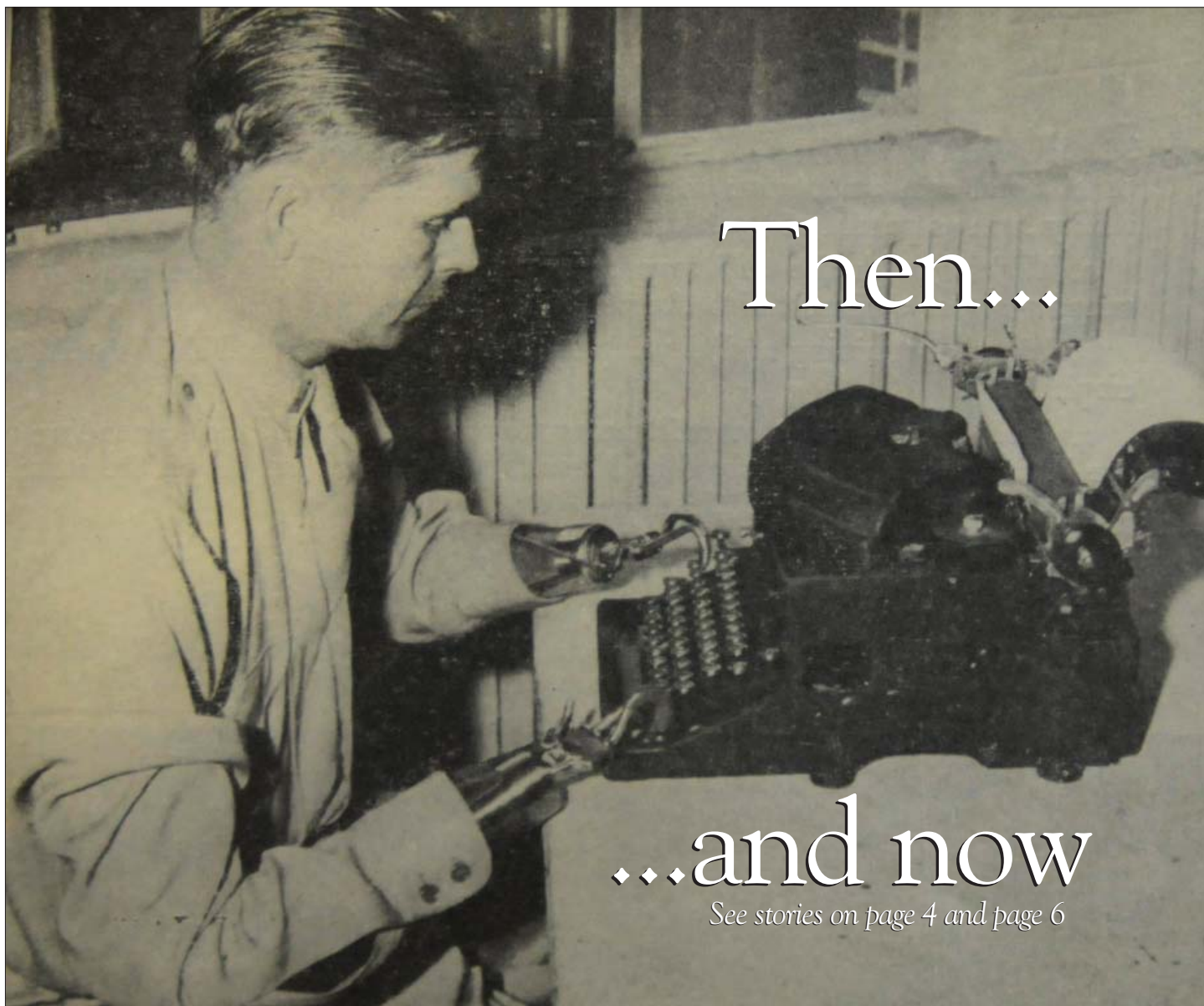


Caring

Headlines

April 7, 2011

Occupational Therapy



From its earliest days, Occupational Therapy has focused on functional skill re-training and helping patients engage in purposeful activities. Above photo is from the 1940s post-WWII era.

Nursing-sensitive indicators paint vivid picture of organizational commitment

Today, nursing-sensitive indicators are widely used as a barometer of quality care by the Centers for Medicare and Medicaid, the Patient Care Link, the National Quality Forum, and the Magnet Recognition Program.

The use of nursing-sensitive indicators as a measure of quality care is a relatively new development in the healthcare industry. It wasn't until the mid-1990s that many national healthcare organizations and regulatory agencies began to recognize a correlation between certain interventions performed by nurses and the overall quality and safety performance of healthcare institutions. In 1998, the National Database of Nursing Quality Indicators (NDNQI) was established by the ANA to begin formally collecting data related to (at that time) ten nursing-sensitive quality indicators. In 2002, the Joint Commission started incorporating nursing-sensitive indicators into its standards for accreditation. And today, nursing-sensitive indicators are widely used as a barometer of quality care by the Centers for Medicare and Medicaid (CMS), the Patient Care Link (formerly Patients First), the National Quality Forum (NQF), and the Magnet Recognition Program (the American Nurses Credentialing Center).

