

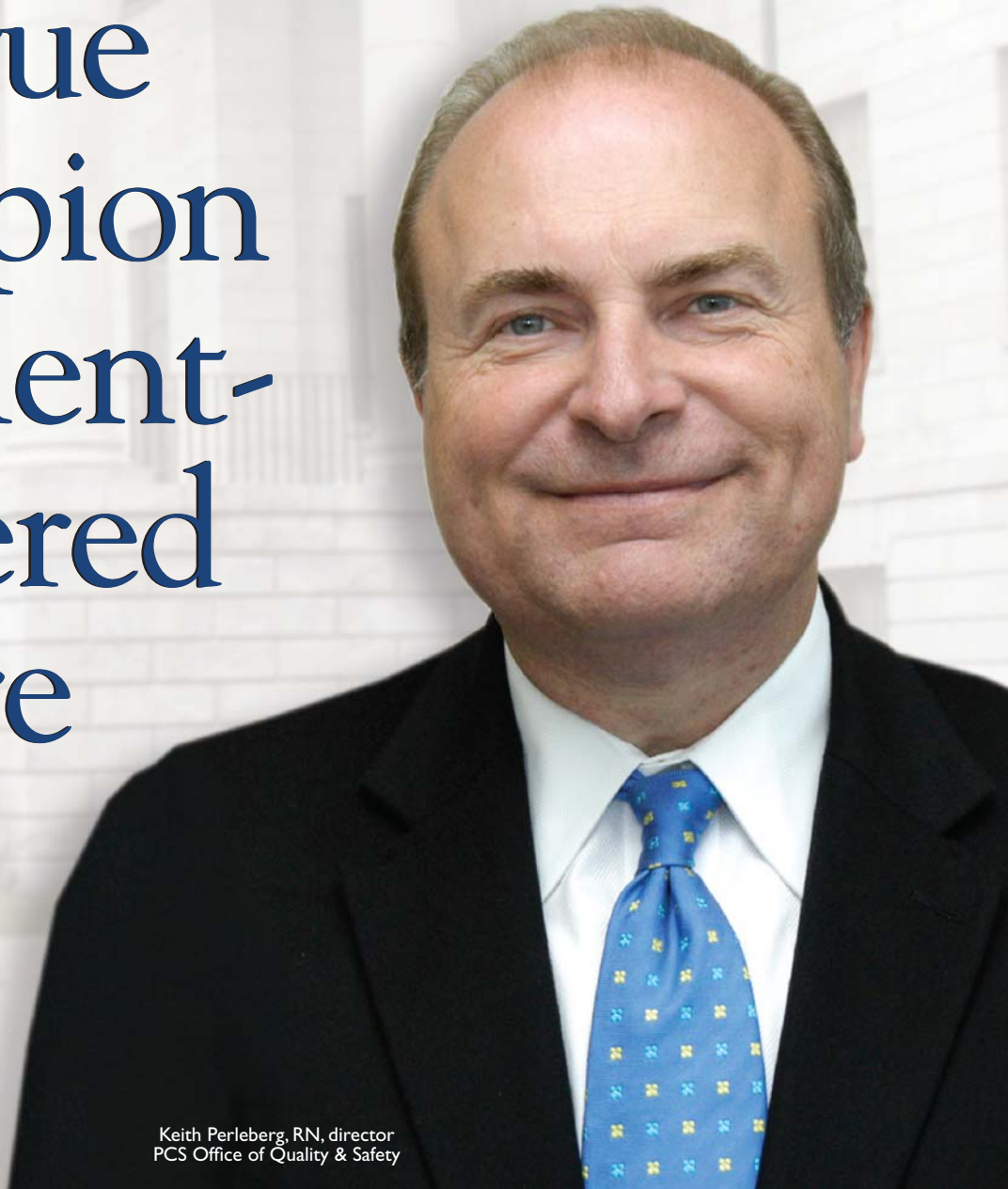
Caring

Headlines

July 5, 2012

A true champion of patient- centered care

*A tribute
to the life
and career of
Keith Perleberg, RN
Stories on pages 2-7*



Keith Perleberg, RN, director
PCS Office of Quality & Safety

Remembering a cherished colleague and friend

*Reflections on the vision and values
of Keith Perleberg, RN*

Keith approached
every situation
through the lens
of his personal
values... As he
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personally and
professionally,
I believe MGH
became his parish.
We were his
ministry.

