

Caring

Headlines

September 1, 2011

Iftar at MGH

a family, community, and multi-cultural affair



See story on page 4

Members of the MGH Muslim community, young and old, pray before breaking fast during this year's Ramadan celebration.

Innovation units: driving change with creativity and forward thinking

An innovation unit is just what it sounds like—a testing ground for new ideas. Establishing innovation units throughout the hospital will help us craft a care-delivery model for the future and quickly determine whether proposed changes work, or don't work.

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s everyone at MGH well knows, there's no such thing as 'the status quo' in health care. Change is the order of the day—*every day*. Technology changes. The economy changes. Patients change. And we change. I am reminded of the quote by German poet/playwright, Bertolt Brecht: "Because things are the way they are, things will not stay the way they are." We can all attest to the truth of that statement.

The best way to keep up with change that I know of, is to be creative, innovative, and always remain open to new ideas. Rising costs and a volatile national economy demand that hospitals run more efficiently while continuing to provide exceptional care and optimal patient outcomes. The work we're engaged in under the umbrella of the Partners Patient Affordability Direct Care initiative is a good example of creativity in the face of a changing healthcare landscape.

For the better part of the past year, inter-disciplinary teams have been looking at care-delivery at MGH with an eye toward re-designing systems to make care more efficient and affordable. Many wonderful ideas have been generated, but the one I want to talk about here is the concept of 'innovation units.' I love this idea. An innovation unit is just what it sounds like—a testing ground for new ideas. Establishing innovation units throughout the hospital will help us craft a care-



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

delivery model for the future and quickly determine whether proposed changes work, or don't work.

The goal of an innovation unit is to:

- increase continuity of care
- increase caregiver productivity
- increase inter-disciplinary teamwork
- introduce new technology and improve existing technology
- re-design the physical environment of care
- focus on patient and family values
- increase time spent with patients
- focus on organizational goals and mission

Innovation units would build on the research around relationship-based care, which states that chaos during hospitalization is minimized when healthcare workers are truly focused on the patient. Relationship-based care stresses three important tenets: the caregiver's re-

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lationship with the patient and family; the caregiver's relationship with his or her colleagues; and the caregiver's relationship with him- or herself (self-awareness).

At the heart of the innovation-unit model is the introduction of a new nursing role, that of attending nurse, or patient care coordinator. The attending nurse would serve as a kind of 'clinical CEO,' managing care on a single unit from admission to discharge. He or she would:

- serve as the primary contact for physicians, the care team, patients, and families, actively engaging them in the care plan
- work with nurses and patient care associates to promote teamwork and shared knowledge
- mentor and support new nurses and residents
- be accountable for continuity and progression of the care plan from admission to discharge
- ensure that patient care meets the clinical standards and vision of patient- and family-centered care
- develop and revise patient-care goals with the patient and the care team daily
- coordinate meetings for timely decision-making and optimize hand-offs across the continuum

We're still conceptualizing many components of the innovation unit, but we know that cohesive teams

achieve better clinical outcomes, work more efficiently, and maintain higher standards of quality and safety. Toward that end, we're meeting with all clinical disciplines to solicit input. Many open forums have already been held.

Success of innovation units will be measured by pre-determined metrics related to length of stay, patient-satisfaction, staff-satisfaction, quality and safety, and certain nursing-sensitive indicators.

Innovation units are being selected through an application process that began last month with proposals submitted by unit leadership. Ideally, we'd like to start with six or seven units from varying services (medical, surgical, pediatric, orthopaedic, etc.)

This is such an exciting opportunity. We are literally altering the future of care-delivery at MGH, tapping into the wisdom and creativity of staff, and using our knowledge to design models of care specifically tailored to our patients.

Applications for innovation units are due September 1st. We will review proposals and make a decision in the coming weeks. I look forward to working with you on this ground-breaking initiative as we continue to drive change with creativity and forward thinking.

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Ramadan celebration symbolizes hope and peace for many in the MGH community

Images of Iftar: The Thier Conference Room was transformed into a Muslim banquet hall and temporary Masjid (Muslim Prayer Room) for Iftar—the traditional breaking of the fast during the Islamic month of Ramadan.

On August 16, 2011, colorful posters and the delectable aroma of Middle-Eastern cuisine transformed the Thier Conference Room into a Muslim banquet hall and temporary Masjid (Muslim Prayer Room) for this year's Iftar—the traditional breaking of the fast during the Islamic month of Ramadan. Now an annual tradition at MGH, sponsored by Patient Care Services and MGH Human Resources, this all-inclusive, multi-cultural evening brings patients, families, staff, and visitors together for a sumptuous feast in observance of this important Muslim holiday.

