

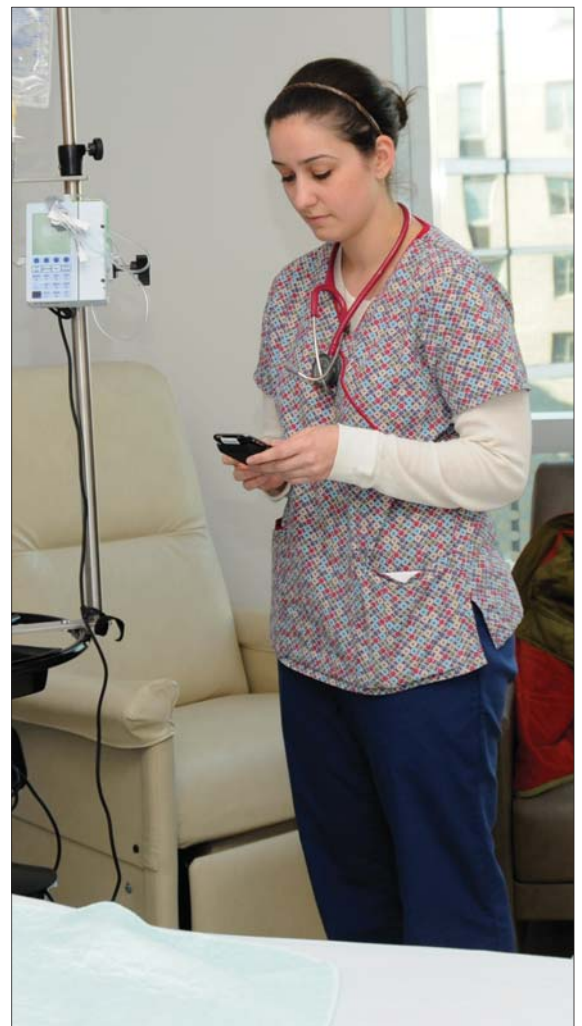
Caring

Headlines

January 19, 2012

New technology enhances communication

- ✓ *improves patient satisfaction*
- ✓ *improves staff satisfaction*
- ✓ *improves efficiency*
- ✓ *minimizes noise*
- ✓ *reduces costs*



Patient care associate, Thi Duong (left), and staff nurse, Kelly Donahue, RN, are among the many caregivers using a new hand-held device to communicate faster and more effectively on patient care units. See story on page 4 for more information.

Accountable Care Organizations

Working together to coordinate care and contain rising healthcare costs

ACOs operate on a shared-savings model that rewards high-quality care, increased coordination of services, and reduction of unnecessary spending.

By now, we've all heard the buzz about accountable care organizations (ACOs), but in some quarters, the news that Partners HealthCare has been selected as a Pioneer Accountable Care Organization has raised more questions than it's answered. So I'd like to use this column to explain what an ACO is, how it works, and why we're participating.

An ACO is a group of doctors, hospitals, and other healthcare providers who join together in a contract with the Centers for Medicare and Medicaid Services (CMS) and agree to be accountable for the quality, cost, coordination, and overall care of Medicare patients. ACOs operate on a shared-savings model that rewards high-quality care, increased coordination of services, and reduction of unnecessary spending. When ACOs are successful in delivering high-quality care more economically (judged against a national benchmark), they share in the savings. When they fall short of national benchmarks, they're held accountable for increased expenditures.

Partners is one of 32 healthcare organizations across the country (five in Massachusetts, including: Atrius Health; Beth Israel Deaconess Medical Center; Mount Auburn Cambridge Independent Practice Association; and Steward Health Care) to be named a Pioneer Accountable Care Organization. The Centers for Medicare and Medicaid Services have established a list of 33 quality measures by which to evaluate the success of Pioneer ACOs. The quality measures we will use reflect five domains affecting patient care:



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

- the patient and caregiver experience of care
- care coordination
- patient safety
- preventive health
- at-risk population/frail, elderly health

In December, letters were sent to the almost 50,000 Medicare patients who receive their primary care at Partners hospitals informing them of our participation in the Pioneer ACO program. We know that any time there's change, there are questions. Some questions you might expect to hear from patients include:

Why are we doing this?

