Caring Headlines
September 21, 2017

Excellence Every Day Rally

Who says regulatory readiness can't be fun!?

(See Jeanette Ives Erickson's column on page 2 and more photos from the rally on page 13)

At left: providing equal parts motivation and comic relief, cheerleaders, Jasmine Gonzalez, RN; Christine Marmen, RN; and Abby Blair, RN.

Nursing & Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Excellence Every Day, perpetual readiness, and the Magnet and JC site visits

You may have heard that our 4th Magnet site visit has been scheduled for November 6-9, 2017. And we're also anticipating a Joint Commission survey some time before the end of April, 2018.

We're fortunate to work in one of the world's best, most renowned hospitals (if you ask me, I'd say *the* best hospital). You don't get to be ranked one of the top five hospitals by *US News & World Report* without substantial evidence that you deserve that recognition. At MGH, excellence in patient- and family-centered care is what drives us. Regulatory readiness is a by-product of our commitment to Excellence Every Day.

You may have heard that our 4th Magnet site visit has been scheduled for November 6-9, 2017. Magnet surveyors will visit as many inpatient and ambulatory care areas as possible over a four-day period.

We're also anticipating a Joint Commission survey some time before the end of April, 2018. Healthcare facilities are visited by the Joint Commission every three years to ensure they meet regulatory standards and are providing safe, high-quality care to patients and families.

Regulatory readiness is important. Part of regulatory readiness is ensuring that staff are aware of and fully understand hospital and unit-based policies, priorities, and initiatives. We employ several vehicles to communicate this information to staff on an on-going basis:

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

- Dissemination of National Patient Safety Goals
- Mock Joint Commission surveys
- Review of past Joint Commission surveys
- Results from the inter-disciplinary tracer program
- Quarterly and routine audits of:
  - Documentation
  - Performance reviews
  - Infection-control practices
  - Environment of care
- Adherence to policies and procedures
- Review of Joint Commission standards
- Review and follow-up of safety reports

Hospital priorities, strengths, and opportunities for improvement are shared broadly via:

- *Caring Headlines*
- *PCS News You Can Use*
- All-user broadcasts
- Monthly 'From the Desktop' messages

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As essential and effective as all these preparations are, they're really secondary to the *most important* factor in providing exceptional care; and that's our commitment to do our very best for patients and families, every moment of every day... When it comes to providing world-class patient care, no one does Excellence Every Day the way we do.

- *Fruit Street Physician*
- Quality Assurance/Performance Improvement Plans
- Unit-based Excellence Every Day quality boards
- The Excellence Every Day portal page
- Results of inter-disciplinary tracers
- Magnet and Joint Commission booklets
- *Tuesday Take Aways*
- Practice Alerts
- National Patient Safety Goal badges

Recent tracers identified some areas where practice could be improved with increased awareness around: the care of at-risk populations (such as ligature risk for suicidal patients in general care areas); fire-safety (such as obstructing access to safety equipment, alarms, and gas valves); and medication safety (such as expired medications and supplies).

Unit leadership engage staff in performance-improvement by reviewing and discussing quality data, action plans, patient-satisfaction survey results, and data related to: fall-prevention; pressure ulcers; CAUTIs; CLABSIs; restraint use; pain assessment and re-assessment; and accurate documentation. Patient and family education is a priority when planning for discharge and includes information about medications and anti-microbial use.

Recently, to engage staff in preparations for our upcoming Magnet and Joint Commission visits, a kick-off rally was held for staff from Patient Care Services and the MGH community as a fun and informative way to celebrate all that we do for patients and families. Set to the theme song from *Rocky* and complete with our own MGH cheerleaders, the event touched on aspects of the Magnet survey; Joint Commission readiness; and what staff and leadership can expect during the visits. And as promised, it was a fun (and funny!) introduction to a series of follow-up educational communications. Each week, new themes will be highlighted in various formats including: vidscrips, e-mails, and Nursing Grand Rounds (held on Thursdays from 1:30-2:30pm in O'Keeffe Auditorium).

As essential and effective as all these preparations are, they're really secondary to the *most important* factor in providing exceptional care; and that's our commitment to do our very best for patients and families, every moment of every day. Which is why I'm confident our Magnet and Joint Commission visits will be so successful. When it comes to providing world-class patient care, no one does Excellence Every Day the way we do.

For more information, contact Colleen Snydeman, RN, director of the PCS Office of Quality & Safety, at 617-643-0435.

In this Issue

Excellence Every Day Rally 1

Jeanette Ives Erickson 2-3
- Excellence Every Day and Perpetual Readiness

Global Nursing Symposium 4-5

National Recovery Month 6

Evidence-Based Practice Initiative 7

Clinical Narrative 8-10
- Casey Vandale, PT

Professional Learning Environment for Nurses (PLEN) Survey 11

Fielding the Issues 12
- Our Journey to Transparent Patient Classification

Excellence Every Day Rally 13

Announcements 14

Magnet Staff Notice 15

HCAHPS 16

(Cover photo by Michelle Rose)

First Global Nursing Symposium at MGH

—by Mary Sebert, RN, international nurse program manager

MGH Global Health held its first Global Nursing Symposium, June 13, 2017, giving global nursing fellows an opportunity to share their experiences training nurse colleagues in Uganda and Tanzania. Generously supported by the Sullivan Family Foundation and the Wyss Medical Foundation, the Global Nursing Fellowship offers short-term opportunities for MGH nurses to provide didactic instruction and clinical mentoring to partners abroad.

