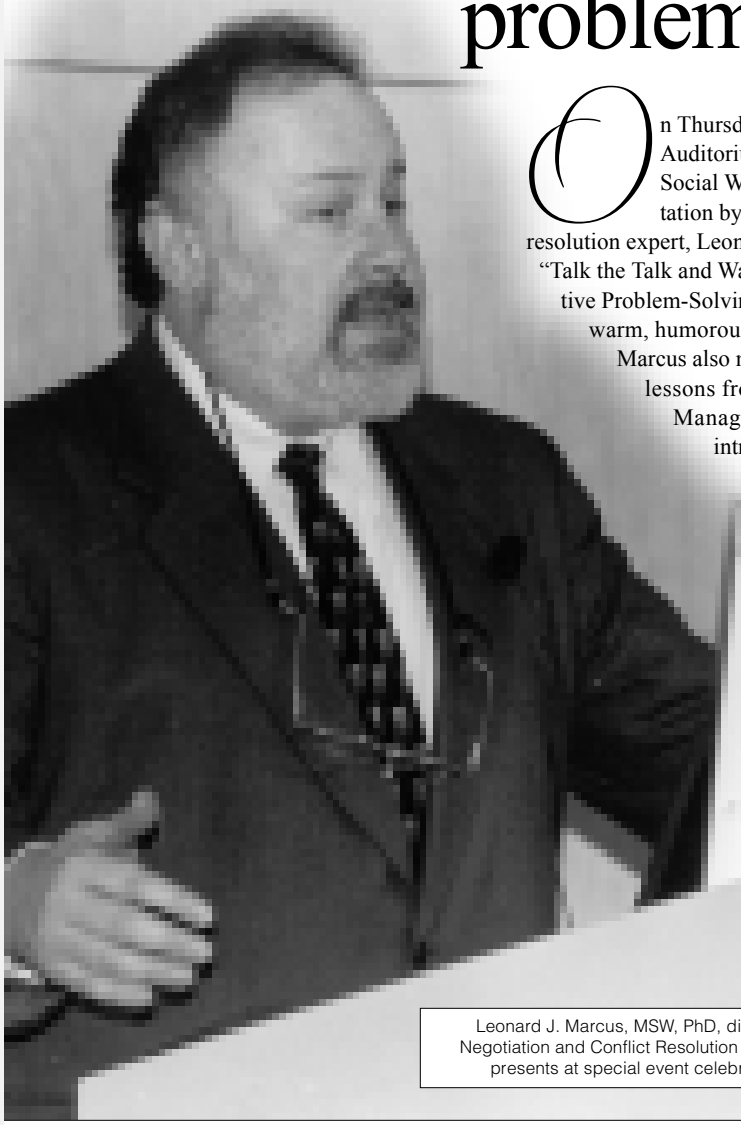
April 4, 2002

Caring HEADLINES

Inside:

Social Work event spotlights collaborative problem-solving



On Thursday, March 21, 2002, in O'Keeffe Auditorium, MGH celebrated National Social Work Month with a special presentation by nationally acclaimed conflict-resolution expert, Leonard Marcus, MSW, PhD, entitled, "Talk the Talk and Walk the Walk: Tools for Collaborative Problem-Solving." In a presentation that was warm, humorous, passionate, and interactive, Marcus also managed to cram in countless lessons from what he called, 'Conflict Management 806,' (not your basic introductory course).

Defining conflict as 'an expressed difference between two or more people,' Marcus observed that conflict management is a growing field that is being applied in such diverse arenas as business, sports, international relations, divorce proceedings, legal disputes, violence prevention, and community-building. It is especially relevant in health care because we practice in a rapidly-changing, problem-solving en-

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Leonard J. Marcus, MSW, PhD, director of Program for Health Care Negotiation and Conflict Resolution at Harvard School of Public Health, presents at special event celebrating Social Work Month, 2002.

MGH

Working together to shape the future

FAQS about The PCS Clinical Recognition Program

As we begin to roll out the PCS Clinical Recognition Program, we are hearing many good questions from staff, questions that help us clarify our goals as we embark on uncharted territory. I'm thrilled that you have brought your questions forward because it shows there is respect and understanding for what we are trying to achieve.

Before I address your questions, I want to announce that the transitional review board for The Clinical Recognition Program has been appointed. This board is charged with reviewing portfolios received during the initial submission phase and recognizing those clinicians currently practicing at the advanced-clinician and clinical-scholar levels. Members of the transitional review board represent all disciplines participating in The Clinical Recognition Program. They are:

- Kristin Parlman, PT
- Ann Jampel, PT
- Gae Burchill, OTR/L
- Tessa Goldsmith, SLP
- Lillian Ananian, RN (co-chair)
- Barbara Cashavelly, RN
- Susan Tully, RN
- Mary Ellin Smith, RN
- Beth Nagle, RN
- Evelyn Bonander, MSW
- Ann Daniels, LICSW (co-chair)
- Bob Kacmarek, RRT
- Dan Chipman, RRT

As I said, there have been many questions. For space reasons, I'll address the most frequently asked questions here.

Question: Is seeking recognition at the advanced-clinician or clinical-scholar level mandatory?