A broad definition of nursing-sensitive quality indicators might be: a set of standardized performance measures intended to help hospitals assess the extent to which nursing interventions have an impact on patient safety, quality, and the professional work environment. A partial list of nursing-sensitive indicators includes:



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

- Mix of nurses and unlicensed staff caring for patients in the acute-care setting
- Total nursing-care hours provided per patient day
- Nosocomial infections
- Patient falls
- Pressure ulcer rate
- Patient satisfaction with overall care
- Patient satisfaction with nursing care
- Patient satisfaction with pain-management
- Patient satisfaction with educational information
- Staff nurse satisfaction

If you think about what the data related to these indicators says about a particular healthcare organization, it really does paint a vivid picture of its commitment to, and focus on, quality and safety.

Our interest in nursing-sensitive indicators dovetails with the new model put forth by the American Nurses Credentialing Center (ANCC) for the Magnet Recognition Program. In an effort to provide greater clarity and eliminate redundancy among the 14 Forces

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When looked at over time, this data tells a story—important themes and trends emerge that inform our practice and drive organizational decision-making. But to derive the most benefit from this data, we need to share it with clinicians at the unit level.

of Magnetism, the ANCC's new model re-configures the Forces into five components placing less emphasis on process and structure and more on outcomes. The Forces continue to be the foundation of the Magnet Recognition Program, but going forward, the primary question will shift away from, "What do you do, and how do you do it?" toward, "What difference are you making?" The new configuration puts Empirical Outcomes at the center of the model supported by Structural Empowerment; Exemplary Professional Practice; New Knowledge, Innovations, and Improvements, and Transformational Leadership.

For several years we have collected data for our own internal use and for inclusion in a number of national databases (NDNQI, CDC, and others). We've collected data to accompany our application for Magnet recognition and re-designation. When looked at over time, this data tells a story—important themes and trends emerge that inform our practice and drive organizational decision-making. But to derive the most benefit from this data, we need to share it with clinicians at the unit level. We need to engage in conversations about what this data means and how we can craft improvements based on what it's telling us. We need to close that information loop.

Starting this month, the PCS Office of Quality & Safety will assist us in this effort by preparing quarterly reports reflecting the data collected on each unit and sharing those reports with nursing directors. These unit-specific reports will serve as a tool to help staff identify unfavorable trends, brainstorm, and implement solutions.

We've already learned a great deal from data related to nursing-sensitive indicators. We've developed new programs and initiatives based on the 'stories' embedded in this data. Our LEAF program (Lets Eliminate All Falls) is an excellent example. Led by Deborah D'Avolio, RN, LEAF is a comprehensive, evidence-based, fall-prevention program that has been rolled out on all inpatient units. The program uses a universal train-the-trainer approach to educate staff on all aspects of fall-prevention with special considerations for older and other at-risk patient populations. (Look for more about the LEAF program in future issues of *Caring Headlines*).

Safety rounds is another initiative related to nursing-sensitive indicators. Studies show that rounding regularly in patient rooms to assess the seven Ps (Person, Plan, Priorities, Personal hygiene, Pain-management, Position, and Presence) has a dramatic affect on many of the areas measured by nursing-sensitive indicators (reducing falls and pressure ulcers, improving pain-management, and increasing patient-satisfaction).

Nursing-sensitive quality indicators are just another way of describing our efforts to achieve Excellence Every Day. It's important to remember: we don't strive for excellence just to raise a score on a spreadsheet. We strive for excellence to ensure our patients' needs are met, to ensure they're safe and comfortable, and to ensure they consistently receive the highest-quality care we can provide.

For more information about nursing-sensitive indicators, call Keith Perleberg, RN, director of the PCS Office of Quality & Safety at 3-0435.

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Occupational Therapy Month

A celebration of our rich history

—by Rachel Benenati, OTR/L, occupational therapist

The roots of Occupational Therapy (OT) date back to the 1800s, but the actual profession was founded less than 100 years ago. Since its inception, the discipline has valued the idea of ‘occupation’ as participation in both meaningful and purposeful activities. Today, according to *Willard and Spackman’s Occupational Therapy*, occupation refers to, “daily activities that reflect cultural values, provide structure to living and meaning to individuals; these activities meet human needs for self-care, enjoyment, and participation in society.”

The principles of OT are deeply rooted in the promotion of health and wellness for individuals of all ages with physical