The MGH Global Nursing Fellowship offers short-term opportunities for MGH nurses to provide didactic instruction and clinical mentoring to partners abroad.

First up was Pat Daoust, RN, director of Nursing for MGH Global Health. Daoust spoke about the importance of the relationships developed between nursing fellows and their in-country colleagues, saying, "This program promotes nursing as a unified profession, one community with shared values. Knowledge increases nurses' confidence in theory and clinical application."

Daoust shared the sentiments of one Ugandan nurse who said, "Thank-you for coming. You have given me a spark that I never had before. Now I am proud to be a nurse."

Said Daoust, "This pride turns into confidence, which turns into effective practice, which is the essence of all quality nursing care."

Global nursing fellows, Bethany Groleau, RN, Lunder 9 staff nurse, and Heidi Abendroth, RN, pediatric oncology nurse practitioner, who spent time in Mbarara, Uganda, spoke about the impact of education on oncology nursing practice. Groleau worked with nurses in Adult Oncology while Abendroth focused on Pediatrics. The hospital they visited had opened a Pediatric Oncology Clinic earlier this year.

On a subsequent visit to Mbarara, oncology nurse practitioner, Kara Olivier, RN, noted a marked increase in the confidence of nurses as they interacted with colleagues. That confidence has a positive impact on patient advocacy and patient safety. Said Olivier, "Everyone shares a universal desire to decrease pain and suffering."

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Clinical staff and university students benefited from wound-care education provided by Medical ICU staff nurse, Sophia Harden, RN, during her eight-week stay in Mbarara. Harden spent many hours in the classroom and Surgical Ward teaching fundamentals of wound care, including the care of burn patients. In fact, the burn protocol developed by Harden and the Mbarara nursing staff is proudly displayed on the wall there.

During a post-assessment visit, international nurse program manager, Mary Sebert, RN, noted, "Wounds are healing better and faster with the use of paraffin, and infection rates have decreased."

In Dar es Salaam, Tanzania's capital city, professional development specialists, Jennifer Curran, RN, and Patricia Crispi, RN, led a clinical instructor course for 47 nurses, enabling them to teach nursing and midwifery students (from Muhimbili University of Health and Allied Sciences) in the clinical setting. Curran and Crispi spoke about the variety of learner-engagement activities they used, but said clinical narratives were particularly effective. Stories were shared about ethical dilemmas and clinical challenges faced by nurses every day. Said Crispi, "We wanted to give them an opportunity to share these experiences so they knew they weren't alone."

Substance use disorder experts, Dawn Williamson, RN, and Chris Shaw, RN, were the final presenters. Williamson and Shaw had worked with nurses and physicians in four different hospitals in Dar es Salaam.

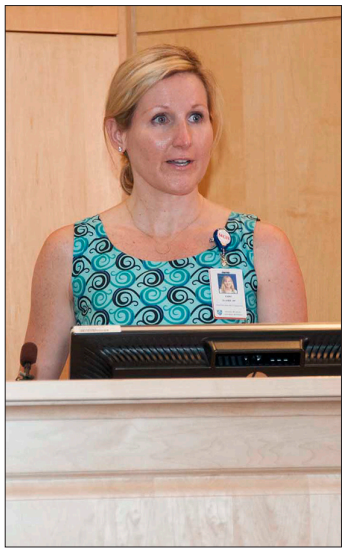
Said Williamson, "They were very receptive to the training we provided. Many of the practices were still steeped in stigma and 'old wives tales.' Sharing information on the neuro-biology of substance use disorder helped them move from out-dated beliefs to understanding that substance use disorder is a disease that can be treated." In 2011, Dar es Salaam opened its first methadone clinic that now serves 900 patients per day.

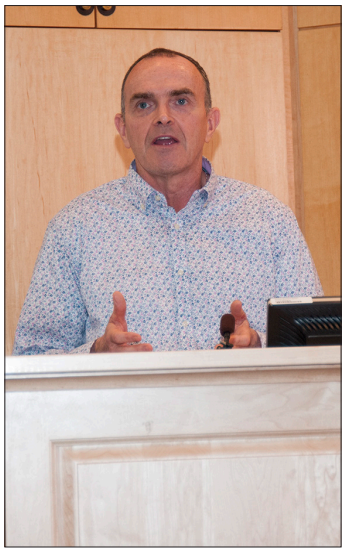
Following the formal presentations, speakers took part in a panel discussion, taking questions from attendees. Many panelists shared how difficult it was to leave their host hospitals after spending so much time with clinicians there. Said Heidi Abendroth, "I wanted to stay and continue to share my knowledge, provide more resources. I had to come to grips with the fact that I couldn't fix everything; I couldn't change those challenging circumstances."

When asked how her experience in Uganda has impacted her practice at MGH, Groleau responded, "I think I do assessments differently now. Over there, we didn't have any of the resources we have here. So you go back to those basic skills—listening, looking, really being part of the environment. I hope I listen differently now, practice differently, using the skills I relied on during my time in Mbarara."

For more information about global nursing opportunities at MGH, contact Mary Sebert, RN, at 617-643-9197.

Opposite page (l-r): panelists, Bethany Groleau, RN; Heidi Abendroth, RN; and Mary Sebert, RN. Below (l-r): Patricia Crispi, RN; Kara Olivier, RN; Dawn Williamson, RN; and Christopher Shaw, RN.



