

Caring

August 5, 2004

HEADLINES

Workplace Education Program celebrates achievement

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On June 25, 2004, the MGH community came together under the Bulfinch tent to celebrate the accomplishments of employees enrolled in the MGH Workplace Education Program. For almost a decade, the hospital has contracted with Jewish Vocational Services to provide English classes for support employees whose primary language is not English. More than 100 MGH

support staff including many unit service associates from countries around the world attend classes twice a week from September through June to learn and practice English. *continued on page 5*

—by Mary McAdams, RN, clinical educator



Unit service associate, Leila Okaf of the OR, reads her original composition during Workplace Education Program Celebration of Achievement

Quality, patient-centered care go hand in hand

Mo no one appreciates more than health-care providers the interdependent relationship between quality and patient-centered care—in a hospital setting, one does not exist without the other. At MGH, our commitment to both is unwavering.

As co-chair of the MGH Quality & Safety Strategic Planning Committee, along with Gregg Meyer, MD, and Brit Nicholson, MD, we are involved in a number of programs and initiatives geared toward improving and enhancing patient care. The initiative I want to talk about today is the Planetree model, a truly holistic approach to health care that has been adopted by many hospitals across the country who are committed to

providing the best in patient-centered care.

A planetree (or sycamore tree) is the kind of tree Hippocrates, the founder of modern medicine, sat under when he taught medical students centuries ago. The Planetree philosophy, which came into being in the late 1970s, encourages healing in all dimensions of the human experience—mental, emotional, spiritual, social, and physical. In addition to conventional treatments, the Planetree model embraces an approach to mind-body healing that encompasses complementary therapies, access to nature and art, pleasing architectural designs and facilities, and a belief that every person, regardless of role, plays an important part in pa-

tient care and has the ability to influence the hospital experience for patients and families.

As a national leader, MGH is committed to a culture of continuous learning and an ongoing quest for best practices in the delivery of patient care. Toward that end, the Culture & Education Committee (a subcommittee of the Quality & Safety Strategic Planning Committee), chaired by Susan Edgman-Levitan, executive director of the Stoeckle Center for Primary Care Innovation, and Georgia Peirce, director of PCS Promotional Communications and Publicity, is embarking on a series of site visits to hospitals that have successfully adopted a culture of quality and safety. Their first visit



Jeanette Ives Erickson, RN, MS
senior vice president for Patient Care

was to Griffin Hospital in Derby, Connecticut, on June 18, 2004.

The multi-disciplinary team that visited Griffin Hospital was comprised of a variety of staff and role groups throughout the hospital, including:

- Kiki Benjamin, RN, pediatric staff nurse
- Melanie Cassamas, project manager, Service Improvement
- Jeff Cooper, corporate director, Partners Biomedical Engineering
- Theresa Gallivan, RN, associate chief nurse
- Sheila Golden-Baker, RN, clinical educator
- Adele Keeley, RN, nurse manager
- Gregg Meyer, MD, medical director, MGPO
- Greg Pauly, administrative director, Primary Care
- Georgia Peirce, director of director of PCS Promotional Communications and Publicity
- George Reardon, director of Systems Improvement

- Pam Ressler, parent
- Mike Stone, manager, Coffee Central

Members of the delegation were asked to lend their ‘eyes, ears, mind, imagination, and invaluable perspective’ to the visit. Each person was given a packet containing background information about the Planetree model and a copy of the book, *Putting Patients First: Designing and Practicing Patient-Centered Care*. They were asked to ‘set aside assumptions,’ observe carefully, and absorb whatever they could about what goes into creating a culture of quality and safety.

A report is being generated to share the team’s observations with the Strategic Planning Committee, but some of their preliminary impressions were very illuminating. MGH visitors to Griffin Hospital were immediately struck by the welcoming physical environment: soft lighting, carpeted hallways, quiet

continued on next page



MGH delegation visits Griffin Hospital in Derby, Connecticut

Acceptable and unacceptable abbreviations in medical records

Question: Why is it important to avoid using certain abbreviations, symbols, and dose designations when documenting in medical records?

Jeanette: JCAHO and others have found that certain abbreviations, symbols, and dose designations contribute to medication errors. One of the National Patient Safety Goals put forth by JCAHO focuses on the effectiveness of communication among caregivers. A provision of this goal requires hospitals to standardize a list of abbreviations, acronyms, and symbols that should not be used.

Question: A list of unacceptable abbreviations and acronyms was implemented last year. Is this list being expanded?

