

Caring

Headlines

February 3, 2011

Creating a welcoming and inclusive environment for patients with disabilities

The Platinum Rule

“Treat others the way *they* want to be treated, not the way *you* want to treat them”

(See story on page 4)



Cecilia Gandolfo, program manager,
Institute for Community Inclusion, UMass, Boston

A closer look at PCS strategic goals for 2011

2011 PCS Strategic Goals

- Meet or exceed expectations of patients and families
- Enhance care-delivery by improving the efficiency and effectiveness of systems
- Ensure staff have a strong voice in the design of care and services

In the January 6, 2011, issue of *Caring Headlines*, I shared Patient Care Services' strategic goals for 2011. As we finalize our plans for the coming year and continue to build on past work, I want to go into a little more detail about the scope and objectives of our plan. Since every member of Patient Care Services plays a key role in our success, it's important that we have a clear understanding of the work ahead. Our goals for 2011 are to:

- meet or exceed the expectations of patients and families
- enhance care-delivery by improving the efficiency and effectiveness of systems
- ensure staff have a strong voice in the design of care and services

To accomplish this, we'll employ a number of tactics. For instance, Goal #1, to meet or exceed the expectations of patients and families, focuses on: improving responsiveness to patients' needs; ensuring equitable care to all patients including those with disabilities; reducing hospital-acquired pressure ulcers; and improving the cleanliness of our physical environment.

One way to improve responsiveness is the hospital-wide implementation of hourly (or regular) safety rounds on all inpatient units. Studies show that regular rounding to patients' rooms helps reduce falls and pressure ulcers and improve patient satisfaction.

We are committed to making our care, services, and physical environment accessible to everyone including individuals with disabilities. Toward that end, we will ensure that adaptive equipment and communication aids are available, develop educational materials and discharge instructions for patients with sensory disabilities, provide training and education to staff on how to communicate with, and care for, patients with disabili-



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

ties, and increase utilization of V-POP (video medical interpreting).

Our inter-disciplinary Pressure Ulcer Reduction Task Force is exploring the feasibility of implementing a pressure-ulcer initiative used successfully at Ascension Health, called SKIN Bundle (Surfaces, Keep turning, Incontinence management, and Nutrition.) This program emphasizes re-positioning and nutrition during hourly rounds.

One area where we can all contribute is the cleanliness of our hospital. Unit service associates and environmental service aids work hard to keep patient rooms and public areas clean, and we're improving cleaning techniques and processes all the time. But we all share responsibility for a clean environment.

Goal #2, enhancing care-delivery by improving the efficiency and effectiveness of systems will revolve around: improved documentation; revised scheduling practices to better meet workload demands; moving supplies closer to the bedside to maximize time spent providing direct care; reducing unnecessary re-admissions; and greatly reducing non-salary-related expenses. Executing a safe, successful move into the Lunder Building later this year falls within this goal.

continued on next page

Many efforts, both unit-based and hospital-wide support our work. One simple idea can make a big difference. If you have an idea that will help us meet or exceed patients' expectations, improve the efficiency and effectiveness of systems, or ensure staff have a strong voice in the design of care, I'd like to hear about it.

As you know, we're actively engaged in creating a unified electronic documentation system to combine the many disparate elements of patients' medical records. We hope to pilot that new system in 2012.

In an effort to minimize time spent retrieving supplies from central repositories and increase time spent providing direct care, there is a hospital-wide initiative (with the exception of Blake 11) to move certain supplies closer to the bedside. This will help reduce waste, decrease clutter, minimize the risk of infection, and enable staff to spend more time caring for patients.

To help prevent unnecessary re-admissions, we are piloting a multi-disciplinary strategy that involves enhanced assessment of post-discharge needs, teaching and learning techniques, communication at discharge, and follow-up phone calls with post-acute-care patients.

Much has been written about our Tiger Teams and the excellent work they're doing to identify opportunities to eliminate waste and cut costs. We are continuing this effort with a formal product review to ensure we're targeting the correct products and processes to increase efficiency and reduce expenditures without compromising quality or safety.

Goal #3, ensuring staff have a strong voice in the design of care and services will involve: re-designing collaborative governance to be more aligned with current need; implementing a diversity leadership fellowship; and revamping educational offerings throughout Patient Care Services.