Firdosh Pathan, RPh, a leader in the Muslim community and organizer of this event for the past decade, offered welcoming remarks, and Muslim chaplain, Imam Talal Eid, ThD, led the gathering in prayers.

Said Pathan, "This event is very meaningful for Muslims in the MGH community. It's a symbol of peace and hope, an opportunity for people to learn about the Muslim culture, and a wonderful gesture of inclusion and acceptance."

The ninth month of the Islamic lunar calendar, Ramadan marks a time when Muslims fast from dawn to sunset, abstain from smoking and sexual relations, and perform good deeds, such as giving to charities, giving up bad habits, visiting the sick, and helping those in need. Elderly and expectant mothers are allowed to abstain.

Islam is both a religion and a way of life, teaching peace, mercy, and forgiveness. Islam espouses five simple rules, called the Five Pillars of Islam. They are:

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Ramadan (continued)

Islam is both a religion and a way of life, teaching peace, mercy, and forgiveness. Islam espouses five simple rules, called the Five Pillars of Islam. They are: Belief, Worship, Fasting, Almsgiving, and Pilgrimage.

Belief, Worship, Fasting, Almsgiving, and Pilgrimage. It is thought that by dedicating an entire month to fasting, Muslims acquire self-control, discipline, generosity, and God-consciousness. It is a way to be less selfish, less self-centered, and more charitable. Ramadan is a 'training time,' a time for Muslims to engage in self-reflection and devotion to God. It is a time of renewal, of setting priorities, of seeking God's forgiveness, and forgiving others.

Because Ramadan is a lunar month, it begins approximately 11 days earlier every year. Muslims cele-

brate Eid-al-Fitr on the first day of the Islamic month of Shawwal, which also marks the end of Ramadan. Eid-al-Fitr will take place on or around August 31st this year (depending on the sighting of the moon).

The Masjid at MGH is located in Founders 109. Friday prayers are held in the Thier Conference Room. For more information, call Firdosh Pathan at 4-7878.



Ben Corrao Clanon Memorial Scholarship for NICU nursing

—by Mary Ellin Smith, RN, professional development manager

The Ben Corrao Clanon Memorial Scholarship recognizes a Newborn Intensive Care Unit nurse whose practice exemplifies the essence of primary nursing. The Corrao Clanons established the scholarship in memory of their son, Ben, who was a patient in the NICU for a short time prior to his death on August 13, 1986.

Award recipient, Alison Strong, RN (center), with (l-r): nursing director, Peggy Settle, RN; Strong's husband, Paul; Regina Corrao; and Jeff Clanon

On July 27, 2011, at the 25th presentation of the Ben Corrao Clanon Memorial Scholarship, nursing di-

rector, Peggy Settle, RN, spoke about life's many milestones. "At thirteen you're a teenager, at sixteen you get your driver's license, and at twenty-five you're considered an adult. Each year we come together, sad that Ben was not able to experience these milestones but grateful that his parents keep his memory alive through this important scholarship." Settle shared that the process of selecting a deserving recipient each year encourages staff to reflect on what it truly means to be a primary nurse and in so doing further develop this important role.

This year's recipient, Alison Strong, RN, has more than 30 years experience as a permanent night nurse. Said Strong, "The night time often affords parents an opportunity to process what has happened during the day. A primary nurse is pivotal in interpreting what's already happened, what could happen, and what will happen." Strong thanked her colleagues for their support, noting that all the nurses nominated were worthy of this recognition.

Regina Corrao and Jeff Clanon thanked the NICU nursing staff for the wonderful work they do. "We know that to you, it's your job. But to us, it's so much more than that. We hope you know how important it is and how grateful we are for each and every one of you and what you do."

For more information about the Ben Corrao Clanon Memorial Scholarship, contact Mary Ellin Smith, RN, professional development manager, at 4-5801.



(Photo by Michelle Rose)

Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy

—by Julie Goldman, RN, professional development manager

Award recipient, Tracey Dimaggio, RN (second from right), with (l-r): associate chief nurse, Debbie Burke, RN; senior vice president for Patient Care, Jeanette Ives Erickson, RN; and nursing director, Barbara Cashavelly, RN.

The Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy was established in 1999 by the families of Paul Cronin and Ellen Raphael in appreciation of the exemplary nursing care their loved ones received while patients on Phillips House 21. The award was created to recognize the contributions of clinical and support staff who consistently go above and beyond in identifying and addressing the

unique needs of patients and families. Cronin and Raphael believed that empowering the individuals who care for patients allows them to grow and flourish and ultimately excel in the important work they do.

On July 19, 2011, at a special reception in her honor, staff nurse, Tracey Dimaggio, RN, became this year's recipient of the Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy.

Criteria for selection are based on two attributes: patient-advocacy and empowerment. Patient-advocacy can be seen as a search for solutions to particular patient problems or partnering with other disciplines, departments, and family members to provide the highest quality, individualized care. Empowerment can mean empowering patients and colleagues or recognizing the need to challenge others and ourselves to meet the needs of our patients and families.

Dimaggio, a veteran nurse, takes pride in her work, continually seeking opportunities to advance her practice. She was nominated by co-worker, Bonnie Filicichia, RN, and many of her colleagues who wrote, "Tracey reassures patients with her calm demeanor and quick responsiveness when a patient is afraid, upset, or feeling ill. Her clinical skills are superb, but it is her personality and work ethic that make her the 'rock' of the unit. Tracey has genuine concern for every patient she encounters, and this is evident in her practice."

For more information about the Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy, call Julie Goldman, RN, professional development manager, at 4-2295.



(Photo by Paul Batista)

Every journey worth taking begins with a trepidatious first step

Mrs. M was a 74-year-old woman with a past history of esophageal cancer and colon cancer. She had been admitted for persistent abdominal pain, nausea, vomiting, and diarrhea.

My name is Lori Lancaster, and I am a nurse resident in the New Graduate ICU Nurse Residency Program. I feel grateful for the opportunity this program has afforded me; I cannot think of a better way for a new graduate to transition from student to clinician. Over the past four weeks since my induction into the program, I have spent three days on my 'home' training unit, the Surgical Intensive Care Unit (SICU), and three days on the Phillips House 20 General Care Unit.

I was very nervous my first day on Phillips House 20. I was accompanied by another nurse resident, and I think we were both filled with trepidation wondering about the kind of reception we'd receive. I'm happy to report that everyone went out of their way to make us feel welcome.

After being introduced to my nurse preceptor, we went over our assignments for the day. We had three patients. One patient, Mrs. M, was a new admission to the unit.



Lori Lancaster, RN, new-graduate nurse

Mrs. M was a 74-year-old woman with a past history of esophageal cancer and colon cancer. She had been admitted for persistent abdominal pain, nausea, vomiting, and diarrhea. After administering medications to our two other patients, we retrieved Mrs. M's medications from Omnicell. I was very focused on the process of getting the medications, double-checking that the meds I was retrieving were for the correct patient, double-checking the dosages, routes of administration, times of administration, scanning the meds to get the green check mark on the screen, remembering my password, and entering the correct clinical key.

On our way to Mrs. M's room, I rehearsed subcutaneous injections in my mind, I envisioned switching

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her IV fluid from normal saline to D5W. That's what was going through my mind when I noticed that Mrs. M's call light had come on.

We entered her room and introduced ourselves, and I asked Mrs. M how we could help. She immediately began to apologize, saying she thought she'd made a mess. When we pulled back the sheet, her suspicion was confirmed.

We began the process of cleaning her up and changing her bed, and when we finished, Mrs. M began to

cry. She was frustrated at being hospitalized again. She wanted to know why this was happening and why it wouldn't stop. My preceptor offered her words of comfort and I patted her leg reassuringly as tears rolled down her cheeks.

At that moment, all my thoughts of how to handle the technical aspects of her care—giving her an injection, changing her IV bag, programming pumps, and getting that green check mark—left me. I stood in the moment with Mrs. M. I realized that because we were nurses, this patient, this

woman, was able to lay her soul bare to us even though she had only just met us moments before. I was struck by the enormous responsibility we have as nurses to help people in the most vulnerable times of their lives.

I've only been working at MGH for a few weeks, but each day I feel I'm learning so much. A lot of what I'm learning is technical—how monitors work, how pumps are programmed, etc. But I'm also learning the human side of nursing—how to comfort, be supportive, and really *care* for patients. And I'm seeing how nurses care for each other.

I feel as if I'm at the beginning of an exciting journey. I know in the coming months and years I'll learn a lot and grow so much as a person and as a nurse. For now, though, I'm just grateful to have the opportunity to care for these vulnerable people we call patients.