Jeanette: The JCAHO established a, "minimum list of dangerous abbreviations" this year. MGH has already implemented some of these abbreviations. Several new ones have been added to our list to ensure compliance to this safety goal. Some of the new unacceptable abbreviations include:

- Instead of QD and QOD, write out 'daily' and 'every other day'
- Instead of D/C for discharge or discontinue, write out 'dis-

charge' or 'discontinue'

- Instead of MS, MSO₄, and MgSO₄, write out 'morphine sulfate' or 'magnesium sulfate'
- Instead of HS for bedtime or half-strength or, write out 'bedtime' or 'half-strength'

Question: Is the use of unacceptable abbreviations prohibited in all documentation?

Jeanette: The use of prohibited abbreviations applies to all handwritten and free-text, electronic, clinical documentation. Provider Order Entry is being updated to reflect these changes.

Question: Is there a list of 'acceptable abbreviations' that can be used at MGH?

Jeanette: MGH no longer maintains a master list of acceptable abbreviations. Abbreviations used by more than one department may have different meanings to different clinician or employee groups. Abbreviations should be understandable to a diverse cross-section of clinicians and employees and make sense in the context of the medical-record entry. If there is a possibility of confusion by others, the word should be spelled out. The meanings of commonly accepted abbreviations can be found at <http://www.pharmallexicon.com> (no spaces).

Question: Where can I find out more about this policy?

Jeanette: The policy, "Abbreviations: Appropriate Use to Prevent Errors," can be found in the on-line *Clinical Policy and Procedure Manual*, which can be accessed through Partners Handbook. Pocket-sized cards containing the list of unacceptable abbreviations have been distributed (and may be used as guides at computer terminals, too). For more information or to receive more cards, contact Janet Madigan, project manager, PCS Information Systems at 6-3109.

Jeanette Ives Erickson

continued from previous page

music, picturesque courtyards (complete with bird sanctuaries). There was an official 'greeter' at every door. A lullaby played over the public address system every time a new baby was born, heralding the arrival of a new life.

Team members reported feeling a palpable sense of patient-centeredness as they toured the hospital. Unit-based waiting rooms had been replaced by resource centers and reading rooms that were easily accessible to patients and family members. Patient-

and family-education began immediately upon admission and continued throughout discharge planning, ensuring that family members had the knowledge and skills to care for patients at home after discharge.

The Griffin Hospital visit was a great opportunity to see the Planetree model 'in action.' As we continue to work to create a culture of quality and safety at MGH, we will be exploring many new and innovative ideas. We will bring our own considerable knowledge and expertise to the table while open-

ing our minds to new strategies and new approaches to providing high-quality, patient-centered care.

Quality and safety are not static issues; they change as society and the world around us change. For as long as we strive to deliver the best possible care to our patients, we will continue to strive to learn more about improving the quality and safety of our systems and our environment. As one educator and philosopher put it, "The wisest man has something yet to learn."

New column

I will keep you informed of the work of the Quality & Safety Strategic

Planning Committee and initiatives from the Office of Quality & Safety. I also want to inform you about an upcoming addition to *Caring Headlines*. Because quality and safety are such a vital focus of our daily work, beginning on September 2, 2004, *Caring Headlines* will carry a new, regular column dedicated to quality and safety topics. Each column will offer valuable insights into patient-safety issues, trends, research, and stories in the news. I encourage you to take the time to read and share this information with your colleagues, and feel free to suggest ideas for future topics. For more information

about this new column, contact Georgia Peirce at 4-9865.

The DNC

As this issue of *Caring Headlines* goes to print, we're just days away from the beginning of the Democratic National Convention. We're starting to see real signs of how day-to-day activities in and around the hospital will be affected. I have the utmost confidence that MGH employees will rise to the occasion, as they always do, and meet this challenge with the grace and professionalism that have become the hallmark of this great institution.

Fiore, Pierson receive Durante Award

It was the sixth annual presentation of the Susan and Arthur Durante Awards for Exemplary Care and Service to Cancer Patients. This year's recipients, Anne Fiore, RN, nurse practitioner at the Center for Sarcoma and Connective Tissue, and Barbara Pierson, oncology financial counselor, were honored at a ceremony in O'Keefe Auditorium on June 3, 2004.

Susan and Arthur Durante established the Respite and Relaxation Fund in the mid 90s when Arthur was a patient at MGH. The fund provides two \$1,000 awards to be given annually to MGH staff who demonstrate exceptional care and service to cancer patients. The Durantes had many opportunities to witness the impact of these positive interactions on the patient experience, and it was in that spirit that they established this award. The award continues to be presented by Susan Durante in honor of her husband, who passed away in August of 2000.