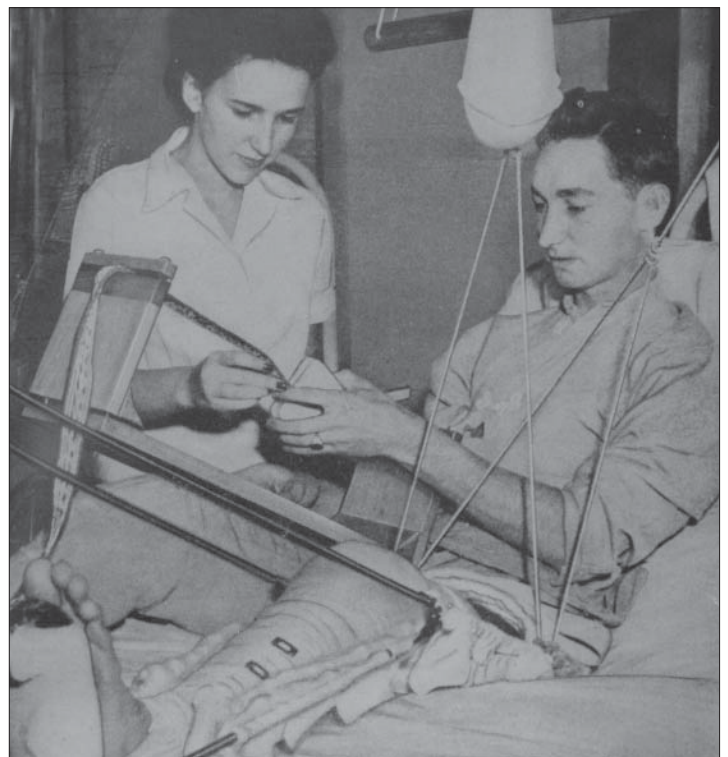
and mental dysfunction. During the 1800s activity and work were central to developing moral treatment, and for the first time, work was defined as a therapeutic agent. Occupational Therapy at MGH, dates back to 1822 when it was an integral part of moral treatment at McLean Asylum (later McLean Hospital), originally part of MGH. Rufus Wyman, MD, was the first physician to supervise a program in Occupational Therapy that used the novel concept of promoting wellness by engaging patients in crafts, gardening, and recreation.

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At left: amputee uses adaptive forearm brace to practice hand-writing.



At right: occupational therapist uses leather lacing task with patient to promote re-learning of skills related to his job.



(Historical photos provided by staff)

Occupational Therapy (continued)

In 1905, OT was the first paramedical service to be included in the broad scope of rehabilitation services offered at MGH. By 1907, a clay-modeling class was available for 'psycho-neurotic,' dermatologic, and orthopaedic patients. Mary Murphy, the first OT at MGH, ran a cement shop from 1913 to 1917 to employ men with disabilities and help them engage in occupation.

The profession was founded in 1917 by the National Society for the Promotion of Occupational Therapy, which later became the American Occupational Therapy Association (AOTA). Given the emphasis on science-driven practice in the 20th century, OT linked its practice directly with established scientific knowledge. Following WWI, Occupational Therapy expanded from the psychosocial realm to include physical rehabilitation. OTs discovered that soldiers who sustained physical injuries in war recovered faster and more thoroughly when engaged in activities that encompassed their minds and emotions as well as their physical state.



At right: senior hand therapist, Carol Harmon Mahony, OTR/L, fabricates custom wrist splint for patient as part of his hand rehabilitation.

Below: clinical specialist, Suzanne Curley, OTR/L, simulates return-to-work activity for patient following nerve injury.



In the decades following the 1940s, the Rehabilitation Movement was born with a focus on veterans returning from WWII. OT practice revolved around interventions to help individuals resume participation in their peacetime occupations. In 1940, under medical direction, Occupational and Physical Therapy merged at MGH. In 1951, MGH opened Baystate Rehabilitation Clinic where OTs adopted a strong focus on functional intervention, later called, 'work therapy.' They provided vocational training, helped develop work tolerance, and facilitated incentives for patients to return to work.

Over the next 20 years, the profession began to specialize in two distinct areas: physical disabilities and psychosocial dysfunction. Pediatrics was introduced in the 1960s with OT treatment of developmental disabilities. Starting in 1972, patients were treated on the rehabilitation service on White 10. In April of that year, Drs. Leffert and Smith came to MGH from New York Hospital and created a hand and upper-extremity specialization team that included both occupational and physical therapists.

In keeping with the perspective of the World Health Organization's International Classification of Functioning, Disease and Health, OT practice supports health and participation in life through engagement in occupation. Over the years, the focus of Occupational Therapy has shifted toward promotion

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New program is Wii bit o' magic on Blake 11

—by Stephanie Karban, OTR/L, occupational therapist

Drawing on my occupational therapy background in physiology, neurology, psychology, group process, and my personal passion for technology, I wanted to introduce a new program to help facilitate participation in occupation by using the Nintendo Wii gaming system.

Through Occupational Therapy has developed in many practice areas including pediatrics, neurology, hand therapy, and acute care, the roots of Occupational Therapy are centered in mental health. This is where occupational therapy established its

unique approach to patient care—assessing and integrating occupations and occupational performance into the client's treatment plan. As defined by Townsend, occupational performance refers to, “the active processes of looking after ourselves and others, enjoying life, and being socially and economically productive over the lifespan and in various contexts.” Given the challenges that people with mental illness often face, including loss of independence, difficulty socializing, and public stigma, occupational therapy directly addresses the needs of this population by helping patients regain, not only functional independence, but a sense of competence and control.