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

What a powerful statement that is: "I stood in the moment with Mrs. M." And such an important milestone for a new nurse. Clinicians are expected to be competent, to deliver safe, effective, appropriate care. But clinicians who can be present to their patients in moments of fear, confusion, and vulnerability, are truly providing patient-centered care. We are fortunate that Lori learned this lesson so early in her career.

Thank-you, Lori.

The Nurse Residency Program is an innovative model for new-graduate nurses transitioning from student to practicing nurse. The Program is based on the concept of caring as the core value of the nurse-patient relationship. It is designed to promote, foster, and cultivate the concepts of caring in new-graduate nurses to enable them to meet the unique and varied needs of patients and families. The Nurse Residency Program is deeply rooted in our philosophy of patient- and family-centered care.

MGH Imaging ahead of the curve in reducing the risk of radiation exposure

—by Matthew Miller, Radiology

Recently, concern about radiation exposure associated with CT scans and other tests has been in the news and on the minds of patients and families. Because imaging is such a crucial part of diagnosis and treatment for so many patients, MGH Imaging would like to allay those concerns with some accurate information about what we do to ensure patient safety and minimize exposure to radiation.

MGH Imaging has employed a radiation-reduction program for more than a decade; we are leaders in developing and implementing dose-reduction technologies. Our physicians have published more than 100 articles on how to optimize the use of radiation, reducing the amount delivered to patients to the lowest effective levels.

In 2010, we established the Webster Center for Radiation Dose Research and Education (www.massgeneralimaging.org/webster). This

unique center brings together medical imaging physicists and radiologists to focus on dose-reduction strategies for every major organ system and disease. Our dose levels for CT scans are from 30% to 95% lower than reference levels used by the National Council on Radiation Protection. The chart below shows the reduced doses we've achieved relative to the national average for head, chest, and abdominal CT scans. In the past 18 months we have reduced the dose for CT enterography by 42%, follow-up kidney-stone CT by 87%, and cardiac CT exams by 75%.

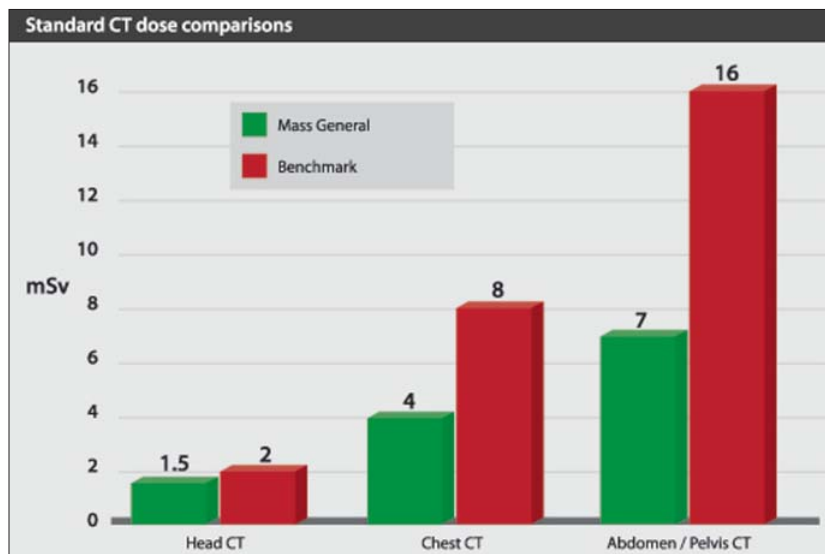
Says James Thrall, MD, radiologist in chief, "Our relationship with our patients is based on trust. It's our responsibility to make sure scans are safe and in the best interest of each patient based on their age, size, gender, and medical conditions."

Customizing radiation dosing is a delicate balance. Too little radiation can lead to inferior images that can limit diagnostic accuracy—necessitating additional scans.

Teams of specially trained radiologists, physicists, and CT technologists continually refine our CT protocols looking for opportunities to reduce radiation while maintaining optimal integrity of the images. Radiology Order Entry (ROE), our online ordering system, suggests radiation-free alternatives, such as MRI and ultrasound, when appropriate and alerts clinicians when exams aren't warranted based on indications. And our scheduling system has a built-in mechanism to help prevent duplicate scans.