The re-design of collaborative governance focuses primarily on merging the Nursing Practice and Quality committees, introducing an Informatics Commit-

tee, and transitioning the Nursing Research Committee to an Interdisciplinary Research Committee. Five new sub-committees reporting to the joint Practice & Quality Committee will focus on: fall-prevention; pain-management; restraints; skin care; and policies, products, and procedures.

To continue to expand the diversity of the PCS workforce, we will implement a diversity fellowship with an eye toward recruiting and retaining employees of diverse backgrounds, create a formal diversity database and pipeline program with nursing and health professions schools, and create a forum for employees with disabilities to network, mentor, educate, and evaluate our disability program.

The Institute for Patient Care recently completed an assessment of educational offerings throughout PCS to begin to identify opportunities for greater efficiency and increased inter-disciplinary collaboration.

While these tactics represent our strategic plan for 2011, we're not limited to these initiatives. A Tiger Team has been created to address disruptive behavior of patients and family members, a growing problem in many hospitals. The work of this Tiger Team will have a positive impact on the patient experience by creating a safe environment for staff to provide care.

Many efforts, both unit-based and hospital-wide support our work. One simple idea can make a big difference. If you have an idea that will help us meet or exceed patients' expectations, improve the efficiency and effectiveness of systems, or ensure staff have a strong voice in the design of care, I'd like to hear about it.

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Raising awareness about access to care: make no assumptions

As employees of one of the most prestigious and accomplished hospitals in the world, MGH clinicians and support staff should ask themselves, “Is there anything I can do to make my work space, area, office, exam room, etc., more accessible for people with disabilities?”

On Wednesday, January 19, 2011, in the second of five sessions focusing on improving access to care for persons with disabilities, Cecilia Gandolfo, program manager at the Institute for Community Inclusion, at UMass,

Boston, presented, “Creating a Welcoming and Inclusive Environment for Patients with Disabilities,”

in O’Keeffe Auditorium. At the center of Gandolfo’s talk was the reminder: “Make no assumptions.” Good advice no matter what the topic. Said Gandolfo, “Some disabilities are invisible—illiteracy, epilepsy, sensory impairments, learning disabilities—so we can never assume a person has or doesn’t have a disability. All services need to be accessible to *all* patients.”

As employees of one of the most prestigious and accomplished hospitals in the world, MGH clinicians and support staff should ask themselves, “Is there anything I can do to make my work space, area, office, exam room, etc., more accessible for people with disabilities?” We need to be proactive in planning services and care so that every aspect

of our environment is universally accessible. Gandolfo offers the following suggestion for when you think a patient may require assistance:

- offer to help
- listen to what the person is saying
- demonstrate your understanding
- ask what has worked or been successful in the past
- ask, “What can I do? What assistance do you need?” or, “Do you have any questions?”
- let the patient know what you plan to do in response to his/her need
- always offer to help before physically touching the patient
- always ask permission before touching or moving a cane or wheelchair
- never interact with, touch, or distract a service animal (if the animal is wearing a harness, it is working)

For more information on how to better serve our patients with disabilities, click on the Accessibility link from the MGH home page; consult a member of the MGH Council on Disabilities Awareness; or call Zary Amirhosseini, disability program manager, through the Office of Patient Advocacy (at 6-3370), or address e-mail to: MGHaccessibility@partners.org.



Cecilia Gandolfo, program manager,
Institute for Community Inclusion,
UMass, Boston

A look back at humble beginnings

—by Georgia Peirce, director, PCS Promotional Communications and Publicity

At right is the original charter for MGH, granted by the state legislature in 1811. The etching below depicts the original hospital as it appeared in 1821. And the photo at right, taken in 1853, shows the Bulfinch Building after construction of the west and east wings, which were added in 1846 and 1847 respectively.



On August 20, 1810, founding physicians, James Jackson and John Collins Warren, distributed a circular to citizens of Boston articulating the need for a general hospital and requesting financial support to build one. Three years earlier, President Thomas Jefferson, caught in a trade dispute between Britain and France, had declared an embargo closing all American ports to foreign trade. This severely affected Boston's economy. It wasn't an ideal time to be soliciting donations for a new hospital.