Like so many others in the MGH community, I lost a dear friend with the recent passing of Keith Perleberg, our beloved director of the PCS Office of Quality & Safety. For such a quiet and unassuming person, he had an incredible impact on the culture, operations, and reputation of this hospital. And all for the better. Since hearing the tragic news, I've had occasion to reflect on Keith's tenure at MGH and hear from many of you about the countless ways he touched our lives. We were truly blessed to have had the gift of his wisdom and friendship for as long as we did.

I remember when Keith was appointed to the role he held at the time of his death. He was quoted in *Caring Headlines* as saying, "I'm honored and privileged to be appointed the new director of the Office of Quality & Safety. I hope to use the power of relationships, both internal and external, to make quality and safety central to the experience of each patient, family, and staff member at MGH and beyond." In just four and a half years, Keith not only made good on that promise, he did so with grace and gentility. He approached every situation through the lens of his personal values,



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

and that made him an invaluable confidant and healer. As he matured, both personally and professionally, I believe MGH became his parish. We were his ministry.

Keith had a unique ability to blend his many roles—nurse, priest, brother, friend, uncle, colleague—the list goes on. I thought I knew Keith well, but from the stories people have shared, I realize there was more to him than I ever knew. For instance, he baptized the babies of many of his MGH colleagues. He presided over weddings and funerals of co-workers and their family members. He prayed with sick employees. At his memorial service, I learned he para-glided over New Zealand on a recent vacation (see photo on page 5). And of course, he comforted and inspired thousands, both at MGH and far beyond our walls.

continued on next page

I'll be forever grateful that I took that opportunity to tell him how loved and respected he was and what a great job he was doing for our patients and families.

As I reflect on it now, I think that cab ride was a message to all of us. Keith was telling us to thank God every day for the privilege of doing healing work, to live life to the fullest... and most importantly, to enjoy the ride.

When I asked Keith to lead our quality and safety efforts, it meant attending a multi-day training program. He was thrilled to do it, but he had one condition: I had to accompany him on one of those days. So there we sat, amid scores of national quality and safety leaders. Keith was once again a novice, the least experienced person in the room. But he knew what mattered, and he wasn't shy about reminding us. He brought the patient into every conversation, and soon he was the person to whom everyone in the room was turning.

The memory of Keith I will hold most dear is the time we spent together the night before he died. Several of us attended a nursing event at a local university that had gone on way too long. Toward the end of the evening, I broke away from my table not looking forward to the late-night cab ride home, when I saw Keith. He had stayed, later than he probably would have, just to es-

cort me home. In the cab as we talked, Keith shared how proud he was to be a nurse, how much he loved MGH and his colleagues. I'll be forever grateful that I took that opportunity to tell him how loved and respected he was and what a great job he was doing for our patients and families.

As I reflect on it now, I think that cab ride was a message, a message to all of us. Keith was telling us to

thank God every day for the privilege of doing healing work, to live life to the fullest... and most importantly, to enjoy the ride.

I have no doubt that Keith has left this earth to share his gifts with humanity on a grander

scale. But we are in good hands. He taught us well. His influence on our lives and practice will endure. His devotion to the profession he loved will live on in the safe, high-quality care we provide to every patient and family, every single day.

"Do your little bit of good where you are; it's those little bits of good put together that overwhelm the world."

—Desmond Tutu, South African cleric and activist

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Keith Perleberg, RN

*a caring leader who 'walked softly'
through the halls of MGH*

In his role as
director of the PCS
Office of Quality &
Safety, Perleberg had
a profound influence
on the practice,
morale, and culture
at MGH.

Every day that Keith Perleberg, RN, showed up for work was a good day for patients and families. In his role as director of the PCS Office of Quality & Safety, he had a profound influence on the practice, morale, and culture at MGH. His passing on May 15, 2012, left the entire hospital community shocked and saddened.