The presentation ceremony on June 3rd was an opportunity to celebrate the life of Arthur Durante and recognize the outstanding care and service provided by both Fiore and Pierson.

Colleagues who nominated Fiore described

her uncanny ability to coordinate the many aspects of care required for this complex patient population. One patient wrote, "Thank-you for taking the time to show you care." If you asked Fiore, she'd tell you that patient care is her passion.

Pierson works with patients in the Cancer Center who require assistance with insurance coverage. Sarah Kurker, LICSW, the social worker who nominated Pierson, wrote, "Barbara goes above and beyond her job description in helping our patients. She

—by Julie Goldman, RN,
professional development coordinator

treats every patient with respect and values where they're coming from. She meets with them in person and on the phone and relieves their tension while walking them through the process of getting insurance."

The MGH community is grateful to the Durantes for establishing this award that recognizes the invaluable contributions of clinical and support staff in caring for cancer patients. For more information about the award, contact professional development coordinator, Julie Goldman, RN, at 4-2295.

Educational Offerings available on-line

The Center for Clinical & Professional Development lists educational offerings on-line at: <http://pcs.mgh.harvard.edu>

For more information, or to register for any program, call the Center at 6-3111.

The Employee Assistance Program presents Training for Managers and Supervisors

Learn how the Employee Assistance Program can help with behavioral health, mental health, and substance-abuse concerns. Join us for a presentation that will include case studies and discussion. Participants will be given tools to help with time-management, stress-reduction, and staying focused on work.

**Thursday, September 7, 2004
8:00-9:30am
Burr 3 Conference Room**

For more information, contact the EAP at 726-6976.



Susan Durante (center) with award recipients, Barbara Pierson (left), and Anne Fiore, RN

(Photo by Paul Batista)

Workplace Education Program

continued from front cover

MGH president, Peter Slavin, MD, delivered the keynote address in which he expressed pride in MGH employees who manage to balance work and family obligations while attending English classes. Slavin shared that his own ancestors had come to the United States from Eastern Europe by way of Ellis Island and that they, too, struggled to learn English in their new country. Slavin called MGH employees, “our most valuable asset,” and described the Workplace Education Program as exemplary. “The effort you make,” said Slavin, “improves patient care and makes MGH a better place to work.”

Student representatives, Florentina Spinola and Omar Merino, presented Slavin with a copy of the 2004 Workplace Education Program Yearbook that had been signed by every student in appreciation for Slavin’s support of the program.

A now-traditional highlight of the annual ceremony is the reading of compositions by student representatives from each class. This is an opportunity to showcase the hard work and progress made by students at all levels of the program.

Says Amarilis Pina, unit service associate in the Surgical Intensive Care Unit (SICU), “The MGH Workplace Edu-

cation Program was the best thing that could have happened to me.” Pina credits the support she received from her volunteer tutor, Nancy Hiller, and the staff of the SICU for the courage to go on. Because of her improved ability to read and write English, Pina recently graduated from the Red Cross Nursing Assistant Program, passed the state CNA exam, and will soon begin training as a patient care associate on Ellison 12.

Jeff Davis, senior vice president, Human Resources, expressed thanks to all the managers of employees enrolled in the Workplace Education Program for their continued support in helping our employees improve their English skills. Special recognition was given to the dedicated faculty of the

Jewish Vocational Services and Jane Ravid, the lead instructor for the program.

For more information or to enroll in the MGH

Workplace Education Program, please call or e-mail Jane Ravid (4-3976). Registration is currently open for classes beginning in September.



Above: unit service associate, Majouba Chanaf of White 11, reads her composition to the gathering.



At left: students from various classes of the Workplace Education Program listen as classmates read their compositions.

For more information about the MGH Workplace Education Program, call 4-3976.

Listen, comfort, support: 'tools of the trade' for clinical social worker

My name is Marilyn Wise and I have been a social worker at MGH for 19 years; I've worked in the MICU (Medical Intensive Care Unit) for 12. Although most of our patients improve and recover from their injuries, I often work with families of patients who are critically ill and may die with little warning. For these families, it seems especially important to be there to listen and bear witness at such intimate times.

My pager went off that morning as I headed toward my office. It was the MICU. It's not unusual for the MICU to page me, but a page that early in the morning generally signals something urgent and troublesome.