Says JoAnne Martino, RN, director of nursing for MGH Imaging, "In September, we'll be providing an educational session for Patient Care Services nursing leaders, educators, and clinical specialists, so they'll be better prepared to speak to patients and families about these matters."

For more information, go to: www.massgeneralimaging.org/radiation.



Radiation doses for common CT exams at MGH compare favorably with national averages based on published studies

Journal Club looks at relationship between physical activity and glucose levels in type 2 diabetics

—by Martha Root, RN, on behalf of the REBPC Journal Club

In fact, the charts were more persuasive than verbal discourse, confirming that this data can be used to help influence inactive individuals to become more active.

At the July 13, 2011, meeting of the Research & Evidence-Based Practice Committee Journal Club, Yvonne L. Munn nurse researcher, Nancy Allen, RN, presented the published study, “Feasibility and acceptability of continuous glucose monitoring and accelerometer technology in exercising individuals with type 2 diabetes.” Allen used an accelerometer and a continuous glucose monitoring system (CGMS) to collect information on the relationship between physical activity and glucose levels in type-2-diabetics who exercise, then used the data to design a pilot study for non-exercising type 2 diabetics. She used the Social Cognitive Theory as a basis for measuring change in participants’ self-efficacy (the confidence one has to change behavior). The four factors that affect self-efficacy are: performance-accomplishment; vicarious experience/role-modeling; verbal persuasion; and physiological feedback or self-appraisal. This study could serve as a model for motivating inactive individuals with diabetes to engage in regular physical activity.

The multi-method study was conducted in two phases. In phase I, objective data was obtained about glucose and exercise levels from the CGMS and activity monitors. In phase II, qualitative data was gathered through focus-group interviews. The sample size was small—nine individuals from a cardiac rehabilitative program and an endocrinology clinic. Participants were largely homogenous: seven were male, all were white. A larger population will be used in later stages of research.

Walking was the exercise performed by most participants. Some lifted weights or stationary-bicycled at



moderate intensity. Participants engaged in activity four to seven days a week for 30–90 minutes at a time. Results showed that moderate physical activity lowered glucose levels an average of 63 mg/dl within five hours after exercise. Glucose levels were measured before and after meals. After exercising, pre- and post-meal glucose levels increased an average of only 2 mg/dl compared to an increase of 71 mg/dl with other meals. Participants were given charts to illustrate the changes that took place when they exercised. This allowed them to really see how physical activity and glucose levels were related. In fact, the charts were more persuasive than verbal discourse, confirming that this data can be used to help influence inactive individuals to become more active.

The next Journal Club meeting will be held Wednesday, September 14, 2011, from 4:00–5:00pm in Founders 311. Discussion will focus on the article, “The Value of Adding a Verbal Report to Written Handoffs on Early Readmission Following Prolonged Respiratory Failure,” published in the journal, *Chest*. For more information, call Martha Root, RN, at 4-9110.

Photo: Yvonne L. Munn nurse researcher, Nancy Allen, RN, at recent meeting of the Research & Evidence-Based Practice Journal Club.

MGH Youth Scholars: a new program and a new name

—by Susan Leahy, communications manager, Center for Community Health Improvement

For more than 20 years, MGH has been committed to expanding the horizons of Boston youth as a pathway from poverty to better health through programs that support education and personal growth and development. With a focus on science, technology, engineering, and math, the MGH Center for Community Health Improvement (CCHI) provides students with comprehensive programming, mentoring, summer employment, and paid internships.

The ProTech Program introduces young people to the diverse careers in health care through work-site rotations, professional-development forums, and paid summer and after-school internships. Since 2002, ProTech has graduated 83 students—26 still currently work at MGH or Partners, some in supervisory roles. Every ProTech graduate is college-bound, and 90% of graduates surveyed report that they are pursuing or planning to pursue careers in health care or the sciences.

Says Christy Egun, director of Boston Partnerships for CCHI. “Four years ago, the Center embarked on a strategic-planning process to create a comprehensive program that would be both inspirational and aspirational to Boston youth.” The result is a new program with a new name: MGH Youth Scholars. The new program offers students, grades 9–12, in-depth knowledge and access to employment opportunities in health care and the sciences.

On Wednesday, August 17, 2011, this year’s graduates of the Summer Jobs and Youth Programs were honored at a standing-room-

only celebration in the Starr Center Auditorium. Executive director of the MGH Institute for Patient Care, Gaurdia Banister, RN, delivered the keynote address, sharing details about her own personal journey and the lessons she learned along the way. Banister urged graduates to, “Know yourself; don’t underestimate yourself; have fun (lots of fun!), always look for opportunities, and never, never give up on your dreams.”