Even so, the people of Boston responded generously. On February 25, 1811, the Massachusetts State Legislature granted a charter to build Massachusetts General Hospital, only the third general hospital in the country at the time. The War of 1812 further challenged fund-raising, but on July 4, 1818, the cornerstone of the Bulfinch Building was laid, and in 1821, the hospital officially opened its doors.

NICU nurse provides delicate balance of hope and honesty



Jennifer Curran, RN, staff nurse, Neonatal ICU

My name is Jennifer Curran, and I am a staff nurse in the Neonatal ICU. I arrived to work well rested and ready to start the day. I looked at the ‘yellow sheet’ and saw I was assigned to Baby H. The resource nurse told me, “I hope you’re up for a challenge.”

Baby H was a full-term infant born the previous day at a community hospital. Her birth had been complicated by her entanglement in the nuchal cord and by the presence of thick meconium. She had immediately required a full resuscitation. The MGH transport team stabilized her and brought her to the MGH Neonatal ICU for further treatment.

Upon entering her room I saw a very pale infant lying on a warming table. The table was turned off, and she was lying on a cooling blanket. The team was purposely inducing hypothermia in an effort to preserve her brain function after the hypoxic event she endured at birth. I received report from the night nurse. I was told that Baby H was on vaso-pressor support and was having a difficult time being adequately sedated. The night nurse told me that Mom had also been transferred to MGH and was on the postpartum unit. She expressed concern that the parents didn’t fully understand how critically ill their baby was; that she could very well die or be severely impaired. This troubled me.

Shortly, after receiving report, I was told that Dad had arrived. When I first met Mr. H, I saw a young,

I wanted to answer honestly, so I told him that every baby is different, that Baby H had as good a chance as any baby, but only time would tell.

scared, anxious parent. I introduced myself and updated him on Baby H’s condition. He asked appropriate questions and wanted to know if I’d seen babies like this before and whether they had survived. I wanted to answer honestly, so I told him that every baby is different, that Baby H had as good a chance as any baby, but only time would tell. That was a statement I repeated many times to Mom and Dad during the nine weeks Baby H was at MGH.

After three days on the hypothermia protocol, Baby H faced another hurdle. She had developed primary pulmonary hypertension, and it was becoming difficult to keep her adequately oxygenated. She had three chest tubes placed, and her X-rays did not improve. After nine days and many interventions, it was necessary to place her on extra-corporeal membrane oxygenation (ECMO), a treatment that uses an external pump to support patients with acute respiratory failure.

When Baby H was placed on ECMO, Mom asked, “What if this doesn’t work?”

continued on next page

I felt privileged to have taken care of Baby H. I learned a great deal from this family. Through all the stress and anxiety of their baby's illness, they kept their faith and sense of humor. I am eternally grateful to this family for their confidence and perseverance.

I explained how ECMO can help the lungs rest and allow oxygen levels in her body to come back up.

A few days later when I arrived at work, the night nurse mentioned that Mom and Dad were expecting Baby H to come off ECMO today. This was not going to happen since Baby H's condition had not improved. I wondered why they thought this, and I was concerned about their reaction when they learned their daughter *wouldn't* be coming off ECMO today. When they arrived, I told them. I could see the disappointment and frustration on their faces. Mom had tears in her eyes. As it turned out, they had been told that ECMO usually takes about five days, but every case is different. It was another day of pain and disappointment for these parents. But they took it in stride saying they could get through this knowing Baby H was making a little more progress every day.

After eight days on ECMO, the decision was made to do a bronchoscopy. The hope was that a bronchoscopy might help remove any meconium she may have swallowed at birth. The bronchoscopy did, in fact, allow us to remove copious amounts of meconium, which was the reason Baby H had been struggling. Immediately after the procedure, I told Mom and Dad the good news.

Two days later, I was pleased to see that Baby H was scheduled to be removed from ECMO. Dad was worried and excited "What if it doesn't work? Can they put her back on?"

I explained that Baby H would not be taken off ECMO if doctors didn't feel she was ready. I explained the weaning process and suggested they speak with the doctor who immediately put them at ease. Baby H was removed from ECMO with no problems.

The next day was a huge milestone for Baby H and her parents. After almost three weeks, Mom was finally able to hold her daughter. It was great to see the smiles on Mom and Dad's faces.

Next, Baby H needed an MRI to confirm everything was okay. Waiting for the results was stressful. As it was being done, I turned to the respiratory therapist and said, "I don't know who's more nervous about this, me or the parents."