Jeanette: Seeking recognition at the advanced-clinician or clinical-scholar level is voluntary. The decision is up to you.

Question: I have never written a narrative and am not sure how to begin. Are resources available to help me?

Jeanette: A guide to writing narratives can be found in the Clinical Recognition Program resource packet on your unit. This guide is also available on-line at http://pcs.mgh.harvard.edu. If you would like someone to work with you on writing a narrative, speak to your manager or director or members of your clinical leadership team. They will be able to offer guidance or help you identify another clinician who has expertise in this area.

Question: Is it possible to skip levels in the program?

Jeanette: Yes. Each clinician is recognized at the level at which he or she consistently practices.

Question: How are individuals who are practicing at the clinician level rewarded?

Jeanette: All clinicians in Patient Care Services are expected to perform at the clinician level after an appropriate period of orientation (the length of orientation varies according to each clinician's needs.) Practice at the clinician level represents a level of excellence that is valued and rewarded by our current systems. These systems include our salary and benefits package, opportunities for certification, tuition reimbursement, participation in collaborative governance, and eligibility for professional awards.

Question: Is there a limit to the number of advanced clinicians or clinical scholars a unit can have?

Jeanette: No. Recognition is based on each clinician's individual practice. A unit or department may have many clinicians at the advanced-clinician or clinical-scholar level, or it may have none.

Question: Can operations coordinators or other non-clinical people write letters of support?

Jeanette: Operations coordinators, patients, families, and others are important members of the care team. However, non-clinicians are not able to assess all aspects of a clinician's role. For this reason, only professional clinicians are eligible to write letters of support.

Question: How does The Clinical Recognition Program differ from our annual performance appraisal?

Jeanette: The annual performance appraisal is designed to address how well an employee fulfills specific responsibilities, such as getting to work on time, providing competent care, or working as a member of a team.

The Clinical Recognition Program challenges clinicians to look more closely at their practice, including their relationships with patients and families and their in-depth expertise in a particular area. Where a performance appraisal is a way to document that a

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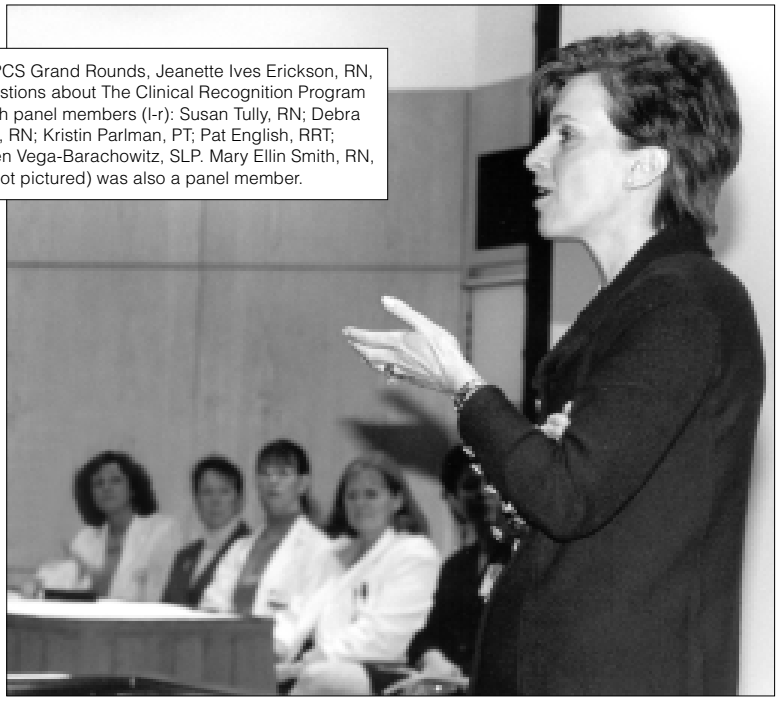


At recent PCS Grand Rounds, Jeanette Ives Erickson, RN, fields questions about The Clinical Recognition Program along with panel members (l-r): Susan Tully, RN; Debra Burke, RN; Kristin Parlman, PT; Pat English, RRT; and Carmen Vega-Barachowitz, SLP. Mary Ellin Smith, RN, (not pictured) was also a panel member.

Jeanette Ives Erickson

continued from previous page

clinician is fulfilling basic job responsibilities, The Clinical Recognition Program is an opportunity for clinicians to be recognized as their practice develops over time.

Question: Why do I have to defend my practice before a review board?

Jeanette: It's important to stress that you will be *presenting*, not *defending,* your practice to the review board. The review board plays an essential role in maintaining the integrity of the recognition process.

Clinicians are asked to present information about their practice both in writing (through their portfolio) and in an interview with members of the board. Presenting information in writing and through dialogue helps ensure that the board understands the full range of a clinician's practice. Some individuals are more comfortable communicating in writing, while others prefer interactive discourse.

Question: What kind of questions will the board ask? How should I prepare?

Jeanette: Prior to your interview, all members of the board will review your portfolio. Three members of the board will participate in your interview (one of who will be a member of your discipline). The interview gives clinicians a chance to more fully describe their practice. It gives the board a chance to gain deeper understanding of your practice and ask questions about your portfolio. The interview should take approximately 30 minutes. Compiling your portfolio and reflecting on your practice is all the preparation you will need.