Recruitment for this fall’s Youth Programs is underway. Join the more than 200 MGH employees who are already playing an important part in a student’s future. If you’re interested in volunteering for MGH Youth Programs, contact Joan McCarthy at 4-3210.



(Photos by Michelle Rose)

Above left: 2009 ProTech Program graduate, Elizabeth Centeio, shares personal insights. Above right: manager of MGH School Partnerships, Galia Wise, addresses gathering. And at left: all the participants of the Summer Jobs and Youth Programs who attended the graduation ceremony, August 17, 2011, at the Starr Center.

Administering and documenting pneumococcal and flu vaccines

The Unit Census Monitor (UCM) displays a blue 'V' to indicate an active vaccine order. The V turns red if not acted on in 48 hours, and it goes away once it has been documented in EMAR.

Question: Why is there such an emphasis on vaccinating patients?

Jeanette: The Centers for Disease Control (CDC) mandate that hospitals screen for and vaccinate patients with both flu and pneumococcal vaccines. Hospitalization is viewed as an opportunity to vaccinate patients to help prevent pneumonia and flu. And hospitals are required to publicly report vaccination data.

Question: I know MGH has standing vaccine orders. How does that work?

Jeanette: Provider Order Entry (POE) automatically searches for prior vaccination of pneumovax and flu in the longitudinal medical record (LMR), Oncall, and the electronic medication administration record (EMAR). If no electronic documentation is found and the patient meets the age criteria, POE initiates a standing order.

Question: How would I know if my patient had an active vaccine order?

Jeanette: Vaccine orders are found in the PRN folder. In terms of vaccines, that means to administer when appropriate, ideally in the first 24 hours of admission.

The Unit Census Monitor (UCM) displays a blue 'V' to indicate an active vaccine order. The V turns red if not acted on in 48 hours, and it goes away once it has been documented in EMAR.

Question: Is it necessary to document in EMAR whether vaccine is administered or not?

Jeanette: Yes. EMAR documentation is required for all vaccine orders. If the vaccine is not given, click 'Not Given' and indicate the reason in the drop-down menu. This ensures patients don't receive the vaccine during future admissions, and is in accordance with regulatory standards.

Question: Are there other changes in EMAR related to vaccines?

Jeanette: Starting on September 7, 2011, nurses will be prompted with a hard stop upon printing discharge forms if there's an active flu or pneumovax order that hasn't been documented. Nurses will be able to complete the discharge paperwork but won't be able to print it until the flu and/or pneumovax order is documented. With flu season just around the corner, this is a way to ensure our patients are offered protection against the flu and/or pneumonia.

Question: The July 21st issue of *Caring Headlines* had an article on vaccine safety. Where can I find more information on vaccines?

Jeanette: An educational module on flu and pneumococcal vaccines was recently developed and is available in HealthStream.

For more information on flu and pneumococcal vaccines, call Chris Annese, RN, staff specialist, at 6-3277.

Announcements

Clinical Recognition Program

The Clinical Recognition Review Board and Steering Committee are happy to announce a new initiative by which clinicians applying for recognition at the advanced clinician and clinical scholar levels can submit their portfolio for a preview prior to formal submission. This voluntary, anonymous process gives clinicians an opportunity to receive feedback on their portfolios from former review board members.

Reviewers will provide feedback on specific areas identified by clinicians, leadership, and review board members based on past experience.

For more information, e-mail questions or portfolios to MGH PCS Clin Rec (in the Partners directory).

Clinical Pastoral Education

Three Schwartz Center fellowships will be awarded for the winter 2012 Clinical Pastoral Education Program for Healthcare Providers

Open to clinicians from any discipline who work directly with patients, families, or staff and who wish to integrate spiritual care-giving into their practice, The Clinical Pastoral Education Program for Healthcare Providers is a part-time program with group sessions on Mondays from 8:30am–5:00pm. Additional hours are negotiated for the clinical component.

Program starts January 9th, concludes May 18th. Applications are due by September 15, 2011.

For more information, call 6-4774 or 4-3227.

September 11th Remembrance Service

10-year anniversary

Friday, September 9, 2011
9:00am and 12:15pm
MGH Chapel

Remembrances will also be part of the 11:00am Shabbat Service, the 4:00pm Catholic mass, and be broadcast on MGH Channel 16.