Raising awareness about recovery from substance use disorder

—by Dawn Williamson, RN, and Christopher Shaw, RN

During the month of September, MGH is hosting several events as part of National Recovery Month, a nation-wide campaign to raise awareness and increase understanding of substance use disorders (SUD). The theme of this year's campaign is, "Join the Voices for Recovery: Strengthen Families and Communities." The scope of the SUD epidemic is great and requires the attention and effort of the entire country to effectively address it. National Recovery Month is an opportunity to highlight the importance of community in responding to this epidemic.

SUD affects more people nation-wide than you may realize, and drug overdoses rose sharply in the first nine months of 2016. Overdoses from opioids, especially fentanyl and carfentanil are major drivers of the problem. Despite dire SUD statistics, it's important to understand that recovery *is* possible, people do make breakthroughs, and those affected *are* able to constructively alter their lives. MGH is committed to bringing all its resources to bear in addressing SUD. MGH staff, patients, and families are encouraged to Join the Voices for Recovery; Strengthen Families and Communities.

Top: Dawn Williamson at methadone clinic at Muhimbilli Hospital. Below: Christopher Shaw with students in front of MUHAS Academic Medical Center.

Recovery involves the healing of individuals suffering from addiction. It embraces the families and loved ones of those who suffer from or have died from substance use disorders. Communities that want to intervene early are supported by MGH. Our SUD Initiative strives to decrease the stigma associated with SUD and encourages healthcare workers to be change agents in this effort in their own practice.

This year, as part of the MGH Global Nursing Fellowship, two nurses traveled to Tanzania to provide addiction training to healthcare workers in East Africa, an area that's also experiencing a major opioid epidemic. Substance use disorder specialists, Dawn Williamson, RN, and Christopher Shaw, RN, designed and facilitated curricula and mentorship programs for 93 allied health workers at four hospitals, covering topics such as epidemiology, neuro-biology, morbidity, stigma, and treatment considerations.

Williamson and Shaw visited the methadone clinic at Muhimbili National Hospital in Tanzania. The clinic has more than 1,200 registered patients and sees approximately 900 individuals daily. Medication regimens are customized for patients who have comorbid illnesses, such as HIV and TB, to promote optimal treatment adherence.

An increase in the rate of blood-borne diseases, such as HIV, could be devastating for Tanzania, one of the world's poorest countries. Emphasizing the importance of family and community connections is crucial. Shaw and Williamson met with peer specialists at the methadone clinic, who like their counterparts here at MGH, provide important connections for patients seeking recovery. The concept of 'connection' is so important in any effort to curb this epidemic. Nurses and other clinicians can save lives simply by being present and connected to patients seeking recovery.

For more information on substance use disorders, call either Williamson, at 617-643-2307; or Shaw, at 617 840 7326.

Working together to advance evidence-based practice

implementing a psychosocial distress screening tool

—by Mary Susan Convery, LICSW, clinical social work specialist and co-lead of the Advancing Evidence-Based Practice Initiative

How do nurses, physicians, and other healthcare professionals know when a patient is experiencing severe emotional or psychosocial distress? Is it when he sobs or raises his voice in anger? Is it when she refuses to talk or interact with staff? Actually, it's all of the above. But those are just a few examples of patient distress. Recognizing psychosocial distress is like seeing an iceberg; what's visible above the surface is only a small piece of the picture. When these conditions go undetected or under-treated, they can lead to decreased compliance with medical treatment, longer hospitalizations, and a negative impact on quality of life for patients and families.

An inter-professional team was created recently to better understand the various levels of distress and see whether a screening tool could impact clinical practice. With the support of Lunder 9 nursing director, Barbara Cashavelly, RN, a team of nurses and social workers began to study the implications of introducing routine distress screening. Lunder 9 is a 32-bed, acute-care, oncology unit, where nurses manage the complex care of patients with a variety of cancer diagnoses. To better capture the psychosocial needs of hospitalized cancer patients, the study team utilized the psychosocial distress screening tool created by the National Comprehensive Cancer Network (NCCN).

(Photo by Paul Batista)

(L-r): Barbara Cashavelly, RN; Sarah Brown, RN; Bettyann Burns-Britton, RN; Mary Susan Convery, LICSW; and Lauren DeMarco, LICSW.

The attending nurse administered the NCCN Distress Thermometer tool to newly admitted patients who were capable of completing the self-reporting screening tool independently. Patients were asked to indicate their level of distress on a scale of 0-10; patients who scored greater than 6 were automatically referred to a social worker. Patients also described the source of distress: emotional; practical; family-related; spiritual; or physical. Completed screenings were given to the unit social worker who documented the scores and initiated referrals.

Of 64 patients screened, 52.4% were male, 47.6% were female. Patients between the ages of 55-74 made up 64.8% of the population. Initial data indicated high levels of psychosocial distress with 58% of patients scoring themselves greater than 6 on a scale of 0-10. Of the patients screened, 89.9% were referred to Social Work as a direct result of being screened by the attending nurse.

Routine distress screening can improve clinical care, ensure early referral for those in need of psychological interventions, and facilitate coordination of care and communication.

Inter-professional teaming brings together different competencies and perspectives that can foster assessment and problem-solving; it can increase effective communication and job satisfaction. This project demonstrated how high-functioning teams can adjust, adapt, and innovate to develop strategies to support patient-centered care, improve the patient experience, and lead to positive outcomes.