Perleberg began his nursing career at MGH in 1991, in the inpatient Psychiatry Unit. As a staff nurse, he quickly distinguished himself and was soon appointed chair of the Staff Nurse Advisory Committee.

In 2001, Perleberg was appointed by associate chief nurse, Theresa Gallivan, RN, to lead Phillips House 20

and 21, inpatient medical units. As nursing director, he was a passionate advocate, committed to improving the hospital experience for patients and families. He earned the respect of his staff and clinicians from all disciplines with his inclusive, compassionate leadership. In 2006, Perleberg, served as co-chair of the Magnet Recognition Re-Designation Team where he inspired Magnet champions to showcase their care. He energized the workforce to strive for excellence in every pursuit.

Inevitably, Perleberg's contributions caught the attention of senior vice president for Patient Care, Jeanette Ives Erickson, RN. For many years, she and Perleberg enjoyed thoughtful conversations about his future, the future of MGH, and the future of health care in general. In 2007, when the position of director



Keith Perleberg, RN, introducing guest speaker, Ann Scott Blouin, RN, in 2009.



Perleberg with colleagues in the office of senior vice president for Patient Care, Jeanette Ives Erickson, RN, moments after receiving news that MGH had been re-designated as a Magnet hospital in 2008.

In Memoriam (continued)

for Quality & Safety for Patient Care Services was created, Perleberg was invited to apply, and a new leadership journey began. He attended the IHI Patient-Safety Officer Training Program. It was during this training program that Perleberg articulated his vision for patient safety and advocacy that came to be embraced by staff throughout Patient Care Services.

Perleberg helped create an environment where discussions about quality and safety became the norm, the culture. The patient was at the center of every conversation. His relationship-based approach created new alliances. His work and influence helped foster collaboration among medical staff in addressing disruptive behavior. In April, 2012, Perleberg and Cam Wright, MD, were recognized for their work in addressing disruptive behavior when they received the prestigious Nesson Award that

honors innovation in medical practice and inter-disciplinary collaboration.

Perhaps assistant chief of Medicine for Quality, Christopher Coley, MD, described Perleberg best when he said, "Keith was endowed with many admirable qualities. Whether he was innately blessed with an abundance of character and integrity, had very special patients, or simply worked harder than most to make himself a better person, Keith was a wonderful role model. I came to appreciate his intelligence and grace under pressure in my current clinical and administrative roles. I had many occasions to witness his ability to defuse potentially contentious meetings with

a well-chosen opening remark.

Then he'd sit back and listen, absorbing oth-

ers' perspectives before speaking again. Keith never pre-judged. He made everyone feel heard and honored. He did walk softly, but never needed a 'big stick' to make his point. He aimed for consensus but wasn't afraid to point out short-comings if it meant making MGH a better place for patients and families."

The MGH community is fortunate to have had the benefit of Perleberg's gentle wisdom and kind heart for more than 20 years. Said Marianne Ditomassi, RN, executive director for PCS operations, "Keith left MGH with a road map, a map that, if we continue to follow it, will always lead to 'Excellence Every Day.'"

Far left: Perleberg with Yanpei 'Vivien' Cao, associate chief of Nursing at Huashan Hospital in Shanghai and Perleberg's preceptee.

Near left: a whimsical moment at a hotel in Las Vegas while attending a recent ANA Nursing Quality Conference.



With staff of the PCS Office of Quality & Safety at a luncheon in 2010.



Para-gliding over New Zealand with his trademark ease and serenity.

"We'll all miss Keith so much. He was a kind, gentle, caring person who made you feel special when he spoke to you."

—Ruth Bryan, RN,
patient safety staff specialist

"My few meetings with Keith were rather extraordinary. They quickly turned to exploring deeper issues. I felt truly blessed in his presence. There is solace in knowing that if there is a Heaven for the souls of healers, he is most certainly there."

—Karen Donelan, senior scientist
Mongan Institute for Health Policy

"I spent five weeks with Keith in 2010, and he made me feel welcome and supported. He was such a gentle, respectable man. He taught me about strategic goals and Excellence Every Day. When I went with him to round on patient care units, clinicians hugged him and shook his hand. They thanked him for passing his passion for nursing on to them."