Question: Will experienced clinicians be 'grandfathered' into the program?

Jeanette: The Clinical Recognition Program offers clinicians a chance to have important dialogues with their manager or director about their practice. If clinicians were grandfathered (automatically advanced) into the program, they would miss this opportunity for growth and development. And as I said earlier, recognition is not based on years of experience.

Question: Are clinicians eligible for recognition at the advanced-clinician or clinical-scholar level if they have a record of frequent absenteeism?

Jeanette: Excessive absenteeism is an example of something that should be addressed by managers and directors through a performance appraisal. Absenteeism can affect a clinician's opportunity for recognition, particularly if it adversely affects the clinician's practice and relationships with patients and colleagues. Absenteeism will be one of the many factors considered when managers and directors decide whether to endorse a clinician for recognition.

Question: Why would the board deny an application for recognition?

Jeanette: The board may deny recognition if, through your portfolio or interview, you cannot demonstrate consistent practice at the level you are seeking. Perhaps you have not yet achieved that level of practice, or perhaps you didn't adequately support the criteria through your portfolio and interview.

If recognition is denied, you will receive a letter from the board explaining their decision. You will be offered an opportunity to meet with a member of the group that interviewed you to discuss their conclusions. If the reasons for denial can be readily addressed, you may reapply for recognition the following month. If the board feels you have not achieved a particular practice level, the letter will provide you with information about how to develop your practice to be ready to re-apply in the future.

Question: A colleague has asked me to write a letter of support for her portfolio. I don't think I can endorse her practice at the level she is seeking. I don't want to jeopardize our relationship, but I don't want to be dishonest. How should I handle this?

Jeanette: Ask your colleague if her manager or director has endorsed her plan to seek recognition (endorsement by the manager or director is required at the advanced-clinician and clinical-scholar levels). The manager or director may have similar reservations and advise your colleague to develop certain areas of practice before applying for recognition.

If the clinician does have the endorsement of her manager or director, advise her that you need to review the recognition criteria to ensure you can write a strong letter of support. If you feel you can't fully endorse your colleague's practice, explain why. If she still wants you to write a letter, write one that reflects only what you know to be true. That way, you have been honest, and it's up to her whether or not to include your letter in her portfolio.

As we move forward with the roll-out of The Clinical Recognition Program, we will continue to challenge ourselves to create a system that is fair and meaningful. Your input and feedback will be an important part of the process. Portfolios are now being accepted for the PCS Clinical Recognition Program.

Update

I'm pleased to announce that Charles Ciano accepted the position of operations coordinator for Ellison 14 and officially joined our team last month.

Welcome Charles.

Call for Portfolios

PCS Clinical Recognition Program

The Patient Care Services Clinical Recognition Program is now accepting portfolios for advanced clinicians and clinical scholars. Beginning May 1st, portfolios may be submitted on the first of each month, and decisions will be made within three months.

Refer to the http://pcs.mgh.harvard.edu/ website for more details and application materials, or speak with your manager or director.

Completed portfolios should be submitted to The Center for Clinical & Professional Development on Founders 6.

For more information, call 6-3111.

April is Occupational Therapy Month

—by L. Jane Evans, OTR/L, clinical service coordinator, Occupational Therpay

The profession of Occupational Therapy (OT) has been around since 1917, yet many consumers and medical professionals still don't understand the scope of our service. Just the name, 'Occupational Therapy,' confuses some people. In OT, 'occupation' refers to those activities that are meaningful to an individual within the environment he or she lives and functions. Occupational therapy addresses skills for the job of living. Everyone performs daily activities that give definition to their life. These activities include personal care, work tasks, and play activities. For you it may mean driving a car, or working in the garden. To another person it might be cooking, using a computer, or playing an instrument. Every day, people of all ages experience physical and/or psychological problems that may affect their ability to manage their daily lives. From an infant born with a birth defect, to a young man who sustains a work injury, to an elderly person diagnosed with multiple sclerosis, their ability to perform daily functional tasks is affected. Occupational therapy helps restore function and/or helps individuals adapt to their disability and promote independence.

Occupational Therapy, like all healthcare professions, has been challenged to meet the needs of an increasingly older population and to keep pace with the medical advancements that impact the treatment of our patients. At MGH, 28 occupational therapists provide services in the inpatient and outpatient settings, including clinical specialties in pediatrics, neonatal, burn care, and hand and upper-extremity rehabilitation.

Our inpatient teams cover all ICU and general-care units, including Neurology, Orthopedics, Cardiac, Medicine, Trauma and Surgery. Following evaluation of a patient's physical and functional abilities, occupational therapy is designed to help restore function, educate patients and their families, and provide critical information regarding appropriate discharge planning. OTs address issues such as coordination, muscle strength, vision, and memory deficits, since all these factors impact a person's ability to safely perform activities of daily living.

(Above): senior occupational therapist, Colleen Lowe, OTR/L, performs soft-tissue and joint mobilization with patient, John Lee. (Below): Lowe works with patient, Angel Serrano, on the BTE machine simulating activities of daily life and work.