Answer: We are committed to providing high-quality, affordable care. Through the Pioneer ACO we will be working in a more coordinated way to meet your medical needs. MGH and Partners have always led the way in exploring innovative solutions to healthcare challenges; our participation in the Pioneer ACO program is another opportunity to break new ground in care delivery and re-design.

continued on next page

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Will my benefits change?

Answer: No. Your benefits will not change. Your health coverage, premiums, and insurance arrangements are not affected by our participation in the Pioneer ACO. You remain free to choose any doctor or hospital that accepts Medicare at any time.

Is there a cost to patients?

Answer: No. Patients incur no cost as a result of our becoming an ACO.

How will this affect patients?

Answer: Primary care physicians are participating in this program to be part of a better, more coordinated care team. The goal is to ensure that patients receive the right care at the right time in the right setting.

Who will have access to my health information?

Answer: Access to your health information will continue to be limited to your health providers and those responsible for your care. Medicare will not share specific details about your health. Medicare will combine some information (such as number of visits to the doctor, medical conditions, and prescriptions) in order to better understand how patients use healthcare services and what their needs are. This will allow us to develop better systems and improve care.

I hope this clarifies some of the questions people have about accountable care organizations. Health care is a dynamic, constantly changing, service-oriented industry. We are accustomed to challenges. We will do what we always do as we explore this new opportuni-

ty—we'll let the safety and welfare of our patients guide us to new solutions and new ways to deliver patient- and family-centered care.

For more information about accountable care organizations, call the PartnersHealth Pioneer ACO hotline at 1-855-644-1544.

Update

I'm pleased to announce that Barbara Blakeney, RN, innovation specialist, has been selected to participate in the CMS Innovation Advisors Program. The program, launched by the CMS Innovation Center in October of 2011, is designed to engage individuals in the healthcare industry to refine, apply, and sustain the managerial and technical skills necessary to drive delivery-system reform. Barbara is one of only 73 individuals chosen from 23 states who will be participating in the program. Innovation advisors will work with the CMS Innovation Center, testing new models of care delivery in their own organizations, creating new partnerships, and sharing the ideas they generate regionally and nationally.

Barbara tells me she's, "thrilled to be a part of this exciting, cutting-edge opportunity to join with others across the country to test innovations and advise CMS on emerging models of care. I look forward to sharing with the MGH community all that I am privileged to learn throughout this coming year's work."

For more information about this exciting opportunity, contact Barbara directly at 4-7468.

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Revolutionizing communication on patient care units

—by Jennifer Lassonde, senior project specialist

Lunder 9 staff nurse, Katie Aguilar, RN, uses new cell-phone technology to communicate quickly with her colleagues.

Effective communication is essential to the delivery of high-quality health care. Technological advances are making it easier and easier for staff to communicate in the fast-paced, clinical setting of inpatient care units. After piloting several products last year, a new device was selected for use by staff within Patient Care Services. The new product combines a

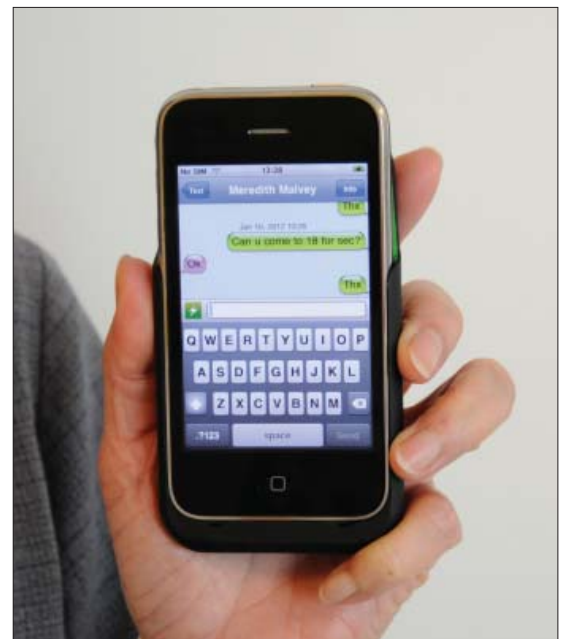
software application designed by Voalté with the user-friendly interface of an iPhone, the result of which is a communication system that is quick, quiet, effective, and easy to use. These specially programmed phones are now being used on Lunder 6–10 and in the new Blake 12 ICU.