When I answered the page, the nurse explained that Kate, who was 45 years old, had been admitted overnight from a small community hospital. She was experiencing major complications following gastric bypass surgery she'd had several weeks earlier. She was admitted to our MICU on a ventilator, her kidneys beginning to fail. She had been given multiple medications to help maintain her blood pressure and address a fever and systemic infection. I'm not a nurse or a doc-

tor, but I knew this was a bad situation. The nurse added that the patient's fiancé, David, had been in the waiting room all night and was alone. I grabbed my folder and headed for the MICU. I knew very little about Kate at this point, but I thought about how it must be for her and her fiancé that an elective medical procedure that was supposed to improve her life had resulted in such a terrible turn of events. I felt afraid for her.

I knew Kate would be sedated, but I worried for her fiancé who would be vividly experiencing this event. It troubled me that he was here by himself. Times like these are hard enough when shared

with family and friends. I wanted to hear from him how events had led them here. I wanted to learn what would help. I wanted him to know he wasn't alone.

After speaking briefly with Kate's nurse, I went to see Kate. She was sedated and appeared comfortable despite

her deteriorating condition. I found it sad and frustrating that I couldn't speak directly to her to learn who she was in her own words.

I headed for the waiting room. David was sitting by himself; his face seemed drawn and tired. I suspected he'd been crying. I introduced myself and asked if he wanted to talk. He seemed quite eager to have someone's ear. I suggested we go to a smaller room within the main waiting area for more privacy. He seemed grateful for a quiet moment to collect his thoughts. I asked him to tell me what happened, starting with what he thought was the beginning of the story. And then I listened.

David began with Kate's decision to have gastric bypass surgery after years of struggling with her weight. As he spoke, I sensed he was struggling with the 'what ifs,' and that he felt guilty for not having 'talked her out of it.' I explored this with him, and he concurred that he was



Marilyn Wise, LICSW
clinical social worker

feeling like he should have been able to do something to prevent this. We talked about how we can be there to support others and be sounding boards, but we can't ultimately change what others do or want. He agreed she had made a well-thought-out decision and felt better about herself after the surgery. I watched the sadness deepen as he talked about the difference between what she had hoped for and what she now faced, but his sense of responsibility for this seemed to have lightened. He spoke of how unfair life events can be no matter how well thought out they are. He was even able to remark that he felt good that he had been there for her from the time she made the decision until now. When I asked, he confirmed that although she hadn't signed a health care proxy, she did tell him what she wanted should 'anything go wrong.' We both appreciated the sad irony of that discussion.

I wondered with David how life had been for them before all these medical issues began. I wanted him to know it was important to me to learn more about who they were as individuals and as a couple. He seemed pleased that I wanted to know who Kate was. He spoke lovingly of her warmth, strength, intelligence, independence, and the way she cared for others. He was proud that she had probably saved other women's lives through her work as a mammographer. I commented on the caring he conveyed as he spoke of her, and he seemed pleased that I could hear that in his words. He began to cry. I sat with him and made sure there were Kleenex nearby. I felt sad for them both and shared his fear of what might happen.

David slowly collected himself. He seemed comfortable talking with me about other important people in their lives and of the complications that

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".. from my experience, it's not unusual for family members to need very different things in times of crisis... being there for one another while also letting each other move through the experience as they need is a true gift."

Exemplar

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often exist long before a medical emergency occurs. I've learned to listen closely to these concerns as they can become inflamed by the raw emotions that arise during stressful times. I also ask about children who may be involved as they can benefit from age-appropriate supports, but that was not a concern for this family.

David spoke about the difficult time the couple had been having. They had recently moved back to New England from California to be closer to their families, to renew relationships, and 'mend fences.' As I gently explored this, David was able to explain that Kate's father had died while Kate was living out of state, and Kate's mother had never forgiven David for 'taking her away.' Now, he was concerned about how things would be when Kate's mother arrived at the hospital later in the day. I, too, was concerned being very aware that difficult decisions may need to be made and that Kate was facing a potentially poor outcome. I knew this could be particularly difficult for a family already dealing with conflict. It could result in a legacy of conflict rather than family members feeling they had supported one another and done all they could do for their loved one.

I let David know we all shared the common goal of wanting to help Kate; that we knew her condition affected all who were concerned; and that we would work closely with everyone to help. I added that from my experience, it wasn't unusual for family members to need very different things in times of crisis, that being there for one another while also letting each other move through the experience as they needed was a true gift. He seemed to appreciate this 'permission' to do what he needed to do and not have to monitor the needs of others. I wondered how it would be when Kate's mother arrived. Then, the doctor walked in.