The outpatient OT Department has nine board-certified hand therapists, who primarily treat traumatic and post-surgical hand injuries. Outpatient OT also provides wound care, custom splinting for protection or function, edema control, scar management, and therapeutic exercise to improve the use of injured extremities. Outpatient clinicians are skilled at body mechanics and ergonomic assessment to help prevent work-related or instrument-related injury.

Occupational Therapy services are extended to the pediatric outpatient population by an occupational therapist certified in sensory integration. We provide comprehensive developmental assessment of infants and children up to age 18. Children who have difficulty with motor skills, writing, attending, or performing age-appropriate self-care tasks may be appropriate referrals.

The outpatient OT Department provides ongoing therapy to individuals suffering from functional limitations related to neurological, orthopedic, general medical conditions, or diagnoses such as stroke, arthritis, or Parkinson's disease.

OT services are also available at the MGH Revere Health Center.

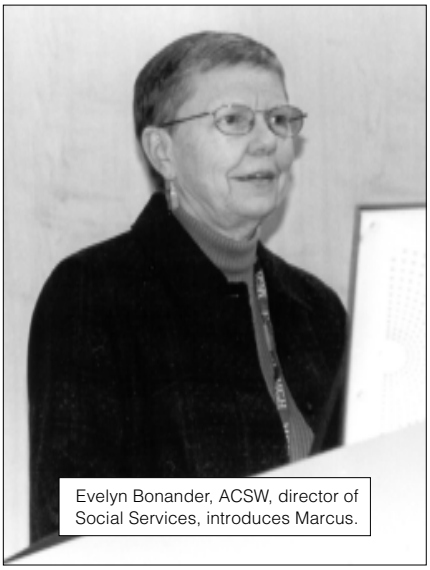
The Occupational Therapy office is located on the first floor of the WACC. For more information about Occupational Therapy and the services they provide, call 724-0140, or visit the educational display booth April 10th and 11th in the Main Corridor.

Social Work Event

continued from front cover

vironment. We juggle complex issues and shoulder high-consequence responsibilities. We interact with individuals of many different backgrounds, values, and cultures. It is imperative that we be able to resolve differences quickly and equitably for the sake of our patients.

In a particularly illuminating demonstration of the importance of cooperation, Marcus asked audience members to assume an 'arm-wrestling' position with the person next to them. He



Evelyn Bonander, ACSW, director of Social Services, introduces Marcus.

then instructed participants to push their partner's hand down as many times as possible in 30 seconds. While some audience members engaged in a traditional arm-wrestling battle of strength, others saw this as an opportunity to work together, collaboratively pushing each other's hands down as many times as possible in 30 seconds.

Said Marcus, "Do you see how much progress we can make when we shift from a 'me against you' perspective, to an 'us working together' perspective?"

Marcus spoke about what he called, 'a walk in the woods' approach to conflict resolution. He explained that the approach is based on an actual event that took place during the now-famous Geneva peace talks when US and Soviet leaders were going head-to-head at the negotiating table, and making no progress. It wasn't until they left the table and went for an informal walk in the woods that they started to communicate in a meaningful way. They began to talk about each other's interests instead of positions, which led to a decision to support, rather than oppose, each other.

Audience members, Mary Connolly, RN (left), and Alice Rotfort, MSW, participate in 'arm-wrestling' exercise as part of a demonstration conducted by Marcus. Ann Daniels, LICSW, clinical director of Social Services (back left) is also pictured.

Marcus suggests that we all 'take a walk in the woods' when it comes to managing conflict. He suggests a process that begins with stating (and listening to) each other's interests.

The next stage is an enlarged view of the problem that involves seeing each other's perspectives, seeing the problem as a multi-dimensional challenge.

From there, both parties move to an enlightened view where all interested parties brainstorm ideas, present alternatives, offer creative solutions. Your imagination, says Marcus, is the greatest asset at this stage.

These ideas should lead to a place of aligned interests where parties can agree to move forward based on mutual gains. This is where we re-define success in a way that allows us to proceed in agreement.

And this whole process leads to a solution that is mutually satisfactory, or as Marcus described it, "When you succeed, I succeed; and when I succeed, you succeed."

Using this approach, said Marcus, working together instead of against each other, it's possible to exceed the expectations of both negotiating parties.

The most important things to remember when trying to resolve conflict are to be flexible, ask questions, and *listen*.

2002 Oncology Nursing Career Development Award

The Oncology Nursing Career Development Award recognizes professional staff nurses for meritorious practice. The award provides financial assistance for continuing education.

Nominees must be MGH registered nurses functioning at the staff level in the inpatient or outpatient setting. He or she must:

- be a registered nurse
- provide direct patient care
- demonstrate consistent excellence in delivering care to patients with cancer
- serve as a role model to others in the profession
- demonstrate a commitment to professional development.

Nomination packets may be obtained from Joan Gallagher by calling: 6-2551.

Only completed nominations will be considered. All nominations should be received no later than May 24,2002.

Patience, understanding and expertise: a winning combination for OT patient

Carol Mahony, OTR/L
occupational therapist

My name is Carol Mahony, and I have been an occupational therapist for 20 years, 13 at MGH. I specialize in the treatment of hand and upper-extremity injuries, and am a board-certified hand therapist.