This project is part of the Patient Care Services' Advancing Evidence-Based Practice initiative. For more information on developing your own evidence-based practice project, go to the Evidence Based Practice portal page at http://www.mghpcs.org/eed_portal/EED_evidence-based_practice.asp.

Physical therapist thinks outside the box to motivate young patient

Casey Vandale, PT, senior physical therapist

My name is Casey Vandale, and I am a senior physical therapist. I first met 'Kyle' and his parents in our busy outpatient physical-therapy waiting room. He was waving two American flags, giggling, and mumbling as he watched them flutter in his hand. He didn't look at me when I introduced myself, but when his mom took his hand and re-directed his attention to me, he gave me a sly smile out of the corner of his eye.

I was seeing Kyle as part of the MGH Adult Down Syndrome Clinic. He was 22 years old and had a one-year history of right-arm pain and loss of function. His mom had driven for more than an hour to bring him to MGH. She wasn't sure how physical therapy could fix the problem, but she was willing to try anything to help Kyle.

I brought Kyle and his mother back to a private treatment room. Kyle sat down and started to twirl and flap the flags, mumbling quietly to himself, and watching his fingers as they moved. Mom reviewed his medical history and explained that Kyle had stopped using his right arm and hand about a year ago. She wasn't aware of any injury to his arm, neck, or shoulder, and said he only complained of pain when she asked him to use it.

Kyle had already seen a neurologist, a hand specialist, and spine surgeon, and no one had been able to give her an explanation for his pain or why he'd stopped using his dominant arm. This was their first time seeing a physical therapist. Mom shared that Kyle no longer showed interest in some of the things he used to love, like dancing, using his iPad, watching movies, and playing ball with his nieces and nephews. She had wondered if he was depressed, but medication adjustments by his psychiatrist hadn't seemed to make a difference.

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As I began my PT examination, I realized that although Kyle had a limited vocabulary and repeated words, he was able to follow directions and comprehend what I was asking him to do in simple language and single-step instructions. I observed that he braced his right arm against his body as he pulled his T-shirt over his head with his left hand. I asked him to raise both arms over his head so I could assess his active shoulder range of motion. He reached as high as he could with his left hand. But when I asked him to try with his right, he grabbed his shoulder and said in his deep, raspy voice, "I can't. It hurts."

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Mom asked him to try again. He rolled his eyes and said, "I can't," then lifted his arm twice to about the level of his shoulder.

I asked him to lie down so I could assess his passive range of motion. He demonstrated full, pain-free motion and hypermobility of his glenohumeral (shoulder) joint in both the right and left extremities. When I tried to test his strength, he wouldn't cooperate for standard, formal, muscle-performance testing. I knew I had to think of an alternative way to assess him — something fun that would motivate him to try. Mom had mentioned that he liked to play ball with his niece and nephew, so I thought I'd give that a try. I was pleased that Kyle was willing to toss a number of balls, demonstrating that he was able to load his rotator cuff appropriately, so a tear or tendonitis was unlikely. He quickly lost interest in participating any further in our session that day.

I discussed my findings with Kyle's mom — his physical presentation, my observations of his behavior, careful consideration of his medical history, and the subjective data she had shared. I mentioned my concern that Kyle may have glenohumeral instability in his right shoulder. I explained that the literature shows that glenohumeral instability can affect anyone but is especially present in patients with increased ligamentous laxity, such as individuals with Down syndrome. If Kyle hadn't been using his arm for more than a year, he didn't have the muscle stability he needed to accommodate his joint laxity. Therefore, every time he loaded or lifted his arm, he was shearing through the glenohumeral joint and experiencing pain. That would explain why he lost interest in so many activities he used to love; he'd been in pain and couldn't verbalize what was hurting.

I explained to Mom that in working with other patients like Kyle, I'd learned that a single painful experience can lead to disuse of an extremity or fear of certain activities. Over time, that can lead to weakness and a vicious cycle of trying to manage pain.

I asked Mom if she'd be willing to bring Kyle back to see a shoulder specialist. I was hoping Kyle could receive a cortisone injection to reduce his pain, and it would allow us to strengthen his shoulder and restore his confidence in his ability to use his arm. Mom agreed.

I contacted the referring physician, shared my clinical findings, and asked that we refer Kyle to a shoulder specialist. I explained that I worked in a clinic with the specialist and would be present for Kyle's appointment and could advocate for his care. She agreed with the plan.

About a month later, Mom brought Kyle in to see the specialist, and as planned, I was present for the appointment. Mom reviewed Kyle's history, and I provided my clinical findings. The specialist said he preferred to send Kyle for an MRI to rule out any structural problems before considering a cortisone injection. I understood and urged him to consider the injection if Kyle's MRI came back normal, and he agreed.

Kyle's MRI revealed no structural abnormalities, and he was given an intra-articular joint injection. He returned to physical therapy a month later, and Mom reported some improvement in his ability to dress and bathe himself, but he continued to favor his right arm with all activities. She mentioned that he'd started to go to the gym with his sister-in-law and enjoyed using the machines there.

My goals for this session were to begin to strengthen Kyle's right upper extremity, improve his confidence in the use of his right arm, and teach Mom some strategies to encourage the use of his arm at home. I suspected the traditional way of strengthening with bands and weights wouldn't work for Kyle, but since he was enjoying going to the gym, I thought I'd give it a try. No luck. Kyle refused to do any activity with a band or weight, saying, "I'm too old," or "No, I can't."