I will always remember my respected mentor, Keith Perleberg."

—Xiaoli 'Lili' Yang, a nurse from the Huashan Hospital in Shanghai

"He was a very special person. I feel fortunate to have had the opportunity to know him. A couple of times a month, I would share a bus ride with him to or from the Navy Yard. It didn't matter if it was six o'clock in the morning or eight o'clock at night, he was always happy to talk, ask me how my day was, and share life lessons."

Every time I spoke to Keith, I left feeling like I wanted to be more like him."

—Lauren Lebrun, administrative fellow

"When I reflect on Keith's memory, I immediately think of all his wonderful qualities, especially his ability to be present to those around him, his compassion, his eagerness to listen to your stories, his resiliency to accept what life has dealt, and his fabulous sense of humor. I think the best way to celebrate Keith's life is to live in the moment and truly appreciate the love we have for family and friends."

—Bessie Manley, RN,
nursing director, Phillips 22

"Keith brought us all, 'excellence every day.' I have no doubt he's doing the same on the other side of St. Peter's gate."

—Gregg Meyer, MD,
former senior vice president for the MGH
Center for Quality & Safety

"You can go your whole life without meeting another person like Keith. His personal integrity, kindness, and support of every individual (patients and employees) did more to advance a culture of trust and safety than any amount of scientific knowledge ever could."

—Carol Camooso Markus, RN,
staff specialist, PCS Office of Quality & Safety

"I didn't know Keith well, but when I arrived at MGH, he reached out to me. Every time I saw him over the ensuing years, his warm smile evoked an immediate smile in me. He had an ability to connect with a kindness that was genuine and infectious. It's rare to find someone in such a frenetic, high-powered place whose first impression is one of true goodness."

—Lisa Iezzoni, MD,
director, Mongan Institute for Health Policy

Gone but not Forgotten

You may be gone out of sight but not forgotten.

In every breeze, we feel your gentle spirit.

In every ray of sunshine we experience the warmth of your smile.

For every drop of life-giving rain that falls, we will remember your nurturing spirit.

When we look across the oceans and vastness of every shore and distant land, we will be reminded of your big heart and generosity.

Gone from this life, but in our hearts you will forever flourish.

Farewell, until we meet again.

—Linda Akuamoah-Boateng,
senior project specialist, on behalf of the PCS
Quality & Safety family

"Keith, I feel your presence in these rooms and halls where you devoted yourself and gave so much. Your boundless spirit, your joy in life, your laughter remain and resonate here. God bless you on your journey, sweet man."

—Anonymous, from the memory book in the MGH Chapel

"When I think of Keith, I'm reminded of the passion he brought to every endeavor. He taught us the invaluable lesson of making every day count."

—Marianne Ditomassi, RN,
executive director, PCS Operations

"A friend, a mentor, a leader who set the bar high in his ability to be so good at so many things. He brought light and love into each of our lives."

—Debbie Burke, RN, associate chief nurse

"Keith was full presence... in every interaction. He brought us to a level of caring, dignity, and mutual respect that we wouldn't have achieved otherwise. We'll have to work hard to guard and emulate the gift of himself that Keith so generously gave."

—Theresa Gallivan, RN, associate chief nurse

"He was a wonderful person with a boundless spirit capable of encompassing and uplifting us all. I knew him just briefly, but I'll miss him greatly."

Judi Carr, RN,
Office of Quality & Safety

"I used to feel I fell short when I compared myself to Keith's core values. But over the years, knowing and working with him, I think he made me a better person. I'll be forever grateful for having known him and will continue to strive to emulate his special qualities."