Be a collaborative governance champion

Applications are now being accepted for collaborative governance, the committee structure that integrates multi-disciplinary clinical staff into a formal decision-making body within Patient Care Services.

Applications due by October 7, 2011.

For more information, visit: <http://www.mghpcs.org/IPC/Programs/Governance.asp>, or contact Mary Ellin Smith, RN, at 4-5801.

Jeremy Knowles Nurse Preceptor Fellowship

Call for Applications

Applications are now being accepted for the Jeremy Knowles Nurse Preceptor Fellowship recognizing preceptors for excellence in educating, inspiring, and supporting new nurses or nursing students in their clinical and professional development.

The one-year fellowship provides financial support to pursue educational and professional opportunities.

Applications due September 12th. For more information, call Mary Ellin Smith, RN, at 4-5801.

Blum Center focuses on pain-management

September is Pain Awareness Month. The Blum Center will host free lectures on pain-management every Thursday.

Topics will include:

September 1st
"Communicating with Your Doctor About Pain"
with Paul Arnstein, RN

September 8th
"Coping Skills"
with Ronald Kulich

September 15th
"Pain Control for Surgery"
with Adam Carinci, MD

September 22nd
"Cancer Pain"
with Shihab Ahmed, MD

September 29th
"Prescription and Non-Prescription Pain Medications"
with Paul Arnstein, RN

All lectures held at 5:30pm in O'Keefe Auditorium.

Light refreshments served.

For more information, call 4-3823.

American Assembly for Men in Nursing Seeking members for new chapter

The American Assembly for Men in Nursing (AAMN) is seeking members to launch a New England chapter. AAMN is a national organization that provides a framework for nurses to meet, discuss, and influence factors that affect men in nursing. The AAMN offers scholarships, continuing education programs, and advocates for research and education for the recruitment and retention of men in nursing.

Membership is open to all nurses, male and female. For more information on joining the New England chapter, e-mail Gerald Browne, RN, or visit aamn.org.

One Celebration of Many Stars

Patient Care Services Awards Ceremony

Tuesday, October 4, 2011
4:00pm
Under the Bulfinch Tent

Honoring this year's recipients of:

- the Anthony Kirvilaitis Jr., Partnership in Caring Award
- the Brian M. McEachern Extraordinary Care Award
- the Jean M. Nardini, RN, Nurse Leader of Distinction Award
- the Marie C. Petrilli Oncology Nursing Award
- the Norman Knight Clinical Support Excellence Award
- the Norman Knight Preceptor of Distinction Award
- the Stephanie M. Macaluso, RN, Excellence in Clinical Practice Awards

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

Collaborative Governance Celebration

September 13, 2011
O'Keefe Auditorium

10:00–11:00am

Inter-disciplinary case study with commentary by Michael Bleich, RN, dean and Dr. Carol A. Lindeman distinguished professor at Oregon Health and Science University

3:00–4:30pm

14th annual Collaborative Governance Celebration "200 Years Later: the Importance of Interdisciplinary Collaboration," presented by Michael Bleich

For more information, call Mary Ellin Smith, RN, at 4-5801.

Clinical Research Day Last call for abstracts for Clinical Research Day

October 6, 2011
8:00am

under the Bulfinch Tent

Keynote address by Carolyn
Clancy, MD, director of the
Agency for Healthcare Research
and Quality (AHRQ).

Investigators throughout
the hospital are invited to
submit abstracts at [http://crp.
abstractcentral.com](http://crp.abstractcentral.com).

Submissions must relate to clinical
research conducted at MGH
including manuscripts published
after June 30, 2010.

Deadline for submission:
September 9th

For more information, call
Suzanne Powell at 4-2900.

MGH Nurses: Impact and Influence

presented by
MGH Nurses' Alumnae
Association, Inc. and co-
sponsored by the MGH Institute
of Health Professions School of
Nursing

September 23, 2011
8:00am–5:00pm

O'Keefe Auditorium

Topics will include:
MGH at 200,
MGH Nursing at 200
The Role of MGH Nurses in
Disasters
Nursing Research
and more

\$30 for MGHNAA members and
MGH employees
\$40 for all others

Register by September 16th
6.0 contact hours

For more information, e-mail
mghnursealumnae@partners.org

Staff Perceptions of the Professional Practice Environment Survey

The 2011 Staff Perceptions of the Professional Practice Environment Survey (SPPPE) will be distributed to nurses, physical therapists, occupational therapists, speech-language pathologists, respiratory therapists, social workers, child-life specialists, and chaplains within Patient Care Services between September 12 and October 7, 2011. Each PCS clinician will receive an e-mail with a direct link to the survey.