It was time to think outside the box. How could I motivate Kyle to use and exercise his right arm?

I thought if I could engage Kyle in a meaningful, functional task, I might be able to get the results I wanted. I put two weights on a high shelf and asked Kyle to get them so his mother could use them. He obliged. He reached up with both arms, taking a weight in each hand, and brought them to his mom.

It was time to think outside the box... I thought if I could engage Kyle in a meaningful, functional task, I might be able to get the results I wanted. I put two weights on a high shelf and asked Kyle to get them so his mother could use them. He obliged. He reached up with both arms, taking a weight in each hand, and brought them to his mom.

This gave me a chance to assess his range of motion and see how much weight he could tolerate. We tried this several more times with different weights before he lost interest. Then we tossed a ball back and forth, and I reminded him how much fun it was to play catch with his niece and

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nephew. I encouraged him to use both hands to catch and toss the ball, which he did inconsistently, until he made it clear he didn't want to play anymore.

We sat down and started to play some other games: Memory and Perfection. We played a few rounds of each, as I tried to encourage him to use both hands.

When it was clear Kyle had had enough physical therapy for the day, Mom and I discussed ways to encourage Kyle to use his right arm at home. We knew he liked to use the equipment at the gym, so we talked about different types of cardio and weight machines he could use that would require both arms. I introduced the idea of using, 'high tens,' instead of high fives to convey congratulations because it would get both arms involved. Given that he liked to help around the house, we talked about having him clear the table or put dishes away, activities that would require two hands to perform. And finally, I encouraged Mom to play games with Kyle at home—games like Memory and Perfection to encourage him to use his right hand to manipulate smaller objects. Mom appreciated all suggestions.

Kyle returned to the physical therapy clinic a month later. Unfortunately, Mom reported only minimal improvement. She had encouraged him to clear the table and get dressed using his right hand, but he continued to use his right hand inconsistently. I had to re-think my plan of care, since my suggestions hadn't worked the way I hoped they would.

I looked to the evidence on motor learning. It supports using motivational, functional tasks when learning a new skill, or in Kyle's case, re-learning a skill. He needed to continue with some of the functional tasks we'd discussed before, but I wanted to find other ways to motivate him to use his dominant arm. Maybe we just needed more time.

We discussed his gym program, including the use of free weights, which Mom reported he was now willing to use. I encouraged her to back off helping him with his activities of daily living, because having him do things independently would encourage the use of both hands. He should try getting out of bed and putting on his clothes by himself.

I suggested going back to playing ball with his niece and nephew, which they hadn't tried yet. And we discussed using snack 'treats' that he'd have to open with both hands (a bag of chips or small candy bar) as positive reinforcement for using both his hands during activities.

The following month, Kyle returned to physical therapy, and Mom was very happy to report that Kyle was no longer reporting pain and was involuntarily using his right arm regularly again. He was dressing himself, clearing the table, and eating with both his hands. Mom was thrilled to tell me that the things Kyle had lost interest in were all things he loved to do again—using his iPad, playing with his niece and nephew, dancing, and listening to music. Since our therapy goals had been met, and we had a home program in place, we decided to make that session Kyle's last. We spoke a little more about his strengthening program, and I discharged him from my care.

A few months later, I received an update from Kyle's mother. Kyle was using his right arm normally, and Mom was grateful for the patience, guidance, and care she and Kyle had received. She admitted she hadn't been sure physical therapy would be helpful in getting Kyle to where he needed to be. But she was so pleased she'd been wrong and Kyle was back to his old, playful, entertaining self again.

The following month, Kyle returned to physical therapy, and Mom was very happy to report that Kyle was involuntarily using his right arm regularly again... She was thrilled to tell me that the things Kyle had lost interest in were all things he loved to do again—using his iPad, playing with his niece and nephew, dancing, and listening to music.

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

This narrative is rich with examples of Casey's perseverance and ingenuity in helping Kyle re-gain use of his arm. Casey used Kyle's needs, preferences, emotional age, and abilities as the impetus for her treatment plan. And when Plan A didn't render the results she was hoping for, she re-assessed and went straight to Plan B. She knew motivation was the key to success, so she kept at it until she found the right combination of activities to sustain Kyle's interest and participation. Encouraging Kyle's mom to have Kyle engage in these activities at home only accelerated his recovery.

Thank-you, Casey.

Responding to feedback from the PLEN survey

—by Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development

The PLEN survey is one of the most important data-collection mechanisms employed by the Knight Center as it serves as a roadmap for new educational programs... The Center has completed its analysis of the data and developed a four-pronged response.

Many of you completed the Professional Learning Environment for Nurses survey (PLEN) earlier this year. The survey is conducted biennially to assess the learning needs of nurses and PCAs at all levels of the organization. It gives the Knight Nursing Center an opportunity to communicate directly with staff and solicit feedback about continuing education, professional development, and personal learning needs. The PLEN survey is one of the most important data-collection mechanisms employed by the Knight Center as it serves as a roadmap for new educational programs. In the June 22, 2017, issue of *Caring*, I reported on the results of the recent survey, and it's now my pleasure to announce that the Knight Center has completed its analysis of the data and developed a four-pronged response.

The first prong is a high-impact, day-long conference building on last year's Healthy Workplace Environment conference. The follow-up conference is being planned for March, 2018, and will address a healthy workplace through the lens of promoting staff safety and good health. An interdisciplinary planning group will develop the content based on relevant data and will address physical, emotional, and spiritual well-being.