Will was involved in a motor vehicle accident with a van while riding his bicycle. He lost consciousness and had multiple traumatic injuries which required surgeries. He had a left open wrist fracture, a left wrist joint disruption, a right hip fracture, a right fifth metacarpal fracture, a right femur fracture, a right tibial fracture, and he had lacerated the extensor tendons of his right ring and little fingers. He had spent four months in a rehabilitation hospital. At two months, he developed a right compartment syndrome (extreme pressure on the right forearm), which required immediate release, forearm decompression, and removal of dead muscles around the wrist and finger flexors of his right hand.

I first met Will four months after his accident. He had been discharged from the local rehabilitation hospital and was ready for outpatient physical and occupational therapy. He was still using a wheelchair and was unable to do simple activities of daily living. Prior to his injury, Will had been a construction worker, a husband, and a father of three young, home-schooled children. He was a reformed alcoholic and had some psychosocial difficulties. During his inpatient hospitalization, his father died, which was very difficult for Will.

Will presented many immediate challenges in our fast-paced outpatient hand clinic. On his first visit, he seemed very anxious. He felt sensitive to the light and noise in the clinic. He spoke rapidly and loudly and was very fearful. His worries spilled out about his future, his family and his health, and he wanted me to provide comfort for his fears. He started to cry uncontrollably. I quickly moved Will into a private space to help him feel less anxious, safer and calmer. It was difficult for me to reassure him about his future. I couldn't predict how independent he would become or how much his emotional state would affect his progress. I realized that my limited ability to immediately and honestly address his fears about the future was making Will more anxious. I redirected our conversation and provided Will with small tangible goals that we could address right now. This helped to refocus Will, gave him more control, and helped him feel less overwhelmed.

After our initial visit, I knew I would need support and collaboration from the MGH community. I contacted Social Services for psychosocial intervention and to help Will find a primary care physician. They responded quickly. Both Will and his wife met with Social Services to help determine what support the family needed and what medication might help Will function better at home and in therapy. With these supports in place, I felt I could better focus on Will from an occupational-therapy perspective. What was Will able to do now? What was his prior functional level? What was his prior emotional status? What activities, exercises, manual therapy, or splints could I provide to help Will functionally and emotionally? What were realistic goals?

Will's dominant right hand had little functional movement, initially. His finger and wrist flexors were shortened, tight, and contracted into his palm due to his compartment syndrome. He also had median and ulnar nerve damage, which resulted in an intrinsic palsy and very limited coordination. His left hand and wrist were well healed but stiff and painful. Both upper extremities had significant weakness and stiffness. He very reliably wore his dynamic splints and followed his exercise programs. I worked with Will on mobilizing his fingers, wrists, and forearms bilaterally. I helped him stretch his right long finger and wrist flexors, desensitize a left sensory radial nerve neuroma, and provided activities to gradually increase coordination and strength. Will and I continued to meet privately as he had difficulty controlling his tears and would quickly become very anxious and overwhelmed. Over the following month, Will's tears became less frequent and he became more comfortable.

Will's orthopaedic care was divided among several surgeons. Multiple physician appointments created some confusion for Will. I spoke to the well-known hand surgeon who decompressed his right compartment syndrome, and he readily agreed to manage all of Will's bilateral extremity issues. Consolidating Will's orthopaedic hand care helped further reduce his anxiety and confusion.

Will's physical therapist and I coordinated Will's appointments and met informally on a bi-weekly basis to discuss Will's progress, inform each other of new functional, surgical, or family events and provide each other with support.

Will's physical deficits were challenging. I was able to use hands-on techniques to stretch out joint and tendon limitations and desensitize painful areas. However, the greatest challenge in working with Will was supporting him emotionally through the physical work ahead. Will needed a lot of support, limit-setting, and refocusing from me. What always surprised me, though, was Will's spirit. However troubled he was at times, he always seemed to rise to meet his physical and emotional challenges. He would come in and proudly report that he was able to make pancakes for the family. Each new functional

continued on next page

The i-Bridge human resources and payroll system

The Fielding the Issues section of Caring Headlines *is an adjunct to Jeanette Ives Erickson's regular column. This section gives the senior vice president for Patient Care a forum in which to address questions presented by staff at meetings and venues throughout the hospital.*

Question: I've noticed that the look of our pay stubs has changed. What is the reason for that change?

Jeanette: Human Resources has implemented a new data-processing and time-reporting system called, *i-Bridge*. One of the changes that came with this new system is the design of your paycheck, which now provides more information about your benefits and deductions.

Question: Who can I call if I have a question about my check?

Jeanette: If you have questions about your pay, benefits, and other work-related matters, you should speak with your manager, or contact your Human Resources generalist.

Question: Why does my Long Term Disability (LTD) insurance appear to cost more?

Jeanette: The cost of LTD insurance is based on an employee's weekly salary of standard hours including hourly rates of pay and permanent shift differential. The old system charged for LTD based solely on the employee's standard hourly rate. So if your weekly rate without differentials equals $300 for a 40-hour week, and your weekly pay with differentials equals $364, you now pay for and receive LTD based on your true salary of $364.

Question: Why is my overtime rate just a bit higher than my hourly rate and not time-and-a-half?