I looked at David who sensed the gravity of the conversation we were about to have. I asked Kate's nurse to join us, and David seemed pleased, as did the nurse. The doctor described what they were doing to support Kate but let David know they still felt she might not survive the day. As the doctor spoke about the medical issues and interventions, I watched David's face. He seemed overwhelmed by all the information. I knew he was struggling with his emotions. I didn't want him to miss information he might wonder about later. I took the opportunity to ask David if this was the kind of conversation he had anticipated and whether he had any thoughts or questions he

wanted to share. This allowed the conversation to shift to an exchange of thoughts among all of us rather than simply a report from the doctor. Clearly, it was hard to hear how poorly Kate was doing, but the mutual exchange offered greater support to David. When the other caregivers left, I stayed to see

was coming to the hospital immediately. She was afraid for her daughter, but had thanked David for getting her to MGH. The potential for David to have added family support seemed to bolster him for what we both feared was inevitable. I inquired about his health to be sure there was nothing we should

them. But, for now, I spent some time seeing other patients while David sat with Kate and we awaited her mother's arrival.

It's hard on days like these to move from one patient to another, but the severity of each situation makes it that much more important to find a way to let each patient and family know they have my true attention. It's equally important to help families find ways to identify and draw on their own strengths and support each other when possible. This helps empower individuals in those situations that make us all feel so helpless.

It wasn't long before Kate's mom arrived. I introduced myself and asked if she wanted to see her daughter right away or speak with the doctor first. I thought it was important for her to let us know what she needed and when. She asked to see her daughter. I walked her to the room where we greeted David. I stayed long enough to introduce her to staff and provide support during her first few minutes with her daughter. I brought a chair into the room for her. After we all spoke for a few minutes, I asked if she'd like some time alone with Kate. David took my lead and offered to go to the waiting room. She accepted the opportunity to have some time alone with her daughter. Unfortunately, it wasn't long before the staff asked everyone to

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"It's hard on days like these to move from one patient to another, but the severity of each situation makes it that much more important to find a way to let each patient and family know they have my true attention. It's equally important to help families find ways to identify and draw on their own strengths and support each other when possible."

how David was doing. Though tearful again, he felt reassured that he had 'gotten her to the place where she had the best chance.' He worried again how it would be when Kate's mother arrived. I suggested we contact her and share the information we had just received. He agreed, and decided he should be the one to call. We went to my office so he could have more privacy. He called Kate's mother and other family members who, unfortunately, were too far away to come to the hospital. I waited outside the office so I could be available if he needed me.

The call to Kate's mom went better than David anticipated. She

be monitoring. I asked if he'd had anything to eat or drink. He'd eaten earlier, but had no appetite now. That wasn't unusual.

We headed back to the MICU. Tired as he was, it was clear he needed to be with Kate; and I needed to remain readily available, too. When we got to the unit, Kate's condition was fragile so we agreed to meet again when Kate's mom arrived. I was aware of how painful it is for a parent to see her child in this condition, no matter how old the child is. I anticipated she would need support and wondered how I'd make myself available to both of them if their past issues still presented a rift between

JCAHO implements new accreditation process

—reprinted from Compliance HelpLine

In January, 2004, JCAHO (the Joint Commission on Accreditation of Healthcare Organizations) launched an initiative aimed at improving the accreditation process. The initiative,

Virtually every element of the process has changed. No longer will the process hinge on a pre-announced, every-three-year, scheduled visit to the hospital with little contact in between

collection, measurement, and comparisons with other institutions. In fact, these requirements will continue to grow as more populations and disease groups are added. Hospitals will be required to perform periodic self-assessments of compliance to standards and prepare improvement plans where compliance is lacking.

The most dramatic change that will be seen by staff, though, is the survey process itself. JCAHO will attempt to evaluate hospital systems by focusing on individual patients and their total experience with the institution and caregivers. This is called the 'tracer methodology,' which involves surveyors following a number of patients from their point of entry into the hospital through planning for aftercare. The idea is to evaluate the adequacy of hospital systems (for pain-management, or the consent process, for example)

through the experiences of individual patients rather than looking at hospital policies or interviewing managers.

Patient safety will continue to be a strong emphasis and theme of the accreditation process. Observation and interviews will help surveyors measure levels of understanding and compliance during unannounced visits. It's clear that these changes aim to motivate institutions to be ever-ready for evaluation and to practice each day the important efforts to provide quality care.

The accreditation report will change, too,

ongoing discussion and reporting to JCAHO on a regular basis.

In the coming months, more information will become known about the impact of these changes. Newly organized standards are available online under Partners Applications, Clinical References, CAMH. The content of standards is much the same, but performance elements help staff translate concepts into real-life examples.