At MGH, Occupational Therapy has implemented several programs on the inpatient Psychiatric Unit to address these needs. During my rotation on Blake 11, a locked unit, I observed that certain environmental restrictions often limited patients' ability to engage in meaningful occupations, such as physical activity and socializing. Drawing on my occupational therapy

background in physiology, neurology, psychology, group process, and my personal passion for technology, I wanted to introduce a new program to help facilitate participation in occupation by using the Nintendo Wii gaming system.

Leadership of the department encouraged me to pursue the idea and guided me through the research

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Staff occupational therapist, Stephanie Karban, OTR/L, with Wii on Blake 11.

Occupational Therapy (continued)

and development of a Wii program. I presented my proposal to the Blake 11 multi-disciplinary team to ensure seamless integration with other groups and programs. Funding was generously provided by the Ladies Visiting Committee Fund. Interestingly, the Ladies Visiting Committee (formed in 1869), recognizing the importance of occupational therapy, paid half the salary of the first occupational therapist at MGH. Their value of our profession carries through to present day with the purchase of the Wii for Blake 11.

Nintendo's interactive Wii gaming system detects movement in three dimensions, allowing players to physically interact in an assortment of games. The use of Wii in a rehabilitation setting is not new—research suggests that more and more facilities are incorporating Wii into neuromuscular re-education, cognitive, and balance exercises. There is limited research on the use of Wii in the mental-health setting, but there's reason to be hopeful. One recent study reported significant improvement in depressive symptoms, cognitive performance, and quality of life in the majority of mental-health participants. The Wii system allows players to perform meaningful tasks, such as skiing, cooking, dancing, etc. The basic premise of the Wii is strongly supported by the central dogma of occupational therapy: engagement in meaningful occupation yields improved performance, thereby promoting health and well-being.

The needs of patients on Blake 11 vary greatly, but they ultimately share the same long-term goals—improved socialization and behavior, effective coping, self-regulation, and participation in self-care, work, and leisure. These goals serve as the foundation for the Wii program. Using the Wii, an occupational therapist can work with patients to improve self-awareness, encourage social interaction, facilitate cognitive functioning, and promote overall health and wellness through physical exercise.

The Wii program complements Blake 11's sensory-motor modulation program (using sensory input to facilitate emotional regulation and coping) by providing multi-sensory input through proprioceptive, vestibular, visual, auditory, and tactile-based games.

In order to cater to a wide variety of physical, emotional, and cognitive needs, I created a Wii protocol with specific inclusion and exclusion criteria. Using es-

tablished research criteria from a physical rehabilitation group as a guide, I worked with occupational therapy leadership and physicians, nurses, and psychologists on Blake 11 to ensure the protocol met the needs of this medically and behaviorally complex patient population. Currently, use of the Wii is under the supervision of an occupational therapist to ensure that use is therapeutic and to enable us to monitor outcomes.

The Wii premiered on Blake 11 in January of 2011 during an early Monday exercise group. The pilot group was comprised of four patients, men and women, ranging in age from 20s to 60s, and of varying diagnoses. Though patients were initially hesitant and reported low motivation to participate, with some encouragement everyone engaged in a game of bowling. After only a few frames, every patient was smiling and conversing. The room quickly filled with cheers and laughter when one patient rolled a strike.

The Wii has proven a valuable addition to the already well-rounded approach on Blake 11. Throughout the past several weeks, patients have not only demonstrated improvement in socialization, communication, and self-regulation, but have subjectively reported improvement in mood via a ten-point scale. Some comments that struck me include, "This is the most I've done all day." "I feel less anxious." "It took my mind off things." "It's your turn, good luck." and "I'm ready for the day now."

Clinically, the data we're collecting on the use of the Wii demonstrates improvement in nearly all identified goal-directed areas of patient care. Beyond clinical and quantitative assessment, however, lives the basic belief that providing patients with a sense of control, purpose, freedom and enjoyment—a difficult task on a locked unit—will better their general functioning.

I heard one patient report, "I haven't bowled in forever. This is the best I've felt in a really long time." I realized that not only had the Wii helped re-connect a client with a meaningful occupation, but it enabled him to improve his ability to cope with whatever circumstances had brought him to the unit. That is the heart of occupational therapy: the connection between a person and what they want to do.

For more information about the Wii Program, call Stephanie Karban, OTR/L, at 6-8537.



New graduate nurse navigates the challenges of critical care



Claire deMercado, RN, new graduate nurse, Neuro ICU

Mrs. S was a 77-year-old woman, admitted to the Neuro ICU the night before... She'd had a busy night, and at 7:30 in the morning, I hit the ground running.

My name is Claire deMercado, and participating in the New Graduate in Critical Care Nursing Program was one of the most demanding experiences I've ever been part of. As new grads, we were expected to learn as much as possible while providing care and support to patients and families under the supervision of our preceptors. The responsibility could be overwhelming, but the reward and support at the end of the day was exhilarating. As I continue to develop my practice, I see myself gaining confidence in many aspects of the care I provide, including how to advocate for patients and families.

Mrs. S was a 77-year-old woman, who had been admitted to the Neuro ICU during the night shift. She had been transferred to a community hospital from her nursing home for decreased consciousness and slurred speech. She had been intubated at that hospital for airway protection and remained intubated upon arrival to MGH. A CTA scan confirmed she'd had a peri-mesencephalic hemorrhage with brainstem compression. Her prognosis was poor, but there was much work to do to manage her care.