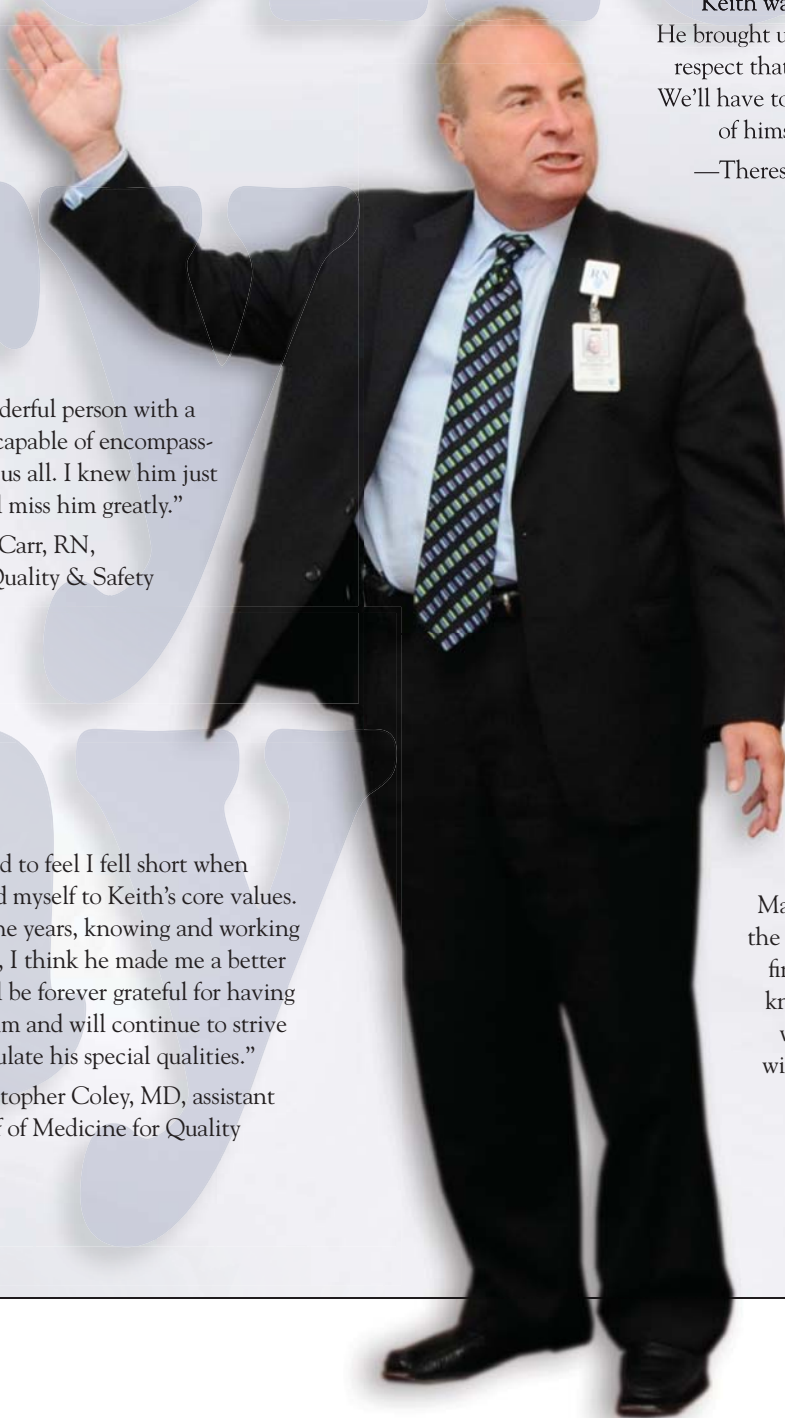
—Christopher Coley, MD, assistant
chief of Medicine for Quality

"Keith had a wonderful sense of humor. Sometimes during meetings, he'd pass me notes that I affectionately referred to as, 'Keith-o-grams.' They often captured what we were thinking but would never say out loud. Trying to suppress the laughter was sometimes a challenge. One more special gift from Keith."

—Robin Lipkis-Orlando, RN,
director, Office of Patient Advocacy

"One of my most vivid memories of Keith is the Magnet meeting we attended in Denver. He brought all the champions (then called ambassadors) together for the first time. We were all small pieces of a big puzzle, not knowing how or if we'd fit together. Because of Keith's words and stories, we came away from that meeting with a passion for our new role. He created the synergy we needed to begin our journey; he gave us the opportunity to learn and grow as colleagues. He was a true mentor and gentleman."