Jeanette: The overtime rate is a composite of the hourly rate and differential (night, evening). Your hourly take-home pay is based on the composite rate (usually higher than your hourly rate) and does equal time-and-a-half.

Question: I recently had to go to the Payroll Office to pick up a manual check and was asked for my work group number. What is a work group number, and how do I know which work group I'm in?

Jeanette: Your work group number is a number that has been assigned to your manager and timekeeper. There is a document that can help you determine the number of your work group. You can find this document in the Payroll Office, or speak to your manager or timekeeper.

Question: My pay stub reflects my marital status as single, but I've been married for years. How do I correct this?

Jeanette: If you're married, but have requested that your tax deductions be taken at the higher, single rate; then your pay stub reflects your tax status as single (not your marital status).

Question: How can I make changes to my direct-deposit status?

Jeanette: You should continue to use the paper direct-deposit form to make changes to your direct deposit status. This form can be dropped off in the Payroll Office on Clinics 1. The *i-Bridge* system will soon have an "Employee Self Service" function, which will allow you to make this change electronically via a computer in your work area or at designated locations in the hospital. You'll also be able to update your personal information (address, phone number, emergency contact, etc.) when the "Employee Self Service" function becomes available.

Question: My year-to-date ET/ESL accruals and ET taken appear to be incorrect. How can I make sure that my ET/ESL balance is correct?

Jeanette: Your new pay stub reflects the amount of ET/ESL you have accrued and/or taken since the beginning of the year. For tracking purposes the year began on 12/23/01 (because you were paid for that week on 01/03/02). While some errors have been identified, Human Resources is working closely with Payroll to correct all errors. In most cases, even when problems occurred with the time accrued and time taken balances, the actual amount that appeared in the ET/ESL end balance was correct.

If you have questions about your earned time account, please contact your Human Resources generalist.

Exemplar

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achievement propelled him on to master new tasks.

Over the next several months, Will freely conversed with everyone in the hand clinic. He made remarkable progress, both functionally and emotionally. When we completed occupational therapy, Will had nearly full range of motion in both arms, good strength, and was able to return to work as a union supervisor in construction. He felt that, "it was a miracle." Will was loud, had emotional swings, and was impulsive. But he was also positive, funny, responsive, and motivated.

Working with Will was both challenging and rewarding. His anxiety, fear and confusion presented a significant threat to his recovery. But working closely with other MGH caregivers, we were able to reduce these impediments. Consistently providing support, structure, and direction allowed Will to focus on his own rehabilitation and not become immobilized by anxiety and fear. I was amazed at Will's resiliency and his ability to overcome obstacles, and I was very glad I was able to help guide and assist him in his recovery.

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

When Carol first met Will, he looked at the road ahead as one big insurmountable obstacle. Carol broke that obstacle down into smaller, individual, achievable goals. Her understanding that Will's therapy would not be effective until his emotional issues were addressed contributed to the postive outcomes Will was able to achieve.

Carol continued to advocate for Will by arranging to have his care coordinated by just one physician, thereby improving communication and continuity. Carol ends her narrative by recognizing Will's courage and resiliency. But I think this narrative paints a picture of mutual admiration and respect.

Thank-you, Carol.

International Day on Big 11: something for everyone!

(At left): Nejoua Elhirech, USA, demonstrates traditional Moroccan tea service; (above): Kitman Tsang, RN, enjoys the festivities; (right): Patrick Baldassaro, Nutrition & Food Services, partakes of international fare.

Organizer of Bigelow 11 International Day, operations associate, Rosaura Martinez (center), is flanked by co-workers (l-r): Michelle Ciaramaglia, RN; Nadia Faiz, USA; Andrea Annelli, RN; Nejoua Elhirech, USA; and Chantalle Alcante, RN. All (except Martinez) are in traditional Moroccan dress.

Bigelow 11 operations associate, Rosaura Martinez, and her co-workers had long talked about having a special event to celebrate the diverse cultures and traditions of staff on their unit. One day, Martinez stopped talking and started planning, organizing, and coordinating a special International Festival complete with music, traditional native dress, and food representing cultures from all over the world, including: Italy, Ireland, Iran, Honduras, Morocco, the Dominican Republic, Mexico, and Barbados.

Martinez invited everyone on her unit and extended the welcome to friends and co-workers on other units and other departments including Nutrition & Food Services, who donated a number of delectable dishes for the occasion.

On Monday, March 18, 2002, with the full support of nurse manager, Eileen Flaherty, RN, the efforts of Martinez and her co-workers culminated in a memorable day of fun, food, and festivities. Says Martinez, "Everybody had a great time, but it was more than just fun; it was an opportunity to get to know each other and learn about the customs and traditions of the people we work beside every day. I think it may become an annual event on our unit."

Incident reports: an opportunity to advance quality and safety

On Thursday, March 14, 2002, in O'Keeffe Auditorium, director of the MGH Office of Quality and Safety, Joan Fitzmaurice, RN, PhD, presented, "Incident Reports: a Component of Performance Improvement," as part of Nursing Grand Rounds.