For more information, or if you have questions about these changes, please contact the MGH Compliance Office at 726-5109.

No longer will the process hinge on a pre-announced, every-three-year, scheduled visit to the hospital with little contact in between visits. The survey will now be unannounced.

ative, "Shared Vision: New Pathways," is an ambitious effort to make accreditation more meaningful, of more value to the public and organizations alike, and more accountable for improving the quality of patient care.

visits. The survey will now be unannounced. Hospitals will provide significant amounts of information about their services, volume and processes during the survey cycle. Hospitals will continue to participate in clinical data-

Patient safety will continue to be a strong emphasis and theme of the accreditation process. It's clear that these changes aim to motivate institutions to be ever-ready for evaluation and to practice each day the important efforts to provide quality care.

with different levels of achievement focusing less on numeric scores and more on identifying areas of accomplishment and areas that need improvement. The JCAHO sees the report as a 'living document' requiring

Reminder that 2003 survey results may be found on-line by going to the MGH Home page, selecting: "Link to Internal Resources," and then choosing: "JCAHO Website."

Caring HEADLINES

Back issues of *Caring Headlines* are available on-line.

Go to the Patient Care Services website at: <http://pcs.mgh.harvard.edu/> and click on 'Caring Headlines'

For assistance in searching back issues, contact Jess Beaham, web developer, at 6-3193

Exemplar

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leave. We used this time to meet again with the doctors.

As we met, I could feel the strain between David and Kate's mom. Still, they both shared the belief that Kate was most important at this moment. I brought this shared goal to the conversation. I remarked that it was helpful to Kate's care that she had family to speak on her behalf and be there for her. This seemed to allow Kate's mom to say that she was here for her daughter and to help David. She knew that he would know her wishes and supported his decisions. They both looked so sad, but each seemed to find relief in her comments.

I sat with David and Kate's mom as they talked about what might happen and what Kate would want. I asked them to share some thoughts about Kate from happier times, which led to a warm discussion of better days. There was some laughter and there were some tears, but for the time being David and Kate's mom had put their differ-

ences aside and found common ground.

Sadly, our conversation was interrupted when the doctor returned. He let us know that the medical situation had taken a very grave turn, that staff had done all they could for Kate, but they had been unable to save her. Grief flooded the room and, at that moment, words fell short. We just sat for what seemed a long time. It was David who spoke first, through his tears, wondering how this could have happened to someone so kind. We talked about how such events make so little sense to us. I listened for opportunities to offer comfort and support their efforts to support one another. I let them know how important their presence was and thanked them for sharing so much of who Kate was. When they were ready, we walked back to Kate's room where they had some private moments with her. (They declined clergy, as that had not been part of Kate's life.)

Sometimes, people have a hard time separating from these moments, especially when things happen so suddenly. After a while, I gently suggested it might be time. They seemed grateful for the subtle prompting, and we walked to the waiting room. We talked about what Kate had wanted in the event of her death, and both family members seemed comforted by the fact that they knew Kate's wishes and didn't have to guess. We spent time again reflecting on how kind and generous Kate had been. I let them know I thought she must have been a special person to have in-

spired so much love from them. This brought soft smiles to their mournful faces. As they prepared to leave, I reminded them that I was here if they had any questions or thoughts in the coming days. Before leaving, they each gave me a hug, thanked me, and asked me to thank the other staff members who had been involved. It seemed so sad to me, as it always does. Yet, I felt good that I, along with other staff, had been able to provide support for this patient and her family. I also hoped that, just maybe, one of Kate's legacies would be one of mended fences.

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

This wonderful narrative describes the complex family dynamics that often come into play as families and patients try to cope in times of crisis. As an experienced social worker, Marilyn listened to David, she took the time to gain an understanding of David and Kate both as individuals and as a couple. She assisted David in seeing his guilt about not deterring Kate from her decision to have surgery, and helped him overcome it. The difficult relationship between David and Kate's mother was skillfully addressed as Marilyn acknowledged their mutual concern and the central role they both played in Kate's life. Marilyn's presence and support allowed them to find common ground in their desire to honor Kate's last wishes.

And Marilyn's 'job' didn't end when Kate died. As David and Kate's mom left the hospital, Marilyn let them know that she would continue to be available if they needed her. We should all be so lucky to have someone like Marilyn by our side at times of crisis.

Thank-you, Marilyn.

Let's Connect a discussion group for heart-failure patients

Are you feeling overwhelmed, apprehensive, or confused about your diagnosis?

Join us in a forum for sharing experiences, ideas, and hearing the perspectives of others.