Staff can send instant messages to individual members of the team or to several recipients at once; they can voice-call using the hospital's secure wireless network, ensuring privacy and security for all communication. And customized, pre-set messages make it even easier to send and receive information.

Says Barbara Cashavelly, RN, nursing director of the Lunder 9 Oncology Unit, “These phones have improved communication on our unit one hundred percent. They’ve reduced the number of overhead pages, and the noise level, in general, has decreased. And staff love having the ability to receive and respond to messages instantly.”

It’s not an exaggeration to say these new phones have revolutionized communication on patient care units, and additional uses are still being explored. The goal is for hospital-wide roll-out of Voalté phones following enhancements to the information network infrastructure.

For more information, call Jen Lassonde at 4-1749.



Home monitoring improves management of hypertension

—submitted by the Partners Center for Connected Health

“The program is a gem,” says Donna Leone, RN. “Patients are happy with the convenience of the blood-pressure cuff and the high level of support they receive. They don’t have to come into the office to have their blood pressure checked, and the equipment is easy to use.”

Patients who experience high blood-pressure readings during doctors’ visits often attribute those higher readings to the stress associated with going to the doctor. Hypertensive patients require frequent blood-pressure checks and medication changes to help manage their care.

Says Robert Singer, MD, of MGH Everett Family Care, “In medical school, we’re taught to diagnose and treat medical problems. We’re not taught how patients will react when learning they have an illness or health condition. It’s surprising how many patients when diagnosed with hypertension don’t believe they have it, insist there’s an alternative explanation, or don’t think they need treatment.”

Blood Pressure Connect is a home monitoring program developed by the Partners Center for Connected Health (www.connected-health.org), that enables patients and providers to view blood-pressure readings and facilitate communication. Patients are given a wireless blood-pressure cuff that stores and transmits physiological data to a (secure) website that can be viewed by their healthcare providers.

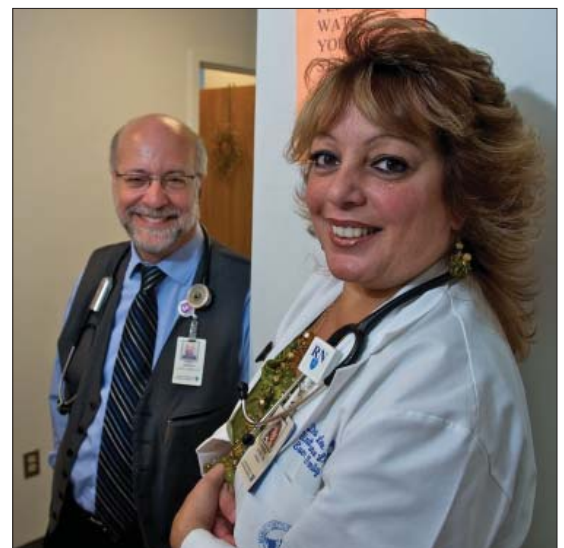
“The program is a gem,” says Donna Leone, RN, of MGH Everett Family Care. “Patients are happy with the convenience of the blood-pressure cuff and the high level of support they receive. They don’t have to come into the office to have their blood pressure checked, and the equipment is easy to use.”

Blood Pressure Connect is offered throughout the Partners HealthCare network. The program allows pro-

viders to remotely assess the status of their patients and proactively manage their hypertension treatment. Providers have access to regular, accurate, patient data, allowing them to titrate medication without patients having to come in for frequent office visits.

Says Singer, “Blood Pressure Connect allows patients to be more involved in their own care and gives them a real connection to their providers. Being able to see their blood-pressure readings is empowering. As a result, patients make better lifestyle choices, are more willing to follow their recommended care plans, and are more satisfied with their care.”

For more information about Blood Pressure Connect, call Khinlei Myint-U at 4-3516.



(Photo provided by staff)

Peeling back the layers of complexity to understand patients' needs

Mr. O is a 48-year-old man with a history of multiple sclerosis and spastic paraparesis; he was admitted to MGH for management of varicella zoster (a herpes virus)

My name is Heidi Cheerman, and I am a physical therapist. Having worked with patients with chronic neurological disorders for the past nine years, I continue to be amazed at their ability to adapt and function under the most challenging conditions. In the acute-care setting, clinicians must be able to understand and build a rapport with patients in a very short period of time, often within a single treatment session. That means gathering, synthesizing, and integrating the most pertinent data to make effective clinical decisions on treatment approaches and recommendations.