In report, I learned that Mrs. S was a full code, and that she had many tests scheduled that day. Mrs. S did not require sedation and was not responsive to commands. She had no gag response and only triple-flexed to painful stimuli during her neuro exam. Overnight,

her external ventriculostomy drain had needed to be replaced. She'd had a busy night, and at 7:30 in the morning, I hit the ground running. I prepared her for the first of many tests while coordinating with Respiratory Care to transport her to MRI.

When Mrs. S's family arrived an hour later, I stepped into the waiting room to give them a quick update, explained that Mrs. S was going to have a busy morning, and unfortunately, they'd have to spend much of their time in the waiting room. Her sons, sisters, and grandchildren were clearly confused and didn't understand much of what was going on. I knew we were going to need a family meeting as Mrs. S had arrived in the middle of the night. And I'd have to find time to update and educate them as much as I could throughout the day.

During morning rounds, I mentioned the need for a family meeting and the ICU team said they would defer the meeting to the surgical team. I finished rounds, made note of whom to page about the meeting, and got back to Mrs. S. In between tests, I received a call

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This experience taught me the importance of advocating for patients and communicating with physicians in a timely manner. I realized how crucial my role was in communicating with the ICU and surgical teams and relaying my concerns. This family looked to me for answers, and I saw a need to amend our plan of care.

from her PCP who wanted to check her condition. After a brief update, the PCP said, "I just want to make sure you know she's a DNR/DNI [Do not resuscitate/Do not intubate]. I wasn't sure whether that information had been relayed during the transfer from the nursing home to the community hospital to MGH."

I asked if she was aware that Mrs. S was currently intubated, and she said she'd been notified that it was for airway protection only and wanted to make sure Mrs. S's status was known. I asked her to fax us the DNR/DNI paperwork. Knowing this could potentially change how we directed our care, I went back to the waiting room to speak with her family.

I mentioned her code status to the family and her son, who was the spokesperson and healthcare proxy, said, "I don't even know what DNR/DNI means."

I took a moment to compose myself and began what I knew would be a long day of teaching and explaining. When I left the waiting room, I knew I needed to page both the ICU and the surgical team to address Mrs. S's status, and most importantly, her code status. Mrs. S's family was asking questions about her diagnosis and treatment. I knew that while it was not my job to convey that information, it was my job to make sure someone spoke with them in a timely manner and be there to clarify and support as much as they needed.

As the day wore on, I got the sense that this family would be interested in withdrawing care, but they needed more information. Understandably, they were angry, anxious, and upset, and I was getting the brunt of their emotions. The family knew Mrs. S was on ventilator support but they were under the impression that she was essentially breathing 'on her own.' I explained that the ventilator was breathing for her and why she needed it given the area of injury in her brain. The family seemed sure that, "If the machine was breathing for her, she wouldn't want that." I knew we needed a meeting, and we needed it as soon as possible.

I knew the attending surgeon would be calling soon to update the son on Mrs. S's condition. When he called, he explained that the plan was to wait 48 hours to see if Mrs. S's condition improved. Having a better sense of the family, I was concerned that the son (and proxy) might not grasp the full situation based on a phone update. I paged the attending surgeon and explained the need for a meeting, but he was unable to take a meeting at that time. I went to the attending physician on the ICU team and explained my concerns. I told him I thought the family was leaning toward withdrawing care and making Mrs. S's status comfort measures only (CMO).

A few minutes later, the surgical senior resident and the ICU attending physician came to Mrs. S's room for a family meeting. I was glad I had been so persistent and relieved that my efforts had paid off. We had the family meeting and once all their questions were answered, everyone was on the same page. The family decided to extubate Mrs. S and put her on comfort measures only.

I spoke with the family about what CMO meant and what they should expect after extubation. I requested a chaplain to speak with them before we extubated Mrs. S. I wanted the family to be out of the room for the actual extubation explaining that we can never be sure how the patient will look or sound after being extubated. I reassured them that we'd make sure Mrs. S was comfortable. I asked them to step out as I disconnected Mrs. S from unnecessary equipment and monitors. After she was extubated, I brought the family back in and told them I'd be right outside the room if they needed me. About ten minutes later, Mrs. S became asystolic. I went back in and explained that she had passed. I answered their questions and gave them more time as I called the ICU fellow to pronounce Mrs. S.

This experience taught me the importance of advocating for patients and communicating with physicians in a timely manner. I realized how crucial my role was in communicating with the ICU and surgical teams and relaying my concerns. This family looked to me for answers, and I realized a need to amend our plan of care.

Mrs. S was unable to make decisions for herself, and her family wasn't sufficiently prepared to make the decisions that reflected her wishes. By addressing the need for a family meeting, I helped empower this family to make those decisions, and we were able to act on their wishes in a timely manner.

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

I'm not sure people realize how difficult it can be to speak up in a fast-paced, critical-care setting, especially when everyone else around you is more seasoned and experienced than you are. This is a wonderful example of perseverance and patient-advocacy on the part of a new clinician. Claire trusted her instincts and had the courage to act on them. If this is the kind of commitment and patient-centered care Claire demonstrates as a new grad, I can only imagine what kind of nurse she will be when she's as seasoned and experienced as her colleagues.