The second prong is a return of the popular Skills Day. Skills Day was the single most requested activity, and we're pleased to offer this event that provides interactive skill stations so staff can hone their clinical technique. In direct response to the survey, stations related to emergency equipment, cardiac review, rhythm analysis, and physiologic monitoring will be offered as well as everyday skills, such as ceiling lifts and infusion pumps.

On-line learning is the third prong, which also supports the Knight Center's 2016-2018 strategic plan to develop, pilot, and evaluate educational innovations. 2018 is a nursing license-renewal year, so the Center will pilot four one-hour, self-directed, on-line courses. These courses will not be part of HealthStream; participants will need to register on-line and complete an entire course in order to receive continuing education credit.

The last prong, 'Knight Center favorites,' includes the most frequently requested courses such as the Preceptor Development Workshop, Disrupting Disruptive Behavior, Transforming the Team, Why Can't They Stop, and numerous cardiac-themed sessions. These and our core offerings, such as Pain-Management, Wound Care, and Peer Review, are currently being scheduled for 2018.

Many courses offered through the Knight Center are inter-disciplinary, and all members of the MGH community are welcome. Also, many courses qualify for continuing education credit toward nursing re-certification and license renewal. For more information, call Gino Chisari, RN, director of the Knight Center, at 3-6530. Go to the Knight Center website at: www.mghpcs.org/knightcenter for a full listing of educational offerings or to register for courses.

Our journey to transparent classification has begun

Transparent classification is a process by which information in eCare is electronically mapped to the various patient-classification and activity indicators in AcuityPlus. It will be implemented across all seven Partners facilities. as part of Partners 2.0

Question: Did we recently upgrade our AcuityPlus methodology?

Jeanette: That's correct. As you know, the AcuityPlus application is a valid, research-based acuity tool used to measure patients' needs for nursing care and has been used at MGH for more than 35 years. The system allows us to measure nursing workload on inpatient and ED observation units, and that information is used to develop our staffing budgets each year. The methodology is updated every 5-7 years to adjust for broad changes in patient populations and patient care delivery models. At the end of April 2017, MGH upgraded to Inpatient Methodology 2.1 which is the latest methodology from the vendor, Harris/Quadramed.

Question: I heard we'll be using *e*Care documentation to classify patients soon.

Jeanette: You're referring to 'transparent classification.' Transparent classification is a process by which information in *e*Care is electronically mapped to the various patient-classification and activity indicators in AcuityPlus. The benefit of transparent classification is that staff will no longer have to manually select indicators to classify patients—their clinical documentation will automatically (transparently) classify patients based on the patient's medical record.

Question: That sounds great. When do we start?

Jeanette: Transparent classification is a multi-faceted project that will be implemented across all seven Partners facilities as part of our Partners 2.0 initiative. Having all Partners facilities on the same electronic health record was the first step on the road to transparent classification. The Partners Nursing Acuity Council, which has been in place since 2007, has already started an initial assessment in preparation for mapping indicators. Finally, a project manager from the Partners *e*Care team will be assigned soon. We hope to be able to move to transparent classification in the next 18–24 months.

Question: Will staff be involved in the transition?

Jeanette: We always welcome input from staff nurses, our front-line users, and units are already participating. We recently kicked off a unit-based Acuity Auditor initiative whereby unit staff serve as auditors to ensure that *e*Care documentation is supporting the selected indicators. This ensures the tool is reliable (used the way it was intended to be used and used consistently). Unit-based auditors help us accomplish two important goals:

- ensure that clinical documentation in *e*Care supports selected indicators
- identify inconsistencies in clinical documentation so we can put a plan in place to ensure more consistent documentation

For more information about our transition to transparent classification, contact Antigone Grasso, director of PCS Management Systems and Financial Performance at 617-724-1649.

Excellence Every Day...

...with pom-poms!

Scenes from Excellence Every Day Rally. Complete with MGH cheerleaders, the event provided information on the upcoming Magnet and Joint Commission visits. Clockwise from top left: Marianne Ditomassi, RN; Colleen Snydeman, RN; Melissa Joseph, RN; Brian French, RN; and Gino Chisari, RN. Below: Kate Benacchio, RN (left), and Trisha Zeytoonjian, RN. At left (l-r): cheerleaders, Jasmine Gonzalez, RN; Christine Marmen, RN; and Abby Blair, RN.

(Photos by Michelle Rose)

Announcements

Collaborative Governance

Applications are now being accepted for collaborative governance, the formal, multi-disciplinary decision-making structure of Patient Care Services.

To learn more about collaborative governance, or to download an application, go to: www.mghpcs.org/IPC/Programs/Governance.asp, or contact Mary Ellin Smith, RN, at 617-724-5801.

Applications are due November 6, 2017.

Fall Reunion Educational Program

MGH Nurses' Alumnae Association

Friday, September 22, 2017
8:00am–4:30pm

O'Keeffe Auditorium

"The Opioid Epidemic, Addictive Disorders, and Treatment"

5.5 contact hours
Cost $40

For more information, call Sheila Burke, RN, clinical educator, at 617-726-1651.

ACLS classes

Two-day certification program
Day one:
November 2, 2017
8:00am–3:00pm

Day two:
November 3rd
8:00am–1:00pm

Re-certification (one-day class):
October 11th
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.