Mr. O is a 48-year-old man with a history of multiple sclerosis and spastic paraparesis; he was admitted to MGH for management of varicella zoster (a herpes virus). Due to this infection he experienced generalized weakness prior to being admitted, which impacted his functional mobility. The day he was admitted, his status had declined to the point that he could barely sit on the edge of his bed. In fact, he had fallen at home while attempting to transfer to his wheelchair.

Mr. O has experienced a steady decline in functional mobility over the last few years. Three years prior to admission he was walking independently. With the progressive nature of his disease, he now spends most of his time in his wheelchair. He has maintained a strong sense of determination, which has allowed him to lead an independent life and be a supportive husband to his wife of 11 years.



Heidi Cheerman, PT, senior physical therapist

In reviewing his chart, I noticed that Mr. O had experienced a number of falls while at home over the last two years. During my interview with him, Mr. O explained that the falls occurred most often when transferring from his wheelchair to his bed (which is 3'2" high). My initial judgment was that Mr. O lacked insight into his current functional limitations. Cognitive deficits are common in patients with MS, and given his history of frequent falls, my thinking was that he probably shouldn't be left at home alone. Experience told me that I needed additional data in order to form an accurate clinical impression.

During my initial evaluation, Mr. O was very positive and outgoing and exhibited a good sense of humor. One member of the team interpreted Mr. O's jokes as not taking his situation seriously. But through further observation, I came to understand that his reliance on humor was a coping strategy; it allowed him to deal with the stress of his current condition and the challenges of what had been a very difficult life.

Mr. O lives in a one-story, ramp-accessible home equipped with grab bars in the bathroom, a shower

continued on next page

Mr. O is an example of how recommendations we initially think are in the best interest of our patients may not actually be optimal. By listening to Mr. O, his wife, and his physician of long standing, I was confident in my clinical decision to advocate for his discharge home... As I continue to move forward in my practice, Mr. O serves as a reminder that clinical decision-making is not a clear-cut process.

chair and commode, a customized wheelchair, and a rolling walker for transfers. He's able to perform activities of daily living while his wife is at work, and she assists him with laundry and grocery shopping and other activities when she's home. His exam revealed decreased activity tolerance; postural control deficits; increased bilateral, lower-extremity tone; strength and motor-control deficits; and range-of-motion deficits.

After being in bed for four days during this admission, Mr. O needed moderate assistance to sit on the edge of the bed. When I removed my hand, he initially lost his balance, but recovered with internal feedback. Evaluating Mr. O's ability to transfer from the bed to the chair was a priority during this initial evaluation and critical to constructing a plan of care and recommendations for discharge.

I decided to set up a transfer that simulated Mr. O's home environment. I set his hospital bed to three feet high (neither foot able to reach the floor while sitting on the bed) and took into account his impairments and history of falling. I found myself doubting the safety of the plan, but Mr. O assured me he felt "100% confident" he could do it (based on doing it at home every day). I decided it was a sound clinical risk. To ensure his safety, I padded the floor around his bed and called his nurse and a patient care associate to help. He performed the transfer with moderate assistance, his movements resembling that of a patient with partial paralysis, i.e., depending on upper body strength for mobility.

I brought up the idea of a short inpatient rehabilitation stay with Mr. O, but he was adamant that he wanted to go home, saying, "I just need to increase my mobility, and I'll get it back quickly. I know my body."

I called Mrs. O after the session, and she shared her concern about his "coming home in this condition." She has developmental issues that affect her short-term memory and problem-solving abilities. She also experiences anxiety in new situations. But she expressed concern that if Mr. O went to rehab, "he might never come home." She agreed to come in the next day to discuss and observe her husband's status.

Prior to our session the next day, in order to gain more insight into Mr. O's care, I consulted with the physician who had been following his case over the past five years at the MS Clinic. I expressed my concern about his going home and my rationale for an acute inpatient rehabilitation stay. He felt strongly that it would be in Mr. O's best interest to be discharged home, citing the resources he had in place, his history of functioning well at home before, his history of de-

pression, and the psychological stress of not being home to support his wife.