Thank-you, Claire.

A week in Burundi, a lifetime of memories

—by Kerry Quealy, RN, staff nurse

As I think back on my time working in a community health clinic in Burundi, a small country in East Africa, it's difficult to summarize my experience. As I examine the time I spent there more closely, one theme seems to prevail: the fragility of life—how quickly it can end, and how with each end comes a new beginning. These new beginnings are what give the Burundi people the hope, resilience, and joy that is such a deep part of their culture. The one thing I saw more clearly than anything else was the cycle of life and death that played out before me every day in the Kigutu Health Clinic.

The clinic is located in the rural, mountainous region of Bururi Province, about a three-hour ride from the capital city of Bujumbura. More than half of the country's physicians practice in the capital city, yet less than 5% of the population reside there. For rural Burundians, access to the most basic health care is rare.

One week in particular captures the ever-present cycle of life and death most vividly in my mind.

In the course of a few days we saw two children die from preventable causes, one child recover from severe malnutrition, and three healthy babies born.

In the first case, a small child was brought to the clinic early in the morning. He was already in a coma-like state, most likely from advanced malaria that had spread to his brain. His family had taken him to a traditional healer, the healthcare provider closest to their village, and the man had made burn marks on the child's chest to "release toxins." The child went without malaria medication for several days. By the time he

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More than half of the country's physicians practice in the capital city, yet less than 5% of the population reside there. For rural Burundians, access to the most basic health care is rare.



Humanitarian Aid (continued)

was brought to the clinic, we treated him with malaria medications, antibiotics, intravenous fluids, and oxygen, but it was too late. Lack of resources wasn't responsible for this death; lack of access to medical care in this poverty-stricken community was.

Another child was lost to malaria when he became extremely anemic and needed a blood transfusion. The clinic has no blood bank and isn't equipped to do transfusions. Coming from MGH, this was shocking. As a nurse on a busy medical unit, performing blood transfusions is standard practice—a practice I'd never given a second thought to until that moment. Watching a child die due to lack of blood was truly heart-breaking.

Amazingly, along with these tragedies came stories of joy. That same week, three babies were born healthy and happy in the clinic. One of the mothers was HIV-positive and had been started on HIV medications during pregnancy to prevent transmission to the child. The baby tested negative for HIV at birth and would be re-checked in six months.

Also that week, a young girl with active pulmonary tuberculosis and severe malnutrition turned the corner toward recovery. She eventually completed the malnutrition program and was discharged as a healthy 10-year-old girl.

In Burundi, even if a person has the physical means to access health care, it's almost impossible due to the incredible poverty. The average per-capita income of a Burundian is less than one dollar per day. Public hospitals have become something of detention centers, holding patients until they can pay their medical bills. Health insurance is unheard of in this culture. I started to realize why the sick people of Burundi would walk for hours through treacherous mountain passes to be seen in our clinic—it was because we offered free, high-quality medical care.

At the end of the week, a group of clinic workers and I went for a hike through the beautiful mountains, and I reflected on the week's events. I thought of all the patients I had seen, knowing they had walked this very same path. But instead of clean drinking water, digital camera, proper shoes, and anti-malarial medications, they carried sick children and loved ones. They had none of the resources or conveniences I had, yet they thrived; they carried on. And even though I was there for only a short time, I could see, it was because they had hope.



Opposite page:

Kerry Quealy, RN, with 13-year-old patient who was treated successfully for malnutrition.

Above: Quealy with two Burundian women in Malnutrition Ward.

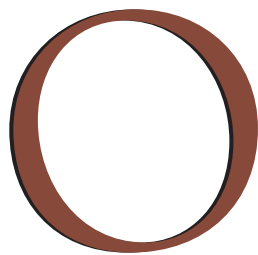
At right: Quealy with Burundian nurse and children in the Malnutrition Ward.



(Photos provided by staff)

New Graduate in Critical Care Nursing Program

—by Gail Alexander, RN, program coordinator



On March 8, 2011, along with family, friends, and colleagues, the 18th class of the New Graduate in Critical Care Nursing Program came together to celebrate their successful completion of the intensive six-month program

that prepares new-graduate nurses to practice in critical care. Eight nurses joined the ranks of the 163 alumnae who have already participated in this rigorous training program.

Gaurdia Banister, RN, executive director, The Institute for Patient Care, commended preceptors for their clinical wisdom and dedication in passing their wisdom on to the next generation of nurses. She challenged participants to continue this legacy of caring, compassion, leadership, and service to the profession.

New graduate nurses (l-r): Gretchen Keough, RN; Erin Hutchinson, RN; Kaitlyn Kariger, RN; Claire deMercado, RN; Mary Bailey, RN; Robin Kwiatek, RN; Jody Roper, RN; and Cameron Calef, RN.

“Look for opportunities to pave a trail that others will follow. Be proud of your legacy. Share it every day.”

