for those with no clinical background. Behind every patient, there's a son or daughter, mother or father hoping that everything will be done perfectly. I learned quickly that it's better to strive for excellence—not perfection. It wasn't an easy lesson to learn.

While my scientific mind may have temporarily overshadowed my faith during this experience, I'm certain that praying for what was best for my mom played a part in this journey.

My mom is still paralyzed, and her quality of life is not the same. But between the tears and the monumental changes, there has been laughter and love and appreciation. I'm keenly aware that I shouldn't generalize, and my narrative of events may be colored by my emotional attachment to my mom, but the impact of my personal experience on my professional life is unquestionable. I don't know what the future holds, but I will continue to be an active participant in this experience and use my knowledge and skills to better serve my patients and families.

I'm proud and honored to be a health professional, as well as a caretaker eager to learn and help.

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

First, Danny, I want to say that the thoughts and prayers of your entire MGH family are with you right now. This narrative is an important reminder of why we say: Treat your patients the way you'd want your loved ones to be treated—with skill, compassion, and kindness. There are so many lessons embedded in this story: being attentive to the *multi-faceted needs* of patients and families; including the patient and family in decision-making; having empathy for those in crisis; and perhaps most important, remembering that behind every patient is a son or daughter, mother or father, putting their faith in us to do our best for their loved one.

Thank-you, Danny, for sharing this experience, and for the expert care you provide here at MGH, and on that tiny island off the coast of Brasil.

Pediatric rotation helps student nurse learn humility and engagement

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 student, Mike Tanguay.

Throughout my pediatric clinical experience, I cared mostly for teenagers who were able to speak and convey their feelings. This was a comfortable place for me, and I felt confident in my care. But ultimately, the time came when I was assigned a 3-month-old baby. I had never held a baby or changed a diaper before, let alone cared for an infant. I was both terrified and excited. Babies seemed so fragile, and the thought of what could happen if I screwed up was very scary.

Once I began taking vital signs and doing my assessment, my nerves started to subside—I was caring for a patient who needed my complete attention. The infant had been admitted for respiratory issues, so monitoring lung sounds and breathing was my primary focus. The mother was very helpful, telling me about his lung sounds prior to arriving at the hospital. She was very comfortable using medical terminology, so I asked what she did for a living. She said she was a Neonatal ICU nurse. My nerves came charging back. I was a student nurse who'd never cared for a child before, and my patient's mother cared for sick babies for a living.

By the end of the day, I had learned some of the most valuable lessons of my nursing-school 'career.' Primarily, I learned what it takes to be a nurse and the caregiver you want to be. This mother could very easily have been upset to find her sick baby being cared for by a student nurse. But it was the exact opposite. She showed me how to take vital signs effectively on a restless baby, how to change a diaper, and how to administer oral medication to a baby who doesn't want to swallow. One of the strongest values of a nurse is the care and help they're willing to give others. This mother couldn't help but guide and teach me, and that really made an impression on me.

After this interaction, I was much more relaxed and excited to care for this patient. Based on AWHONN's virtues of providing care, this day was going to be about engagement. The mother was very knowledgeable and able to engage in discussions about her son's treatment plan. When it came time for him to be discharged, we had an open dialogue about her thoughts. She was happy with how her baby had progressed and confident that it was time to go home.

Mike Tanguay, nursing student

The second virtue of this interaction was humility. I went into this situation with such a small understanding of what's involved in caring for an infant. My instructor had coached me on certain skills. But when I found out the mother was a NICU nurse, I was completely open to the opportunity to learn. I realized the mom wasn't here in her capacity as a nurse; this was her child, so I needed to keep an unbiased approach. My ability to put aside thinking I knew more than I did allowed me to learn so much more throughout the day. I was able to provide the best care possible for this patient.

This clinical experience allowed me to learn so much more than caring for an infant; I learned about the nursing profession as a community. I saw how open nurses are to teaching one another so the profession can continue to grow and get better. If everyone works together like this with students and new nurses, the profession will be incredibly strong. It energizes me to know that in a few short months this is the community I'll be part of.

Multi-disciplinary teams receive Compass Awards

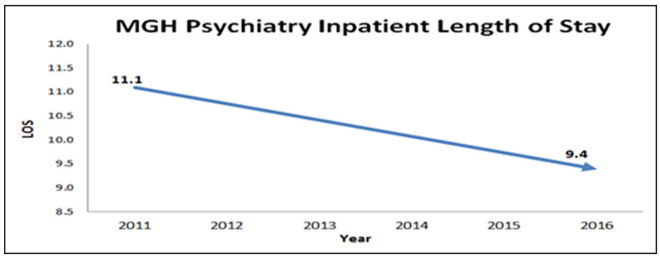
—by Maryellen O'Dea and Jessica Smith Yang, RN