Blum Center Events

Thursday, September 21st

"Can Medication Management and 12-Step Programs for Substance Use Disorders Co-Exist?"

Laura Kehoe, MD, and Christopher Shaw, RN, discuss these beneficial programs.

Monday, September 25th

"Where are We Now? Updates on the MGH Substance Use Disorders Initiative"

Sarah Wakeman, MD, and Marti Kane provide an update on this innovative program.

Thursday, September 28th, 11:00am–12:00pm
Haber Conference Room

"There is Treatment; Treatment Works"

Georgia Stathopoulou, associate clinical director of the West End Clinic, will explain treatment options, andhow to choose the right treatment. A panel of patients will share their experiences.

Friday, September 29th

"When the Community is the Patient: Coming Together around Prevention"

Join Sarah Coughlin, LICSW; Sylvia Chiang; and Jennifer Kelly, LCSW, for a talk about community coalitions in Charlestown, Revere, and Chelsea, including:

- strategies to improve community conditions, systems, and policies
- strengthening protective factors and decreasing risk factors
- increasing access and resources for successful treatment and recovery from substance use disorders

Programs are free and open to MGH staff and patients.
No registration required.
All sessions held in the Blum Patient & Family Learning Center from 12:00–1:00pm unless otherwise specified.

For more information, call 4-3823.

Pharmacology update: the impact of the opioid epidemic on our patients and our practice

Tuesday, October 17, 2017
5:00–7:00pm
Partners Healthcare Assembly Row Conference Center

A two-hour workshop for nursing and physician-assistant professionals who want to learn about the current scope and implications of the opioid crisis on patient care and delivery.
Faculty: Jessica Moreno, PharmD, and Samantha Ciarocco, LICSW.
Sponsored by the MGH Institute of Health Professions.

For more information, call 617-724-6674.

MGH Patient Safety Culture Survey begins this month

The Edward P. Lawrence Center for Quality & Safety invites you to 'speak up' and take the Patient Safety Culture Survey later this month. Literature shows a positive correlation between high safety-culture scores and improved outcomes such as fewer medication errors, lower burn-out, and higher morale.

The questionnaire takes about ten minutes and is anonymous. Understanding staff's perceptions of safety allows us to reinforce and foster our culture throughout the institution. Results of the survey will be shared with leadership in order to facilitate improvement. Candid responses are encouraged.

Thank-you for your participation. Please complete the survey when you receive the e-mail from independent vendor, Pascal Metrics (support@pascalmetrics.com), with the subject line: "MGH/MGPO Safety Culture Survey."

Look for the survey coming soon. For more information, contact Vickie Stringfellow at 617-724-3597, or Jana Deen at 617-724-3075.

Pharmacology update XII: innovation and evidence

Saturday, October 14, 2017
O'Keeffe Auditorium
7:50am–3:10pm

Course will feature sessions on intravenous antibiotics, vaccines, legal intoxication by abuse of prescription drugs, medications for sleep, GI/bowel disorders, and eyes.

Free to MGH employees
Partners employees: $100 per day
Non-Partners employees: $150 per day

For more information, call the Norman Knight Nursing Center at 617-726-3111.

Point-of-Care Ultrasound for Advanced-Practice Providers

October 21, 2017
7:30am–5:30pm
MGH Institute of Health Professions
2 Constitution Road, Boston

Learn point-of-care ultrasound techniques through hands-on, case-based scanning on live models in facilitated small groups during this one-day workshop, building from beginner to intermediate skill level.

Participants will achieve a basic understanding of the application of point-of-care ultrasound in ambulatory clinical settings.