—Sue Algeri, RN, nursing director, Lunder 7



Empowering patients to make informed decisions

a delicate balance between honesty and compassion

An EKG showed left-ventricular hypertrophy, and an echocardiogram showed a left-ventricular ejection fraction of 10-15% and a dilated left ventricle. J was treated and transferred to our Cardiac Step-Down Unit for management and heart-transplant evaluation.

My name is Chimwenwe Clarke, and I have been a nurse for more than ten years. I've worked on the Cardiac Step-Down Unit, a critical-care unit specializing in complex cardiac patients, for the last eight years.

Working here has given me valuable exposure and a keen understanding of how to care for patients with heart failure. Many patients take an active role in their care, which is professionally stimulating. But sometimes patients want complete control, and that can be challenging for the nurse as well as the patient. I want to promote autonomy, but I also want to empower patients to make informed decisions. I've learned that establishing trust goes a long way toward ensuring that patients comply with the treatment plan.

In my experience, when patients are diagnosed with heart failure, their initial reaction is denial. Sometimes their frustration comes across as anger, and sometimes it's inadvertently directed at the nurse. I've learned not to personalize this anger and frustration. I listen to what they're saying and try to understand their fears and anxieties. I encourage patients to voice their concerns, so together we can determine what resources are needed to resolve their issues. I tell patients I won't take it personally if they want to be left alone, but I'm available if/when they need to talk.

I've had the opportunity to work with patients from many cultures. I worked at a public hospital in Africa



Chimwenwe Clarke, RN
Cardiac Step-Down Unit

for a time, so I understand the importance of cultural beliefs to a patient's care and recovery. Understanding a patient's social history is as important as understanding his/her medical history and treatment plan.

I'd like to share a recent experience. J lived out of state and was referred to MGH for heart-transplant evaluation. She had a history of fatigue and muscle weakness, diagnosed in childhood with Ehlers-Danlos syndrome. But a more recent muscle biopsy pointed to myopathy. J had been at a nail salon when she began to feel a warm, heavy sensation, and her vision went black. People at the salon called 911, and she was brought to a local hospital. An EKG showed left-ventricular hypertrophy, and an echocardiogram showed a left-ventricular ejection fraction of 10-15% and a dilated left ventricle. J was treated and transferred to our Cardiac Step-Down Unit for management and heart-transplant evaluation.

J had just graduated from high school, and her family situation is complicated. She lives with her mother and grandmother; she's the only child of divorced par-

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I followed up with J a short time after she was discharged and spoke with her and her mother. She seemed very happy to hear from me. I encouraged her to follow the discharge instructions, keep in touch with her doctors and social worker, and keep all scheduled appointments... J is doing well. She has not been re-admitted. She's being proactive in her care. And she has not missed any appointments.

ents. J cares for her mother, who suffers from depression, anxiety, and a personality disorder. J herself has a history of anxiety and has received counseling in the past. She struggled in high school because she didn't have the energy to attend classes. So she switched to night school, but this limited her socialization even more.

I cared for J for a number of weeks. At first she was quiet and would only say one or two words. She was overwhelmed by the diagnosis of heart failure. She had no idea what it meant to her life. Her father, mother, grandmother, and uncle were at her side when the heart failure attending physician came, accompanied by a nurse practitioner, cardiac fellow, and a social worker who had known J for a long time. We all sat down with J and her family to discuss the treatment plan. The meeting was intense. The fellow shared a lot of grave and detailed information. The family had no medical background, so the technical terminology was daunting to them. This was a young girl who'd just learned she has cardiac disease and might require a heart transplant. J was having a difficult time processing the information, which seemed to be a result of both her age and her limited social skills.

After the meeting, the family left the hospital. I think they were in shock and coped by going home. I went back in to talk with J to help her process what had been discussed at the meeting. She was in tears. She wanted to go home. She was scared.

"I wish my mom was here," she said.

I sat on her bed and gave her a hug. "I'm here for you," I said. "You just heard a lot of information, and it'll take some time to digest. It's too much to deal with on your own."

I was also concerned about how her mother would react to this information, knowing her own mental-health issues could prevent her from giving J the emotional support she needed. I asked J if I could have the social worker come by to talk to her. I reached out to the team, and we decided that all future meetings where serious information was going to be discussed would be attended by a nurse and social worker to ensure emotional support was available. I was pleased that all members of the team agreed. I saw to it that her own pediatric doctor came regularly to talk with her to help her understand the process.