Joan Fitzmaurice RN, PhD, director, MGH Office of Quality and Safety, presents at Nursing Grand Rounds

Fitzmaurice observed that, "Human beings make mistakes. Experienced people, smart people, even expert clinicians make mistakes. We're all well-intentioned individuals trying to do the right thing, but accidents happen." She stressed the importance of filing incident reports whenever a situation arises that isn't consistent with routine care or the routine operation of the hospital.

Said Fitzmaurice, "Incident reports give us an opportunity to embark on non-punitive investigations to gather information that will help improve systems to avoid future incidents. We need to think of incident reports as portals through which we learn about our practice, identify opportunities for improvement, and implement measures to monitor and sustain our quality-improvement initiatives."

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Call for Art work!

The annual Children & Healthcare Week Art Fair is scheduled for the week of April 21–May 3, 2002. Original art work should be submitted to Ellison 1705 no later than Wednesday, April 17th.

Artists may use pencils, crayons or paint on 8.5x11 paper. All entries should inlcude the child's name, age, school, and phone number.

For more information, call 4-5720

The Employee Assistance Program

presents

"Single Parenting"

Presented by
Ann Fishel, PhD, director,
Adult Couples and Family Therapy

A growing number of women and men are raising children alone. This seminar will explore the challenges of daily life as a single parent and provide practical suggestions on how to succeed. Age-specific advice for parenting children at various stages of development will be provided.

April 11, 2002
12:00–1:00pm
Wellman Conference Room

For more information, call 726-6976.

Nursing Green!

Are you a nurse interested in protecting the environment and reducing our negative impact? Come participate in a new nursing "green" group.

First meeting: April 9, 2002—3:45pm
Blake 8 Conference Room

For more information, e-mail: rhorr@partners.org.

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How medical interpreters are trained, hired, and evaluated

—By Andrea Beloff, administrative fellow

MGH has always been committed to providing the highest quality care to our patients, but a new state law has heightened awareness about the availability of interpreters to non-English speaking patients. MGH Interpreter Services is committed to providing around-the-clock access to trained medical interpreters for all patients.

There's a lot more to becoming a medical interpreter than just speaking a second language. It requires special skills and training.

All medical interpreters at MGH have a minimum of two years of healthcare experience and linguistic skills in English and (at least) one other language. Beyond being able to converse in another language, they are trained and proficient in the ethics of interpreting, and are knowledgeable about specialized medical terms and concepts. Medical interpreters document encounters and always maintain a professional demeanor.

In order to become a staff or freelance medical interpreter at MGH, candidates must take a preliminary test to assess their oral and written language skills and their understanding of anatomy and medical terms. If they pass, they attend an orientation session where they learn hospital and department policies and review MGH interpreting guidelines. Following orientation, candidates spend at least 8 hours shadowing a medical interpreter during patient encounters. They undergo a comprehensive assessment to test their accuracy, retention, note-taking skills, and sight and written translation abilities. The assessment also evaluates their ability to respect other cultures. If candidates succssfully complete all of these prerequisites, they may be hired as part of the MGH medical interpreters team. Interpreters are reassessed annually to ensure that all competencies are mainteined.

Most medical interpreters work full time as professional medical interpreters, either as members of the MGH staff or as free-lance interpreters at MGH and other Boston-area hospitals. All medical interpreters are members of the Massachusetts Medical Interpreters Association. Because of their diverse perspectives on different cultures, interpreters are in a unique position to help caregivers understand the impact that culture can have on patients' understanding of, and compliance with, their plan of care.

This year, MGH interpreters started attending an intensive certification program offered through Cambridge College. The one-year program is one of only a few in the country that focuses specifically on medical interpretation.

With this rigorous training and evaluation process, the MGH Office of Medical Interpreters is confident that its staff is providing the very best interpreter services to the MGH community.

The Office of Interpreter Services is open weekdays from 7:00am–midnight, and weekends from 10:00am–10:00pm. Not all interpreters are present when the office is open, so requesting an interpreter in advance is strongly recommended.

During office hours, call 726-6966 to request an interpreter. After hours, call 724-5700 and enter:

- 3-0001 for a Spanish interpreter
- 3-0003 for a Portuguese interpreter
- 3-0005 for an Arabic interpreter
- 3-0009 for all other languages and authorization to use the telephone services.

Look for, "Tips on how to work effectively with medical interpreters," in the May 2nd issue of *Caring Headlines*.

Chinese medical interpreter, Elsa Yee, assists Dr. Ethan Korngold to communicate with patient, Yang Zhong, about his plan of care.