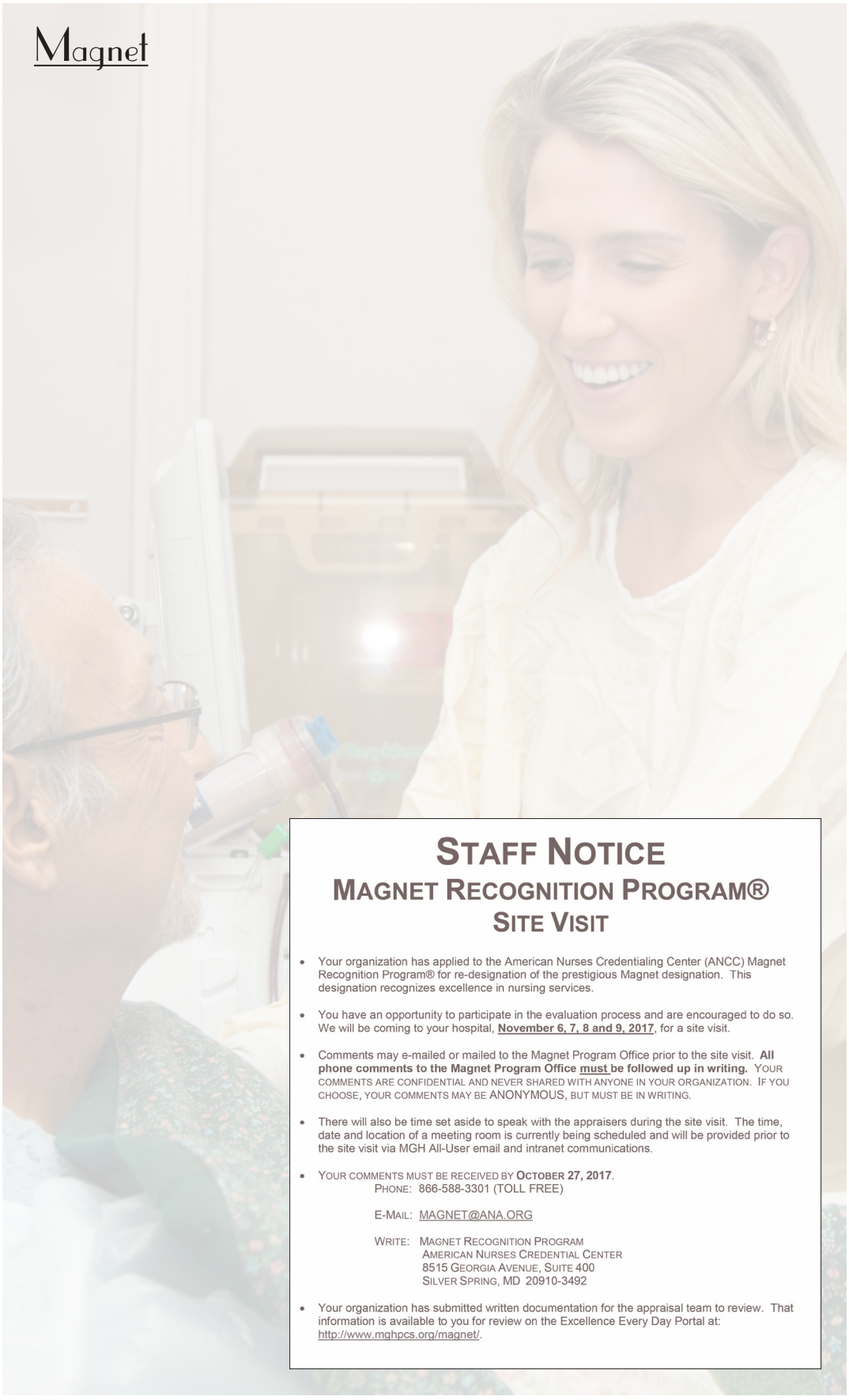
8.0 Nursing contact hours
12.0 AAPA category 1 CME credits

Full Day: $750
Fee includes: pre-workshop on-line education, course materials, light breakfast, lunch, refreshments, and snacks.

Deadline for registration is September 15th

For more information or to register, go to: http://info.mghihp.edu/ultrasoundcourse, or call 617-724-6674.

Magnet



STAFF NOTICE

MAGNET RECOGNITION PROGRAM®

SITE VISIT

- Your organization has applied to the American Nurses Credentialing Center (ANCC) Magnet Recognition Program® for re-designation of the prestigious Magnet designation. This designation recognizes excellence in nursing services.
- You have an opportunity to participate in the evaluation process and are encouraged to do so. We will be coming to your hospital, **November 6, 7, 8 and 9, 2017**, for a site visit.
- Comments may e-mailed or mailed to the Magnet Program Office prior to the site visit. **All phone comments to the Magnet Program Office must be followed up in writing.** YOUR COMMENTS ARE CONFIDENTIAL AND NEVER SHARED WITH ANYONE IN YOUR ORGANIZATION. IF YOU CHOOSE, YOUR COMMENTS MAY BE ANONYMOUS, BUT MUST BE IN WRITING.
- There will also be time set aside to speak with the appraisers during the site visit. The time, date and location of a meeting room is currently being scheduled and will be provided prior to the site visit via MGH All-User email and intranet communications.
- YOUR COMMENTS MUST BE RECEIVED BY **OCTOBER 27, 2017**.
  PHONE: 866-588-3301 (TOLL FREE)
  E-MAIL: MAGNET@ANA.ORG
  WRITE: MAGNET RECOGNITION PROGRAM
  AMERICAN NURSES CREDENTIAL CENTER
  8515 GEORGIA AVENUE, SUITE 400
  SILVER SPRING, MD 20910-3492
- Your organization has submitted written documentation for the appraisal team to review. That information is available to you for review on the Excellence Every Day Portal at: http://www.mghpcs.org/magnet/.

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Submissions
All stories should be submitted to: ssabia@partners.org
For more information, call: 617-724-1746

Next Publication
October 5, 2017

Inpatient HCAHPS

Current data

HCAHPS Measure	CY 2016	CY 2017 Year-to-date (as of 8/21/17)	% Point Change
Nurse Communication Composite	83.0%	84.2%	↑ 1.3
Doctor Communication Composite	82.6%	84.6%	↑ 2.0
Room Clean	71.2%	72.2%	↑ 1.0
Quiet at Night	49.9%	53.0%	↑ 3.1
Cleanliness/Quiet Composite	60.5%	62.6%	↑ 2.1
Staff Responsiveness Composite	64.9%	67.4%	↑ 2.5
Pain Management Composite	72.8%	73.7%	↑ 0.9
Communication about Meds Composite	65.8%	67.3%	↑ 1.4
Care Transitions	61.0%	62.4%	↑ 1.4
Discharge Information Composite	91.9%	93.0%	↑ 1.1
Overall Hospital Rating	81.9%	82.9%	↑ 1.1
Likelihood to Recommend Hospital	89.8%	91.1%	↑ 1.3

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

Data is complete through the end of June with partial data through August. All scores remain higher than 2016, and we're ahead of our goal to improve by 1 percentage point for Quiet at Night and Staff Responsiveness.

Caring Headlines
September 21, 2017

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