The next day, the parents were informed that the results were totally normal. Mom started to cry. I had tears in my eyes, too. It was a great relief.

Over the next two weeks Baby H was weaned from the ventilator and finally extubated. It was a happy and joyous occasion. I knew the next question would be, "When will she be able to go home?" I answered hon-

estly. Baby H had two more hurdles before she could be discharged—she needed to be weaned from narcotics and learn to feed by mouth.

I'm sure the parents thought the worst was over, though I had explained that these last few steps could be the hardest.

Each day Baby H was unable to wean from the narcotics, her parents were disappointed. By this time, they just wanted to bring their baby home. I reassured them that Baby H was making slow, steady progress.

The narcotics also made it hard for her to feed. She would take a small amount from the bottle then fall asleep. This was frustrating for the parents. I decided to consult the feeding team. Jean Ashland, speech therapist, evaluated her and felt she just needed to wake up a bit more for her feedings. When Mom heard this she started to cry. When I asked why, she said, "I'm just so tired of this. I want it to be over with."

I sat with her. I reminded her that we had talked about the fact that she might 'hit the wall' at some point. And this seemed like that point. I suggested that she and Dad take a day off and do something for themselves. We would make sure Baby H was okay. They deserved a break. They did take a day off and later told me they hadn't realized how much they needed a break.

Ten days later, Baby H was completely weaned off her narcotics and was feeding without any problems. She was finally ready to go home. After nine weeks, she left the NICU, and last I heard she was doing great.

I felt privileged to have taken care of Baby H. I learned a great deal from this family. Through all the stress and anxiety of their baby's illness, they kept their faith and sense of humor. I am eternally grateful to this family for their confidence and perseverance.

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

Being honest and providing hope is a delicate balance in any care situation, and especially in the NICU where tiny new lives are at stake. Jennifer never faltered in her honesty with this family, which is precisely why they trusted her. Compassion, presence, and a willingness to have the hard conversations are the core of patient- and family-centered care. Where there is honesty, there is trust. And where there's trust, there's hope.

Thank-you, Jennifer.

The effect of human interaction on quality and safety

—by Lin Wu, RN, staff nurse, White 9 Medical Unit

Healthcare systems excel at measuring the ‘what’ and ‘why’ of medical care, but patients are more concerned about the ‘who’ and ‘how’ of patient care.

Every day, we hear stories of bedside nurses delivering safe, high-quality care to patients at MGH. I’d like to share a story of one instance where human interaction helped improve the quality and safety of care.

Delivering safe, high-quality care depends on many factors: excellent medical technologies; clear, concise policies and guidelines; effective organizational structures; and a robust support system. But included in the list of factors affecting quality and safety should be strong, patient-provider interaction. Simple, human interaction has a profound impact on a patient’s ability to express his feelings, describe his symptoms, or adhere to a treatment plan. It also affects a patient’s perception that she is being respected as an individual. Healthcare systems excel at measuring the ‘what’ and ‘why’ of medical care, but patients are more concerned about the ‘who’ and ‘how’ of patient care.

Mr. M was treated in the Medical Intensive Care Unit for unresponsiveness, respiratory failure related to hyperglycemia, hypotension, and drug and alcohol abuse before being transferred to our general medical unit. He had a complex history of medical and mental illness. When Mr. M was admitted to our unit, he was



Lin Wu, RN, staff nurse, White 9 Medical Unit

alert, agitated, combative, and demanding. His medical, mental, and physical conditions still were not stable, so he required extensive medical treatment and nursing care. His gait was unsteady, and he was very weak, but he refused to cooperate with care. No matter how ill he was, whenever doctors, nurses, or patient care associates tried to explain why he needed certain interventions, he yelled and refused. He behaved the same with dietitians who tried to serve his meals. He even kicked clinicians who tried to assist him out of bed.

Because of his behavior and for his own safety and the safety of his caregivers, it was decided that Mr. M should be restrained. We continued to treat Mr. M and provide nursing interventions, and we arranged for a psychiatric consult. Soon Mr. M’s mental, medical, and physical condition began to improve, and he was released from soft restraints. He was assigned an observer

If we give patients what they need most—respect, compassion, and a sense that they're valued as individuals, they're more likely to accept help and cooperate with care. Giving them opportunities to participate in their own care gives them a sense of control.

to stay with him at all times for his continued safety and ours.