When/Where	Description	Contact Hours
April 16 and 17 8:00am–4:30pm	**Pain Resource Champion Day** Holiday Inn, 5 Blossom Street	TBA
April 18 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
April 18 10:00–11:30am	**Social Services Grand Rounds** "The essentials of Psychotropic Medicine." For more information, call 724-9115.	CEUs for social workers only
April 18 8:00am–4:30pm	**Preceptor Development Program: Level I** Training Department, Charles River Plaza	7
April 22 8:00am–4:30pm	**Kaleidoscope of Pediatric Care: Thought-Provoking Dilemmas** Wellman Conference Room	TBA
April 22: 7:30am–4:30pm April 23: 7:30am–4:30pm	**Intra-Aortic Balloon Pump Workshop** Day 1: New England Medical Center. Day 2: (VBK601)	14.4 for completing both days
April 23 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
April 24 8:00am–2:30pm	**New Graduate Nurse Development Seminar II** Training Department, Charles River Plaza	5.4 (contact hours for mentors only)
April 25 8:00–11:15am	**Intermediate Arrhythmias** Haber Conference Room	3.9
April 25 12:15–4:30pm	**Pacing : Advanced Concepts** Haber Conference Room	5.1
May 2 8:00am–4:30pm	**Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other** Wellman Conference Room	7.2
May 2 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
May 2 1:30–2:30pm	**Nursing Grand Rounds** O'Keeffe Auditorium	1.2
May 7 9:00am–4:30pm	**Management of the Burn Patient** Bigelow 13 Conference Room	6.9
May 8 8:00am–2:30pm	**New Graduate Nurse Development Seminar I** Training Department, Charles River Plaza	6.0 (contact hours for mentors only)
May 8 1:30–2:30pm	**OA/PCA/USA Connections** "September 11th and Diversity: Our Journey, Our Values." Bigelow 4 Amphitheater	- - -
May 8 5:30–7:00pm	**Advanced Practice Nurse Millennium Series** "The Role of Reflective Practice in Advanced Practice Nursing." O'Keeffe Auditorium	1.2
May 13 8:00am–3:30pm	**Continuous Renal Replacement Therapy** (an offering of the ICU Consortium), St. Elizabeth's Medical Center	TBA
May 14 7:30–11:30am, 12:00–4:00pm	**CPR—American Heart Association BLS Re-Certification for Healthcare Providers** VBK 401	- - -
May 14 8:00–12:00am	**Pediatric Advanced Life Support (PALS) Re-Certification Program** VBK601	TBA

For more information about any of the above-listed educational offerings, please call 726-3111.
For information about Risk Management Foundation educational programs, please check the Internet at http://www.hrm.harvard.edu

Patient and Family Learning Center: a nice place to visit

Michael D. O'Connor, librarian,
Patient and Family Learning Center

The Blum Patient and Family Learning Center (PFLC) celebrated its third anniversary last month. Since its opening on March 1, 1999, the PFLC has provided medical information to the public in simple, understandable language and easy-to-read, illustrated formats.

Patients, family members, visitors, and staff come to the PFLC to obtain information in the form of books, pamphlets, and videos, to access the Internet, send e-mail, or tap into the expertise of the on-site medical librarian or patient education specialist. Trained volunteers are also on hand to assist visitors in their search for appropriate information.

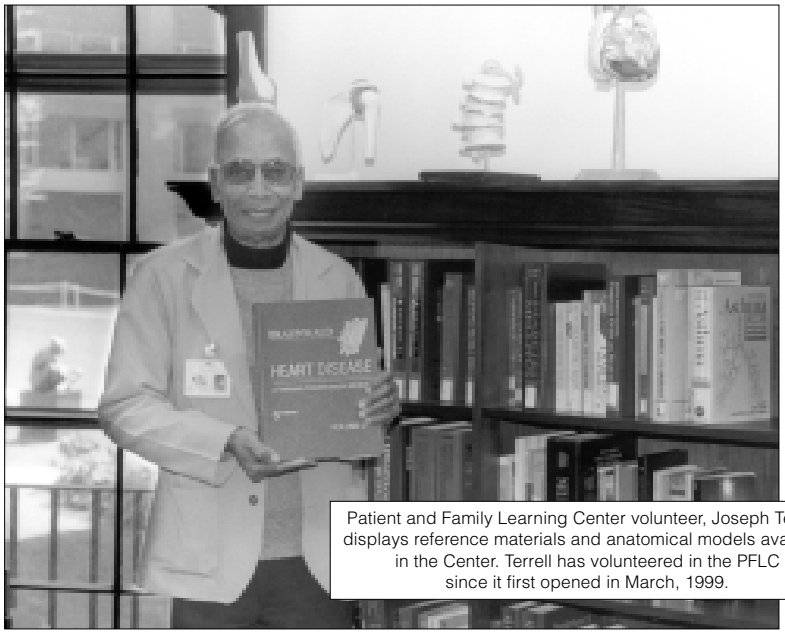
The number of people taking advantage of this valuable resource has steadily increased since day one. In 1999, the PFLC averaged 40 visits per day. Today, almost 100 people visit the PFLC every day. Many are repeat visitors who are familiar with the services, friendly atmosphere, relaxed surroundings, and convenient location.

In an ongoing effort to ensure that the PFLC is 'all-user-friendly,' a new teen resource link was recently added to its homepage. This is the first in a series of outreach projects geared toward specific populations. And the already popular children's area is also being re-designed.

This year, a special network was established between MGH and other resource centers within the Partners community to foster communication and a sharing of best practices.

If it's been a while since your last visit to the PFLC, drop by and see how it's changed. Staff and volunteers are happy to give you a tour.

The Blum Patient and Family Learning Center is located on the Main Corridor at the head of the stairway to the Eat Street Café. For information, call 724-7352.



Patient and Family Learning Center volunteer, Joseph Terrell, displays reference materials and anatomical models available in the Center. Terrell has volunteered in the PFLC since it first opened in March, 1999.

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