After my session with Mr. O and his wife, I had a greater understanding of their situation and was determined to find a solution for Mr. O to discharge home safely. Taking into account their concerns and Mr. O's goals, his physician's opinion, his home set-up, and functional abilities, I felt confident that Mr. O would function well if discharged home. Later that evening, I researched additional resources for Mr. O and his wife to support a successful discharge. Knowing the progression of MS and anticipating continued decline, I gathered information on home, self-transfer, lift systems.

With continued PT intervention, Mr. O was able to safely and independently transfer to a level surface using a slide board. I coordinated with the case manager to have a hospital bed delivered to Mr. O's home to enable him to perform bed and wheelchair transfers at home with greater ease.

Many layers of complexity need to be peeled back to have a complete understanding of patients' needs. Mr. O is an example of how recommendations we initially think are in the best interest of our patients may not actually be optimal. By listening to Mr. O, his wife, and his physician of long standing, I was confident in my clinical decision to advocate for his discharge home. By digging beneath the surface, I was able to find additional resources for Mr. O. As I continue to move forward in my practice, Mr. O serves as a reminder that clinical decision-making is not a clear-cut process.

I ran into Mr. O's wife recently and heard he's functioning well at home. I felt further assured that the plan we put in place for him was working and a great sense of happiness for him and his wife.

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

Flexibility, active listening, and an open mind: three key qualities in the delivery of patient- and family-centered care. Heidi skillfully assessed Mr. O's functional abilities and limitations, even simulating his home environment to ensure his safety. She was thorough and persistent in creating a discharge plan that was clinically sound and met the unique needs of this patient and his wife. And perhaps most important, she left herself open to all options, driven not by the need to be right, but by the desire to do what was best for Mr. O.

Thank-you, Heidi.

Gregory presents at November Journal Club

—submitted by the Research & Evidence-Based Practice Committee

On November 9, 2011, the Research & Evidence-Based Practice Committee Journal Club hosted Katherine Gregory, RN, nurse scientist and assistant professor at the Connell School of Nursing. Gregory presented her original research: “Clinical Predictors of Necrotizing Enterocolitis in Premature Infants,” published in the July/August, 2008, issue of *Nursing Research*. Gregory’s research objectives were to improve the understanding of factors related to intestinal inflammation and ischemia and the enteral feeding regimen in premature gastrointestinal tracts, hoping to identify preceding events or causes of necrotizing enterocolitis (NEC).

Nurse scientist, Katherine Gregory, RN, presents at November meeting of the Research & Evidence-Based Practice Committee Journal Club.



Prematurity is the single greatest risk factor for NEC. Gregory’s retrospective, case-controlled study involved data collected from 247 pre-term infants born in an urban academic medical center in the Northeast. Results showed that premature infants were 13 times more likely to develop NEC if they required increased respiratory support to maintain oxygenation during the early neonatal period, and 6.4 times more likely to develop NEC if they didn’t receive nutritionally fortified enteral feedings of breast milk. When both factors were present, the likelihood of developing NEC increased 28.6 times compared to infants without those factors. Approximately 50% of infants with NEC recover fully with bowel rest and antibiotics, while 50% develop severe disease requiring urgent surgical intervention.

Gregory reviewed the signs and symptoms of NEC and radiological and diagnostic lab findings. She stressed the value of nursing assessments to recognize early signs of NEC as there’s no specific lab test that can identify NEC in infants.

The next step is to look at nurse-sensitive assessments most commonly present in the short window of time prior to NEC diagnosis at each stage of the disease. For example, Gregory recommends assessing infants for changes in respiratory support and close monitoring of infants’ abdominal girth.

The next meeting of the Research & Evidence-Based Practice Committee Journal Club was held January 10, 2012, where Dr. Knight presented her original research on, “Fall Risk in Patients with Acute Psychosis,” published in the *Journal of Nursing Care Quarterly* in 2010. Look for information on this presentation in the next issue of *Caring Headlines*.

For information on upcoming Journal Club meetings, e-mail Laurene Dynan, RN.

Staying on board the SOS Campaign

In September of 2011, the SOS (Save Our SKIN) Campaign was rolled out to help eliminate hospital-acquired pressure ulcers. In 2008, the Centers for Medicare and Medicaid Services (CMS) began recognizing hospital-acquired pressure ulcers as medical errors and discontinued payment for their care.