In most cases, patients become agitated or combative for reasons other than their primary diagnosis. Frequently, fear, frustration, or anger are what trigger adversarial behavior. Based on his medical and mental condition, I added 'increase human interaction' to my care plan for Mr. M. My goal was to identify the underlying cause of his behavior and help him understand that treatment was crucial to his recovery. My hope was that this understanding would induce him to cooperate with care.

Many things influence a patient's willingness to adhere to his care plan. It's not just a question of whether a patient accepts the information. It also depends on the provider's ability to gain the patient's trust and on the patient's perception of the provider's credibility, empathy, interest, and concern. If we give patients what they need most—respect, compassion, and a sense that they're valued as individuals, they're more likely to accept help and cooperate with care. Giving them opportunities to participate in their own care gives them a sense of control.

How we deliver care becomes very important in terms of patient satisfaction and engendering a spirit of cooperation and participation. How do we convey empathy, interest, and concern? How do we communicate? How do we ensure every patient feels respected? And how do we honor their values and beliefs? These are extremely important considerations in the care of all patients.

As these considerations related to the care of Mr. M, I started asking him some non-judgmental questions. Then I listened carefully to his replies. I looked for clues about his deep-seated emotional problems. I looked for ways to enhance his understanding of his condition and treatment, and I looked for opportunities to involve him in his care plan. I shared this plan with team members so we could work together to contribute to the quality of care and safety of this patient.

The first time I entered Mr. M's room, he was angry and looked at me with a challenging glare.

I started the conversation with a friendly, "Hi, Mr. M. Good morning."

I introduced myself and explained my role. He ignored me, showing no interest in my being there.

I said, "Did you sleep okay last night? What would you like to do today? Is there anything I can do to make you feel better?"

He looked at me and slowly started to answer my questions. Even though his answers were unfriendly and demanding, I listened and showed him my willingness to help. We had a conversation about how we could work together to make him feel better. That interaction was the beginning of a calm and mutually respectful relationship. He listened to my explanation and accepted my suggestion to have an observer for his daily activities.

After breakfast, he used his call bell and asked, "What can I do now?"

I knew it was important to spend time with Mr. M. And when I did, he confided, "I'm a good guy. I want to be normal. But I have problems."

I sat across from him and listened. He shared some of the many mental, social, and family issues that contributed to his feeling of hopelessness and frustration. In return, I listed some of his positive qualities. He smiled and I could see happiness in his face. When I asked what he'd like to do to make himself feel better, he said, "You tell me."

I encouraged him to continue working with the psychiatrist, social worker, doctors, and nurses.

He looked at me and said, "I'll try."

One afternoon, he came to me in an agitated state and said, "Lin, I feel anxious. I'm a nice guy. I'm trying to control myself. Please help me."

He was no longer confrontational. He accepted my suggestions. His state of mind was much improved. He was pleasant, cooperative with caregivers, and frequently asked for help. From that day on, Mr. M no longer needed an observer; he was no longer considered a "difficult" patient.

I believe that basic human interactions can have a positive impact on quality and safety. Compassionate, patient-centered care is every bit as important as technology.

Blum Center launches National Health Observance Discussion Series

Barbesino explained the most common forms of thyroid disorders: hypothyroidism (underactive thyroid); hyperthyroidism (overactive thyroid); and the development of lumps or nodules on the thyroid, often called goiters.

Kicking off the National Health Observance Discussion Series, sponsored by The Maxwell & Eleanor Blum Patient & Family Learning Center, on January 20, 2011, Giuseppe Barbesino, MD, presented, “Common Thyroid Disorders.” According to health educator, Jen Searl, thyroid disorders is one of the most frequently requested search topics in the Blum Center, so it was the perfect choice to introduce this new series.

Barbesino explained the most common forms of thyroid disorders: hypothyroidism (underactive thyroid); hyperthyroidism (overactive thyroid); and the development of lumps or nodules on the thyroid, often called goiters. He compared the feedback system between the thyroid and pituitary glands to that of a thermostat where the levels of one affect the output of the other. The goal of treatment for hypo- and hyperthyroidism is to normalize the hormone levels so the body receives the same amount of thyroid hormone as it would with a normally functioning thyroid. Barbesino talked about the connection between thyroid hormone and iodine, saying the use of iodized salt is sufficient to prevent consequences of iodine deficiency in most people. However, due to increased iodine demand in pregnancy, pregnant women should use a multivitamin supplement containing iodine.