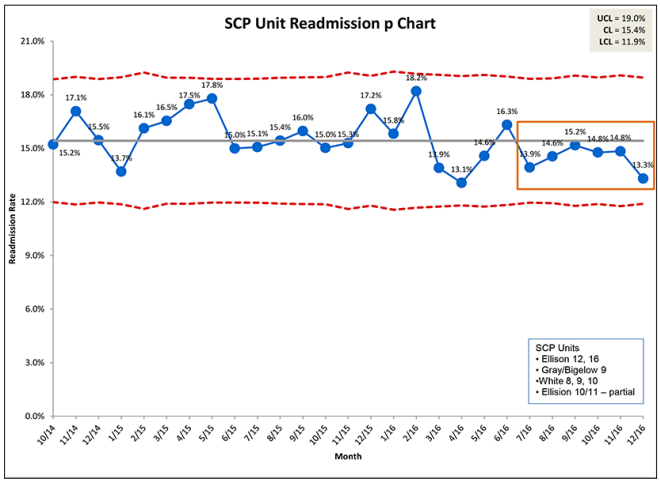
The Massachusetts Health & Hospital Association held its second annual Compass Awards, March 9, 2017, to recognize provider excellence and innovation in the delivery of safe, efficient, high-quality care. Two MGH teams, the Psychiatry Team and the Stay Connected Program, were recognized earning second-place honors. The Inpatient Psychiatry Team was nominated in the Providing Care to Special Populations category, demonstrating a sustained decrease in length of stay (from 11 to 9 days) over several years. The team also showed improvement in pre-noon discharges and admission volume.

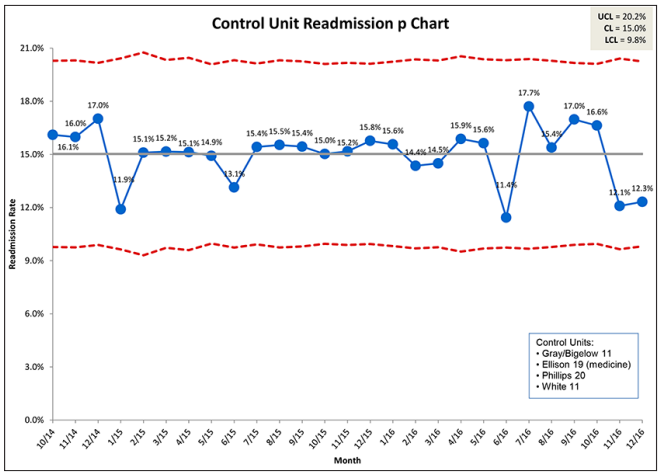
The Stay Connected Program was nominated in the category of Reducing Hospital-Acquired Conditions and Re-Admissions. Implemented in 2016, the program is a bundle of services offered to high-risk patients on six general medicine and two cardiology units. Initial results show a decrease in re-admissions compared to a control group with a similar patient population. Special thanks to the multi-disciplinary team, including: Case Management, Nursing, Pharmacy, Social Work, providers, and inpatient administrative coordinators.

For more information, call Maryellen O'Dea at 617-643-0201.

Accepting on behalf of their teams (l-r): Connie Cruz, RN; Tina Stone, RN; and Karen Rosenblum, RN, from the Psychiatry Team; and Jess Smith Yang, RN, and Maryellen O'Dea, from the Stay Connected Program.







Changes to evaluation process for nursing performance appraisals

Nurses evaluating nurses to elevate practice

Question: I understand there are going to be some changes to the nursing performance appraisal. What's changing?

Jeanette: As chief nurse, I'm responsible for the practice of all registered nurses at MGH. We want to ensure that nursing practice is reviewed by nurse leaders who meet the minimum educational requirements of BSN or MSN. The objective is to align all nurses with a nurse leader who meets those requirements. This reinforces professional standards and our commitment to provide the highest quality patient care.

Question: What's changing?

Jeanette: Performance appraisals of all nurses will now be reviewed by a nurse leader. In working with Human Resources, department managers, staff and leadership, it came to our attention that a number of nurses' performance evaluations were being reviewed by someone who wasn't a nurse. Nurses who don't currently report to a nurse leader will now have a nurse leader assigned to them for participation in their review process. The performance appraisal form has been revised to include a signature line for the newly-identified nurse leader. To access the new performance evaluation document, go to: http://hr.partners.org/mgh/department-of-nursing-perfromance-evalaution-forms.aspx.

Question: Is anything else changing?

Jeanette: Current reporting relationships will not change. Nurses will continue to report to their existing managers. Existing managers and evaluators are responsible for the timely completion of nursing performance evaluations.

Question: How will I know who my newly-assigned nurse leader is?

Jeanette: A nurse leader will be identified in collaboration with your current manager, so you'll know who'll be reviewing your performance.

Question: What is the role of the nurse leader?

Jeanette: The nurse leader will review the performance evaluation documents to ensure adherence with professional standards of practice and recommend an action plan if practice is not aligned with standards. The nurse leader will co-sign the performance evaluation documents.

Question: When will these changes take place?

Jeanette: Changes will go into effect the week of May 14, 2017, and affect all registered nurses at all levels of the organization.

For more information, call Julie Goldman, RN, at 617-724-2295.