The SOS Campaign consists of several components.

The SKIN bundle includes:

S = Skin assessment/risk assessment (Braden Scale) upon admission and daily thereafter

- Ensure that a provider is aware and documents any pressure ulcers present upon admission within 24 hours of admission
- Activate the Skin Integrity Problem List and appropriate interventions based on Braden and sub-scale scores for risk of pressure ulcers
- Document assessment findings each time the dressing is changed
- Document interventions that were implemented, patient's response to interventions, and changes made to treatment plan each shift

S = Surfaces

- Ensure proper mattresses, beds, and chair cushions are employed

K = Moving/turning

- Turn patient in bed every two hours or more frequently
- Don't allow patient to sit in chair for more than two hours at a time
- If patient sits in chair, relieve pressure every 15–20 minutes

I = Incontinence management

- Toilet patient every one to two hours
- Prevent maceration in patients with incontinence or at risk for incontinence

N = Nutrition

- Assist/feed patients meals and nutritional supplements as needed
- Ensure that a dietician is consulted for at-risk patients (a score of one or two on the Braden nutrition sub-scale)
- Ensure that dietician's recommendations are converted to physician orders
- Ensure nutritional supplements are recorded on the Treatment Sheet

Other components of the SOS Campaign include:

- unit-based "huddles" of nursing staff and unit leadership when a new pressure ulcer is first detected and weekly thereafter
- completion of Huddle Data Form to evaluate adherence to the SKIN Bundle
- filing a safety report when a new Stage II, Stage III, Stage IV, un-stageable, or deep-tissue injury is detected
- changing occlusive and long-wear dressings (such as Duoderm and Mepilex Border Lite) at least every three days
- a new Patient-Family Fact Sheet downloadable from the Excellence Everyday Skin Portal Page (http://www.mghpcs.org/eed_portal/EED_skin.asp)
- soon all nursing staff will be required to complete a HealthStream program, "SOS Campaign: a Strategic Initiative to Eliminate Hospital-Acquired Pressure Ulcers"



We're making excellent progress in preventing hospital-acquired pressure ulcers. Our prevalence rate has decreased in each of four consecutive quarters from 2.9% in December, 2010, to 1.7% in September, 2011. For more information about the SOS Campaign or any issues related to hospital-acquired pressure ulcers, consult your clinical nurse specialist or call Virginia Capasso, RN, at 6-3836.

Keeping patient care areas clear of food and beverages

Balancing safety and snacks

Question: I've been told I can't eat lunch at the nurses' station on my unit. Why is that?

Jeanette: That's an excellent question, and one that has come up a lot recently. I'm happy to have this opportunity to clarify our policy around eating and drinking in patient care areas.

OSHA (the national Occupational Safety & Health Administration) prohibits the consumption of food and drinks in areas where there's a risk of exposure to blood and other potentially infectious material. We understand the need for staff to be able to hydrate and eat meals and snacks, so the goal is to balance safety with realistic expectations for access to food and drinks.

The Infection Control Tiger Team, which was highlighted in the October 6, 2011, issue of *Caring*

Headlines, developed the table on this page as a guideline. Individual units may be more restrictive in deference to their patient populations.

We don't eat or drink in patient care areas because we want to:

- protect patients, co-workers, and ourselves from contamination
- maintain a clean and professional environment
- be respectful to those who might be fasting or sensitive to smells
- prevent infestations of insects or rodents

Question: Are there other guidelines we should know about?

Jeanette: As a general rule, remember:

- Drinks should not be placed on the counter-tops around nurses' stations or on workstations in hallways between patient rooms
- Clean and/or sterile patient-care supplies should not be placed on the lower interior shelves of nurses' stations (as these surfaces may hold drinks, which could lead to contamination)
- Staff food and drinks are not permitted in patient lounges (on the unit or on connector bridges)

Where can we eat and drink?

Location	Food	Drink*
Staff lounges/lunch rooms	Yes	Yes
Conference rooms (where permitted)	Yes	Yes
Private offices	Yes	Yes
Inside nurses' station*	No	Yes
In hallways between patients' rooms	No	No

(*Inside the nurses' station means on the low interior surfaces used *only* for clerical purposes. Drinks may *not* be stored or consumed near specimen pick-up bins kept on low interior surfaces. 'Drink' refers to both covered and uncovered beverages.)