The National Health Observance Discussion Series centers around the US Department of Health and Human Services’ Health Observance Calendar. The next lecture, “Heart Disease in Women, Dispelling the Myths,” presented by Nandita Scott, MD, is scheduled for February 9, 2011, in the Blum Center. For more information, call Jen Searl, health educator, at 4-3823.



Giuseppe Barbesino, MD, presents as part of National Health Observance Discussion Series.

Announcements

Lunchtime Fitness Sessions

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

Next session:

February 16, 2011
Haber Conference Room
12:00–12:30pm

For more information, call 6-2900

Red Sox Foundation and
Massachusetts General
Hospital

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—an unforgettable experience for any Red Sox fan.

Runners must raise \$1,000. Support may also be provided by "virtual runners" or donating directly. All proceeds benefit the Red Sox Foundation and Massachusetts General Hospital Home Base Program.

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.

Blum Center events

National Health Observance
Discussion Series:

"Heart Disease in Women,
Dispelling the Myths,"
presented by
Nandita Scott, MD

February 9, 2011
12:00–1:00pm

Healthy Living Series:
"Preventing Heart Disease"

February 22, 2011
12:00–1:00pm

All sessions held
in the Blum Center.

For information, call 4-3823.

Educational Ethics Forum

Save the date

The MGH Ethics Task Force and the PCS Ethics in Clinical Practice Committee are offering an educational program to assist clinicians in differentiating between capacity and competency—their impact on patients' ability to make healthcare decisions, and the ethical dilemmas that challenge providers in providing safe, compassionate care.

February 23, 2011
7:30am–4:00pm

Thier Conference Room

Register by February 16, 2011

For more information, or to register, call The Norman Knight Center for Clinical & Professional Development at 6-3111.

Scholarship to Advance Workforce Diversity

Partners HealthCare and the University of Massachusetts College of Nursing and Health Sciences are offering the Clinical Leadership Collaborative for Diversity in Nursing, a scholarship to advance workforce diversity.

Recipients receive a minimum of \$5,000 to be used for tuition.

Applications must be submitted by February 22, 2011. Recipients will be announced March 15th.

For more information, call Julie Goldman, RN, at 4-2295

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday,
7:30am – 5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday,
Thursday,
7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

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For more information, call:
617-724-1746

Next Publication

February 17, 2011

Focusing on diversity in 2011

Question: Is it true that new standards have been set by the Joint Commission for 2011 focusing on culturally competent care?

Jeanette: In 2010 the Joint Commission published a report called, “Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: a Roadmap for Hospitals.” The recommendations put forth in this report reflect the patient-centered communication standards familiar to us in our practice. Implementation of these standards began in January, 2011; full implementation is slated for 2012. The report calls attention to such topics as:

- leadership commitment to effective communication, cultural competence, and patient- and family-centered care
- integration of unique patient needs into new and/or existing hospital policies
- identification and accommodation of patients’ cultural, religious, and spiritual beliefs and practices throughout the continuum of care

I’m happy to say that MGH documentation practices and unit-based cultural rounds put us ahead of the curve in relation to these particular Joint Commission standards.

Question: My unit usually hosts a Hausman Nursing Fellow during the summer. Is that fellowship being offered this year?

Jeanette: The Hausman Fellowship continues to be a very important part of our diversity initiative thanks to the support of the Hausman Family. We’re actually expanding the program to include ten fellows. I’m looking forward to meeting this year’s fellows; they always add so much to our understanding of issues that affect diverse nursing students and give us a fresh perspective on our practices orienting new nurses.

Question: One of my colleagues mentioned that he participated in an accent-reduction program. That’s something I might like to try. How can I find out more about this program?

Jeanette: Yes, that program is growing in popularity. It was created to assist nurses who want to strengthen their pronunciation of Standard American English. For more information about the program, nurses can contact Barbara Blakeney, innovation specialist, The Center for Innovations in Care Delivery, at 4-7468, or Deb Washington, director of PCS Diversity, at 4-7469.



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