**August 12, 2004
3:00pm
Murphy Conference Room
Bigelow 8**

Topics for discussion will be determined by attendees

For more information: call 726-7592

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Please recycle

Sumner develops teaching tool

Laura Sumner, RN, clinical educator in The Center for Clinical & Professional Development, developed a teaching tool in the form of a crossword puzzle that was published in the book, *Instant Teaching Tools for the New Millennium*, in the chapter entitled, "Instant Tools for Mandatories."

Briggs, Cox publish in Critical Care Nurse

Susan Briggs, MD, and Erin Cox, RN, vascular clinical nurse specialist, published, "Disaster Nursing: New Frontiers in Critical Care," in the June, 2004, issue of *Critical Care Nurse*.

Edwards presents locally, nationally

Annabel Edwards, RN, nurse practitioner for the MGH Pain Center, presented, "Case Presentations in Pain," to the American Society for Pain Management Nursing (ASPMN) Eastern Massachusetts chapter on April 28, 2004.

Edwards presented, "Cancer Bone Pain," at the Annual Conference of the American Society for Pain Management Nursing (ASPMN) on March 20, 2004; and, "Conducting a Neurological Examination: Correlating Findings with Treatment Planning," (with colleagues) on March 19, 2004.

Binda, Gallagher, Joyce, and Tenhover present at Oncology Nursing Conference

Katie Binda, LICSW, director of the HOPES program; Joan Gallagher, RN, clinical nurse specialist; Eileen Joyce, LICSW, thoracic-oncology social worker; and Jennifer Tenhover, RN, nurse practitioner, presented a poster focusing on, "Complementary Therapies..." at the Oncology Nursing Society Conference, April 29–May 2, 2004. The same poster was presented at the Association of Oncology Social Work conference on May 14th in Washington, DC.

Daniels receives Excellence in Supervision Award

Ann Daniels, LICSW, interim director of Social Services, was presented with the prestigious Excellence in Supervision Award recently at the Simmons School of Social Work centennial celebration.

Sinsheimer participates in HMS Forum

Judith Sinsheimer, LICSW, participated in the Harvard Medical School Genetic Disorder Discussion Forum on May 5, 2004, discussing Huntington's disease from a medical, genetic, and psycho-social perspective.

Dungan, Joyce, and Lucas present in Washington, DC

Sheryn Dungan, LICSW, clinical social worker in the Palliative Care Service; Eileen Joyce, LICSW, thoracic-oncology social worker; and Michele Lucas, LICSW, neuro-oncology social worker, presented their poster, "When Does Care End: Providing Bereavement Care in Cancer Centers," at the Association of Oncology Social Work (AOSW) on May 14, 2004, in Washington, DC.

Social Service staff present at Meeting of the Profession

Several Social Service staff presented at Symposium 2004: The Meeting of the Profession, sponsored by the Massachusetts chapter of the National Association of Social Workers (NASW), April 15 and 16, 2004.

Carol McSheffrey, LICSW, offered a pre-symposium intensive on, "Working with Couples: New Ideas and Old Challenges."

Sandy McLaughlin, LICSW, and Chuck McCorkle, LICSW, spoke on, "AIDS 2004: Challenges, Risks, and Opportunities."

Ellen Feldman, LICSW, presented, "Working with Couples Undergoing Assisted Reproductive Technology."

Fredda Zuckerman, LICSW, joined colleagues from other area hospitals to describe a new project aimed at identifying best practices in, "To See or Not To See: Pregnancy Loss Interventions."

Pittman Promoted

Taryn Pittman, RN, patient education specialist and manager of the Blum Patient & Family Learning Center, has been promoted to the rank of captain in the United States Naval Reserves Nurse Corps.

The promotion recognizes her outstanding leadership in service to our country.

Griffith, Larkin present at University of Rochester

Catherine Griffith, RN, clinical nurse specialist on Blake 8, and Mary Larkin, RN, certified diabetes educator in the Diabetes Center, presented, "More Than Just a Journal Club: A Creative Intervention Strategy to Promote Evidence-Based Practice," at the University of Rochester Evidence-Based Practice Conference on June 5, 2004. The presentation summarized the process of establishing the Nursing Research Committee Journal Club as a vehicle for promoting research utilization in nursing practice.

Five MOR posters presented in San Diego

Five posters were submitted by Main Operating Room staff, and five posters were accepted to the 2004 AORN Congress held in San Diego, California, March 21, 2004.

Gloria Moran, Emelia Comerford, and Jim Barone presented, "Magnet Recognition in the Perioperative Setting."