Question: Where can I get more information?

Jeanette: Consult the Bloodborne Pathogen Exposure Control Plan in the *Infection Control Manual* (Section 4.1.3) or contact Infection Control at 6-2036.

Announcements

Judges Needed for Timitly Science Fair

The MGH-Timitly Partnership is looking for volunteers to judge student projects at the annual science fair.

February 6–9, 2012
8:45–11:00am

James P. Timitly Middle School
in Roxbury

Volunteers may sign up for one or more days. Partners shuttles will provide round-trip transportation.

For more information, call Ellen Reavey at 617-643-6287. No prior experience necessary.

Senior HealthWISE events

All events are free for seniors 60 and older

“Boost Your Brain Power”
Thursday, January 19th
11:00am–12:00pm

Haber Conference Room
Speaker: Marie Pasinski, MD,
neurologist

Book Club
Thursday, January 19th
3:00–4:00pm

West End Library
151 Cambridge Street
Community Room
Book Club will discuss
Cleopatra: a Life by Stacy Schiff.
Light refreshments provided.

Hypertension Screenings
Monday, January 23rd
1:30–2:30pm

West End Library
151 Cambridge St.
Free blood pressure checks with
wellness nurse, Diane Connor, RN.

For more information,
call 4-6756.

Blum Center Event

Book Talk:
Beautiful Brain, Beautiful You
Thursday, January 26, 2012
12:00–1:00pm

Blum Patient & Family Learning
Center

Come hear why beauty emanates from the inside out. Marie Pasinski, MD, connects brain health and beauty for women seeking to age well without plastic surgery.

For more information,
call 4-3823.

Attention clinical research nurses

The International Association of Clinical Research Nurses (IACRN) is looking for clinical research nurses interested in participating in a new local chapter.

The IACRN is an international organization dedicated to promoting the role of clinical research nurses and providing a forum for research nurses, research nurse practitioners, and others to discuss issues common to this specialized practice.

Meetings are held three times per year. Next meeting:

March 8, 2012
6:00pm
location TBA

For more information, contact Mary Larkin, RN, at 4-8695, or e-mail bostoniacrn@gmail.com.

Contact information correction

For information about the Comfort and Support after Loss Memorial Service, contact coordinators, Nancy Leventhal, LICSW, at 4-1307; or Clorinda Cottrell, LICSW, at 4-5755.

Beacon: volunteer patient-discharge and escort-request system

This past fall, inpatient units and some outpatient practices began using Beacon, the new on-line system to request volunteer assistance for inpatient discharges and outpatient escorts.

The Volunteer Department would like to share some updates on the Beacon system:

1) Effective immediately, to access the Beacon system, go to the Start Menu on your computer, go to Partners Applications, Utilities, MGH Beacon.

2) On February 1, 2012, the telephone line (6-2283) previously used to request volunteer services will be deactivated. If you call 6-2283, you will be directed to the on-line Beacon system where a self-training link will be provided.

3) The self-training link (at the bottom of the screen) will provide instructions on how to use the system.

Please spread the word about the new Beacon system to avoid missed calls and potential errors in communication.

For more information about Beacon, contact Wayne Newell, manager, Volunteer Department, at 4-1753.



Published by

Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital

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For more information, call:
617-724-1746

Next Publication
February 2, 2012

January 25th is IV Nurse Day



On January 25, 2012, MGH and the rest of the country will observe National IV Nurse Day. In 1980, the US House of Representatives designated this day as the annual occasion to pause and recognize the contributions of the nation's infusion nurses. The theme of this year's celebration: "IV Nurses — with You Every Step of the Way." As we acknowledge the more than three decades of specialized education, advocacy, and professional development of this role group, Patient Care Services and the entire MGH community would like to convey our appreciation to the valued members of our IV Nursing Team. For more information on the work of the IV Nursing Team, call Janet Mulligan, RN, at 4-7453.

IV nurse, Mary Anne Killackey, RN, applies dressing to patient, Carlos Gutierrez, after insertion of a PICC line (peripherally inserted central catheter).

Caring
Headlines
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Returns only to:
Bigelow 10 Nursing Office,
MGH, 55 Fruit Street
Boston, MA 02114-2696

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Permit #57416
Boston, MA