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Next Publication
June 1, 2017

Announcements

Blum Center Events

"Stroke: Time is Brain"
Tuesday, May 9, 2017
12:00–1:00pm
Stroke occurs when blood stops flowing to part of your brain. Join Judith Clark, RN, to learn the warning signs of stroke, what to do if you have these warning signs, and the therapies available.

"Managing Asthma"
Tuesday, May 23rd
12:00–1:00pm
Asthma is a chronic disease that causes the airways of the lungs to swell and narrow. Join respiratory therapist, Nancy Davis, RRT, to learn what happens when someone has an asthma attack, common causes of flare-ups, and ways to help manage asthma at home.

"Rheumatoid Arthritis: a New Era in Understanding and Treatment"
Thursday, May 25th
12:00–1:00pm
Rheumatoid arthritis (RA) is a form of arthritis that causes pain, swelling, and stiffness in your joints. It is the most common form of autoimmune arthritis. Join Sheila Arvikar, MD, for a talk on understanding, diagnosing, and treating RA.

No registration required.
All sessions held in the Blum Patient & Family Learning Center.
For more information, call 4-3823.

MGH Global Health Expo

The MGH Global Health Expo is an opportunity for the MGH community to learn more about the breadth of global-health activities at MGH. Opportunities are available for staff at all levels. The Global Health Expo is a springboard for new collaborations and conversations for those interested in Global Health.
Stop by for refreshments and to learn more about Global Health at MGH.

Wednesday, May 10, 2017
11:00–2:00pm
Under the Bulfinch Tent

For more information, call 617-643-6911.

Healthcare Technology Management Appreciation Week

May 21–May 27, 2017

Every May, Healthcare Technology Management Appreciation Week is celebrated to recognize the people who work in biomedical and clinical engineering. These healthcare professionals service, maintain, manage, and support medical staff in the use of healthcare technology.

Biomedical Engineering is hosting an information table to exhibit some of the equipment they maintain throughout the hospital. Visit the display to meet staff and learn more about the role Biomedical Engineering plays in making MGH a world-class healthcare organization.

Thursday, May 25, 2017
8:00am–3:00pm
Main Corridor

For more information, contact Jean Johanson at 617-726-3239.

Merit Scholarship for Charlestown high-school seniors

The MGH Institute of Health Professions, the MGH Charlestown Community Health Center, and Spaulding Rehabilitation Hospital are offering $6,000 in scholarships to high school seniors from Charlestown. Students entering a two- or four-year college with the intention of becoming healthcare professionals are eligible. Apply at mghihp.edu/merit.

Deadline for applications is Thursday, June 1, 2017.

For more information, call Andrew Criscione at 617-726-0968.

Clinician Administrative Burden and Burnout

MGH clinicians and administrators are invited to attend a lecture by Tait Shanafelt, MD, professor of medicine and hematology at the Mayo Clinic and director of the Program on Physician Well-Being.

Tuesday, May 23, 2017
10:00–11:30am
the Harvard Club
374 Commonwealth Avenue
1.5 CMEs

Register by May 9th.
Space is limited.
For more information, call Maureen Goggin at 617-278-1028.

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):
August 9, 2017
5:30–10:30pm

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

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

AMMP Scholarship

2017 AMMP
(Association of Multicultural Members of Partners)
Scholarship Opportunity

Are you an AMMP member?
Are you currently in school?

The AMMP scholarship was established as part of AMMP's mission to support the educational goals of members and assist in their pursuit of degrees and training at colleges and universities.

Applications are now being accepted for the 2017 AMMP scholarship.

Applications are available at the Employee Access Center in Bulfinch 107 or on the AMMP website at: http://AMMP.massgeneral.org

See application for eligibility.

For more information, go to the AMMP website at http://AMMP.massgeneral.org; or call AMMP Scholarship chair, Sandra Thomas, at 617-643-0140.

Application deadline is Wednesday July, 12, 2017.

Inpatient HCAHPS

Current data

HCAHPS Measure	CY 2016	CY 2017 Year-to-date (as of 4/24/17)	% Point Change
Nurse Communication Composite	83.0%	84.4%	↑ 1.4%
Doctor Communication Composite	82.6%	84.6%	↑ 2.0%
Room Clean	71.2%	72.1%	↑ 0.9%
Quiet at Night	49.9%	53.0%	↑ 3.1%
Cleanliness/Quiet Composite	60.5%	65.5%	↑ 5.0%
Staff Responsiveness Composite	64.9%	66.4%	↑ 1.5%
Pain Management Composite	72.8%	74.4%	↑ 1.6%
Communication about Meds Composite	65.8%	66.4%	↑ 0.6%
Care Transitions	61.0%	62.0%	↑ 0.9%
Discharge Information Composite	91.9%	93.2%	↑ 1.3%
Overall Hospital Rating	81.9%	83.1%	↑ 1.3%
Likelihood to Recommend Hospital	89.8%	90.7%	↑ 0.9%

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

Data is complete through February, with partial data through April. All categories reflect improvement over 2016. Target for 2017 is to improve Quiet at Night and Staff Responsiveness by one percentage point. We are currently on track to achieve those goals.

Caring Headlines
May 4, 2017

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