What is the purpose of the Survey?

The survey:

- provides an assessment of organizational characteristics influencing staffs' perceptions of, and satisfaction with, the MGH professional practice environment
- monitors the impact of unit and organizational changes on staff perceptions of the professional practice environment
- enables us to see trends in staffs' perceptions of the professional practice environment
- identifies opportunities to improve the environment for practice

The survey measures eight organizational characteristics influential in determining satisfaction with the professional practice environment. Questions were generated to determine staffs' perceptions around each characteristic: autonomy, control over practice; relationships with physicians; teamwork; communication; conflict-management; internal work motivation; and cultural sensitivity. The Revised Professional Practice Environment Scale (RPPE, 2007) shows that the instrument provides a reliable and valid measure of staffs' perceptions of the professional practice environment.

What's new this year?

This year, in addition to the question that gives participants a chance to provide extended feedback about their practice at MGH, there will be another open-ended question about staffs' perceptions of empowerment in the clinical setting.

The survey will also be administered to clinicians in ambulatory and health-center settings, as applicable.

Is the survey anonymous?

The survey is voluntary, and all answers are completely confidential. Each survey contains a randomly generated ID number used only by the data analysis team in the Yvonne L. Munn Center for Nursing Research.

This number allows clinicians to complete the on-line survey over multiple sessions, if desired, and prevents multiple surveys from being submitted by the same individual. The ID numbers and survey answers are shared with *no one*, and there is no way to link responses to individual names.

How is this data useful in driving improvement initiatives?

The data is analyzed both quantitatively and qualitatively. Numbers tell a story and point to certain trends over time. This information helps us recognize areas that need improvement, gives us a way to evaluate new initiatives, and guides changes to enhance the practice environment. Qualitative data provides insight into aspects of the professional practice environment from which we can learn.

To ensure confidentiality and maintain the integrity of the data, results of the Staff Perceptions of the Professional Practice Environment Survey are reported in aggregate and grouped in three ways: all of Patient Care Services, discipline-specific, and unit-level. Through discussions at staff meetings, ideas for improvement can be identified and developed.

Participation in the survey by all staff within Patient
Care Services is important.

We look forward to seeing your responses again this year.

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Clarifying the champion role and other changes to collaborative governance

Question: Are there still Excellence Every Day and Magnet champions at MGH?

Jeanette: The champion model is still in place, but it has been broadened and integrated into the collaborative-governance committee structure as part of the re-design of collaborative governance. The work of Excellence Every Day and Magnet champions has been incorporated into the work of collaborative governance committees, so every collaborative governance member is now a collaborative governance ‘champion.’ While the word, champion, has been associated with Excellence Every Day and Magnet efforts in the past, the attributes of a champion (empowered communicators, content experts, and leaders) were the same qualities we look for in collaborative governance members. In fact, many former EED and Magnet champions are now serving as collaborative governance champions.

Question: What are the responsibilities of a collaborative governance champion?

Jeanette: The key responsibilities of a collaborative governance champion are to communicate, educate, and influence. Champions have the ability to bring information to and from committee meetings. They can bring the concerns and ideas of colleagues on their units to meetings, and they can relay what happens at meetings back to their units.

Champions are in a unique position to educate themselves and others about what transpires at committee meetings and about timely issues affecting the hospital. This, in turn, creates opportunities to influence practice and policy and generate interest and enthusiasm on units and throughout departments.

Question: My unit doesn’t have representation on all committees. How can I stay informed?

Jeanette: We recently launched a new Excellence Every Day portal page, a website that serves as a central clearinghouse for information related to collaborative governance, Magnet recognition, and regulatory readiness. Because these areas are so closely connected, it made sense to create a unified site where staff can easily access essential materials and resources.

The portal can be accessed at: http://www.mghpcs.org/eed_portal/index.asp. Here, you’ll find up-to-date information on the work of all the collaborative governance committees, regulatory agencies and standards, and Magnet re-designation. From the collaborative governance site, you can access a list of all the collaborative governance leaders and champions.

Question: Is there a contact person for more information?

Jeanette: My guess is that you’ll find all the answers you need on the Excellence Every Day portal page. But if you have questions, contact Mary Ellin Smith, RN, at 4-5801.



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