Tara Tehan, RN, nursing director, introduced new graduate, Claire deMercado, RN, who read her narrative chronicling her experience caring for a patient in the aftermath of a devastating stroke (see narrative on page 8). DeMercado’s preceptor, Hannah Jelly, RN, spoke about the mutual respect they developed working together. And clinical nurse specialist, Mary Guanci, RN, noted how deMercado’s practice has grown under the tutelage of her preceptors.

Said Guanci, “The practice of both the new nurse and the preceptor benefit from this experience.”

Gail Alexander, RN, program coordinator, reminded attendees how the goals of the program support the department of Nursing’s culture of life-long learning. Said Alexander, “The commitment of nursing leadership, the generosity of the clinicians who share their expertise, and the faculty who share their knowledge and passion for nursing are central to the success of this program.”

For more information about the New Graduate in Critical Care Nursing Program, visit the Norman Knight Nursing Center for Clinical & Professional Development website at: www.mghnursing.org or contact Gail Alexander at 6-0359.

At the March 8th ceremony, certificates of completion were given to:

- Gretchen Keough, RN, Neuroscience ICU
- Erin Hutchinson, RN, Cardiac ICU
- Cameron Calef, RN, Medical ICU
- Kaitlyn Kariger, RN, Medical ICU
- Claire deMercado, RN, Neuroscience ICU
- Robin Kwiatek, RN, Surgical ICU
- Jody Roper, RN, Surgical ICU
- Mary Bailey, RN, NSMC Salem, ICU



(Photo by Paul Batista)

Occupational Therapy (continued from page 5)

Above: senior occupational therapist, Leslie McLaughlin, OTR/L, helps patient use adaptive feeding strategies on the Burn Unit.

Below: staff occupational therapist, Julie Park, OTR/L, positions infant in the NICU.

of health and wellness with prevention, health maintenance, and patient-centered quality of life as the goal of intervention. In the acute-care setting at MGH, clinicians base their practice on a systematic, top-down approach that includes patient-centered evaluation and intervention to facilitate attainment of goals. The long-term goal of Occupational Therapy is for patients to resume participation in the roles and routines they consider important to them.

Since its beginning, Occupational Therapy has embraced the rich culture and high standards of learning that are the norm at MGH. We believe in the importance of clinical education, evidence-based practice, and a service-oriented, patient-centered philosophy. Today, we are a department of 30 clinicians, serving inpa-



(Photo provided by staff)

tients and outpatients on the main campus and at health centers in Revere, Waltham, and Foxborough. We provide care to patients across every service, department, and age group. We are proud to have six advanced clinicians and two clinical scholars in the PCS Clinical Recognition Program, and occupational therapist certified in hand therapy, lymphedema, sensory integration testing (SIPT), and A-One neurobehavioral evaluation.

April is National Occupational Therapy Month. As MGH prepares to celebrate its bicentennial and OT approaches its centennial milestone, we invite you to reflect on the history and evolution of our profession. For more information about occupational therapy services offered at MGH, call 4-0147.

IPOP vs. VPOP

To be fiscally responsible, know when to use one and when to use the other

Question: What is a VPOP?

Jeanette: A VPOP is a device used by MGH medical interpreters to provide Spanish and Portuguese medical interpreting by way of video. VPOPs allow patients and clinicians to access Spanish and Portuguese interpreters on demand. As these video-interpreting devices become available in more areas, Medical Interpreter Services is conducting in-services to help educate staff on the most effective use of IPOPs and VPOPs.

Question: What's the difference between IPOPs and VPOPs?

Jeanette: Interpretation via IPOPs is provided by an outside vendor at a relatively high monthly cost. Much of the IPOP usage is for Spanish and Portuguese interpretation, so in areas where VPOPs are available, it makes better financial sense to use VPOPs. In-services conducted by Medical Interpreter Services highlight the cost of using IPOPs while reminding staff they can obtain immediate Spanish or Portuguese interpretation via the VPOP at no additional cost to the hospital.

Question: Is staff being asked to cut down on interpreter services?

Jeanette: Absolutely not. Extensive IPOP use indicates clinicians are communicating with Limited English Proficient (LEP) patients often and whenever necessary, which is critical to the delivery of safe, high-quality care. Medical Interpreter Services is trying to raise awareness about the cost of using IPOPs for services that can be provided just as effectively (if not more so) by VPOPs at no added expense to the hospital.

Question: Do you track the usage of IPOPs and VPOPs?

Jeanette: Medical Interpreter Services tracks the usage of IPOPs and VPOPs in areas that offer both. The data is tabulated monthly and e-mailed to unit leaders. The goal is to reduce IPOP usage to less than 5% during the hours that the VPOP service is available (Monday through Friday, 8:00am–5:30pm).

Question: What about using IPOPs for languages other than Spanish and Portuguese?

Jeanette: Telephone interpreting provided by the IPOP is meant to be a back-up for face-to-face interpreting. If, in your clinical judgment, you need an interpreter immediately, you should definitely use the IPOP. If the patient is able to wait for an MGH interpreter to come to the room, we encourage you to call Medical Interpreter Services to request an in-person interpretation, especially for lengthy medical conversations.