Laurie Lynch, Angela Altobell, Kerry McDonough, Susanne McCarthy, Chris Fitzgerald, and Joanne Walsh presented, "Staff-Driven Time Planning: a Model for Success."

Bruce Laramee, Katherine Parady, Joanne Monahan, and Maureen Hemingway presented, "Development of an Interventional Radiology Suite in the OR."

Elizabeth Viano, Terry Leddy, and Darrin Brodie presented, "Perioperative Burn Care in Crisis: Our Experience."

Sandy Silvestri and Marion Freehan presented, "Novice Blocks: A Building Block Orientation Model."

Educational Offerings

August 5, 2004

When/Where	Description	Contact Hours
August 19 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
August 23 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
August 24 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
August 25 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
August 26 1:30–2:30pm	Nursing Grand Rounds “Patient Safety.” O’Keeffe Auditorium	1.2
September 2 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
September 7 8:00am–4:30pm	Chemotherapy Consortium Core Program Wolff Auditorium, NEMC	TBA
September 8 8:00am–2:30pm	New Graduate Nurse Development Seminar I Training Department, Charles River Plaza	6.0 (for mentors only)
September 8 1:30–2:30pm	OA/PCA/USA Connections “Handling difficult patient situations.” Bigelow 4 Amphitheater	---
September 8 4:00–5:00pm	More than Just a Journal Club Walcott Conference Room	---
September 8 11:00am–12:00pm	Nursing Grand Rounds “Biotechnology and Caring Philosophies and Practices.” Sweet Conference Room, GRB 432	1.2
September 14 7:30–11:00am/12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
September 14, 15, 20, 21, 27, 28 7:30am–4:30pm	Greater Boston ICU Consortium CORE Program BWH	44.8 for completing all six days
September 15 and 17 8:00am–4:30pm	CCRN Review Day 1: Haber Conference Room. Day 2: O’Keeffe Auditorium	TBA
September 15 1:30–2:30pm	USA Educational Series Bigelow 4 Amphitheater	---
September 16 8:00am and 12:00pm (Adult) 10:00am and 2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
September 16 8:00am–4:30pm	Building Relationships in the Diverse Hospital Community: Understanding Our Patients, Ourselves, and Each Other Training Department, Charles River Plaza	7.2
September 20 and 21 8:00am–4:30pm	BLS Instructor Program VBK601	---
September 20 and 24 8:00am–5:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
September 21 8:00am–4:00pm	Intermediate Respiratory Care Respiratory Care Conference Room, Ellison 401	TBA
September 22 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111. For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

Roll-out of the employee and patient self-audit function

—reprinted from Compliance HelpLine

Beginning March 23, 2004, Partners HealthCare has implemented a self-audit function within the Partners clinical applications. This feature will be available to employees to help ensure confidentiality in patient electronic records. Specifically, employees who are patients of MGH or BWH (inpatient or outpatient) will be able to conduct a self-audit of their electronic health records to alert us if they believe someone has inappropriately accessed their

records in the patient systems. Information being reported includes access to both demographic and clinical information.

The self-audit function is available on any Partners workstation. Any employee, particularly those without computer self-audit access, may request an audit through the Privacy Office in Health Information Services or the Office of Patient Advocacy. Employees and patients also have the right to request a manual audit of their electronic health

record through the Privacy Office.

This initiative has become a priority with the new HIPAA guidelines concerning patient confidentiality. There may be a learning curve as employees become accustomed to the various people who need to access their records as part of their job. Beginning on March 23rd, data will begin to collect in the self-audit application whenever employees' electronic health records are accessed. This new functionality may create a need for

support by managers and Human Resources when names are not recognizable to the employee or an investigation needs to be conducted. For example, when staff review who has accessed their health records, the list of users may include clinicians as well as many other staff involved in their treatment, processing of hospital bills, and other hospital operations, such as translators, patient accounts, residents, etc.

All employees must understand it is a breach of confidentiality to access an employee's demographic information, (address, phone number, birth date, etc.) in order to send a card or chat. It is also a breach of confi-

dentiality to access patient information out of curiosity when you are not directly involved in that patient's care. Remember it's your responsibility to keep patient and hospital information—whether it is spoken, written, in a computer, or just in your head—totally confidential.

A self-audit educational PowerPoint presentation and overview handout is also posted on the MGH Privacy/Confidentiality/HIPAA website under Training at: <http://is.partners.orgmghintranet/hipaa> (no spaces).

For more information about the self-audit function, call Eileen Bryan in the MGH Privacy Office at 6-6360.



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