Question: What about at night? Should staff use the IPOP?

Jeanette: Yes. The VPOP is only available during the day, so that's not an option at night. The expectation is that IPOPs will be used when Medical Interpreter Services is closed. But remember, medical interpreters are on-call at night for Spanish, Portuguese, and American Sign Language, if necessary.

For more information about the cost or utilization of IPOPs and VPOPs, call Medical Interpreter Services at 6-6966.

Announcements

Lunchtime Fitness Sessions

Lunchtime fitness sessions offered by personal trainer, Mike Bento, from The Clubs at Charles River Park.

Next session:

April 13, 2011

Haber Conference Room
12:00–12:30pm

For more information, call 6-2900

One-stop intranet site for strategic priorities

Want to know more about the Partners-MGH patient care re-design, patient affordability, and budget review initiatives? Wondering about the time line?

To read the latest articles about this work, or if you have a cost-reduction idea or better way to deliver patient care, visit the new MGH/MGPO intranet site:

<http://priorities.massgeneral.org>

On-site Spanish classes

Learn commonly used phrases to enhance communication with Spanish-speaking patients. In partnership with HablEspañá Language Center, MGH offers three levels of Spanish classes emphasizing practical communication for the hospital setting.

Classes meet in the Yawkey Building beginning the week of April 10, 2011. Classes meet one evening per week for 10 weeks from 5:30–7:30pm. \$150 course fee includes all materials.

For information on enrollment, call 4-3368.

Living with Cancer: Navigating the Journey

A free conference for patients and families on maintaining quality of life from diagnosis to long-term survivorship.

Featuring information on:

- Advances in cancer research
- Managing side-effects
- Maintaining wellness and balance in your life
- A panel of cancer survivors
- The HOPES Wellness Fair

April 9, 2011

9:00am–3:00pm

Yawkey 2

To register, call 617-724-1822, or stop by the Cancer Resource Room (Yawkey 8C).

Sponsored by the MGH Cancer Center and the Network for Patients & Families.

AMMP scholarships

Applications available on-line

As of October, 2010, previous scholarship awardees re-applying for an AMMP scholarship are no longer required to submit a five-page essay. A two-page update of your educational journey since receiving the last award is sufficient.

Starting in the fall of 2011, the MGH Institute of Health Professions (IHP) will partner with the AMMP Scholarship Program to offer a three-credit scholarship.

Awardees are required to volunteer a minimum of 20 hours at the IHP.

This scholarship is available to applicants with an interest in Nursing, Physical Therapy, and Speech-Language Pathology. Health professionals taking science pre-requisites are also eligible.

For more information, call 4-4424.

Pediatric Grand Rounds

April 26, 2011

12:00 noon

O'Keefe Auditorium

Pediatric Family Advisory Council will present.

For information, call 6-3964.

Remembrance Service

The MGH community is invited to join family and friends of Charles "Charlie" McCarthy for a remembrance service.

Tuesday, April 12, 2011

10:00–11:30am

O'Keefe Auditorium

For more information, e-mail Paul Bartush.

Red Sox Foundation and MGH Home Base Program

Participate in this year's annual Run to Home Base, a 9-kilometer run to support our veterans ending at storied Fenway Park. Registration is now open.

For more information, or to register, go to: www.runtohomebase.org.

Run to Home Base will be held Sunday, May 22, 2011.

New MGH phone numbers

Due to the increasing need for telephone lines, MGH Telecommunications began incorporating the new area code and exchange number: 857-238-XXXX.

Staff will still be able to dial the five-digit extension (8-XXXX) when calling internally.

For information call 6-4357.

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Submissions

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

Next Publication

April 21, 2011

Lunch & Learns bring MGH nurses together

—by Mandi Coakley, RN, staff specialist

The Vascular Center Nursing Group is comprised of nurses from intensive care, radiology, neuroscience, and vascular units in inpatient and outpatient settings, who, together with administrative staff from the Vascular Center, meet each month to plan educational programs for nurses at MGH. The group, co-chaired by Sharon Bouvier, RN, and Erin Cox, RN, hosts an annual Vascular Nursing Conference, coordinates several Lunch & Learn sessions throughout the year, and assists with blood-pressure screenings, carotid-artery screenings, and other vascular nursing events.

Nurses are invited to Lunch & Learn sessions to hear vascular nurses and physicians present on various topics and to network with colleagues. CEUs are available for attending the session.

On March 16, 2011, Paula Restrepo, RN, staff

nurse in the Surgical ICU, and Deb Jameson, RN, nurse librarian, presented their study, “These boots are made for walking.” Restrepo and Jameson were recipients of the Yvonne L. Munn Nursing Research Award in 2010. With coaching from nurse researcher, Diane Carroll, RN, Restrepo and Jameson, conducted a study in the Surgical ICU exploring different patterns of practice related to the use of veno-thrombolytic stockings and other vascular equipment.

Lunch & Learns are held four times a year. For more information, call Mandi Coakley, RN, at 6-5334.



At recent Lunch & Learn, Paula Restrepo, RN (right), and Deb Jameson, RN, share the results of their research study, “These boots are made for walking.”

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