J's family was in shock. I let them know I was available if they had any questions, and I advised them to write down any questions they had for when they met with the heart-failure doctors. I find it helpful to have family members who are involved with the patient's

care present during team planning sessions. J's family would need to understand the basics about heart failure in order to support her at home after discharge.

J went through a lot during her hospitalizations. As her discharge date approached, she seemed to come to terms with her diagnosis. It was determined that she was a candidate for a heart transplant, but she was going to need a lot of support and reassurance at home beforehand. I explored the possibility of having a visiting nurse follow her after discharge. Luckily, she met the criteria. I also developed a home medication schedule so J could maintain her strength and gain some independence. J and her family were grateful for the help in preparing to return home. Her grandmother told me, "We weren't sure how we were going to manage all those medications. This schedule will make it so much easier."

I stressed the importance of following the recommended diet and exercise regimens, including low sodium, low cholesterol and proper fluid intake. Understanding core heart-failure measures is crucial to managing the condition. J was able to repeat back to me what she had learned.

I followed up with J a short time after she was discharged and spoke with her and her mother. She seemed very happy to hear from me. I encouraged her to follow the discharge instructions, keep in touch with her doctors and social worker, and keep all scheduled appointments. As J's nurse, I felt she received the appropriate resources and education to enable her to manage her condition at home. J is doing well. She has not been re-admitted. She's being proactive in her care. And she has not missed any appointments.

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

Every day, clinicians share news with patients—and it's not always good news. Chimwemwe recognized that J and her family needed a higher level of support, and she acted immediately to ensure they got it. She built a relationship of trust through patient-education, genuine concern for J's well-being, and by simply being present during times of heightened stress. All of this gave J a sense of confidence in her care team, which translated to confidence in herself and her ability to manage her care at home. Calling J at home after discharge reinforced their already strong relationship.

Thank-you, Chimwemwe.

Successful treatment of infantile idiopathic scoliosis

—by Mark Tlumacki, CO, manager of Orthotics; Brian Grottkau, MD, chief of Pediatric Orthopaedics; and Erin Hart, RN, pediatric nurse practitioner

Scoliosis is a condition in which a person's spine is bowed from side to side, sometimes in a complex three-dimensional curve. Sharing a mutual interest in the subject, Mark Tlumacki, CO, manager of Orthotics, Erin Hart, RN, pediatric nurse practitioner, and Brian Grottkau, MD, chief of Pediatric Orthopaedics, researched the latest trends in the treatment of infantile and juvenile scoliosis. After extensive investigation and consultation, they learned of a new casting technique being used at Shriners Hospital in Portland, Oregon. Serial body casting (or Risser casting) is being used at Shriners

Hospital with excellent results for young scoliosis patients. So Tlumacki went to Portland to check it out. He was able to observe and learn from Charles D'Amato, MD, orthopaedic surgeon, who is a frequent user of Risser casting. After gaining invaluable hands-on experiences in Portland, Tlumacki brought that knowledge back to MGH for some practical application.

Scoliosis occurs when the lateral curvature of the spine measures ten degrees or greater. It's generally classified as infantile (birth to age 3), juvenile (3–10 years old), or the most common, adolescent (10 years old

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Above left: 4½-year-old, Nicole Pierce, arrives at MGH for final casting application to correct curvature of her spine.
At right: Mom and Dad engage Nicole in some pre-procedure fun.



Clockwise from top left: Erin Hart, RN, measures curvature on X-ray pre-procedure; Mark Tlumacki, CO, performs pre-application spine check; team transfers Nicole to special Risser table; and in a delicate balancing act, team applies cervical and pelvic traction.

(Photos by Joe Ferraro)

or older). Infantile scoliosis can be further classified into congenital (underlying structural abnormality such as hemivertebrae or block vertebrae) or idiopathic (cause unknown). Risser casting can be used to treat both infantile and juvenile curves. Younger patients present a challenge to orthopaedic surgeons because they have so much spinal growth remaining that spinal fusion is not typically a viable option.

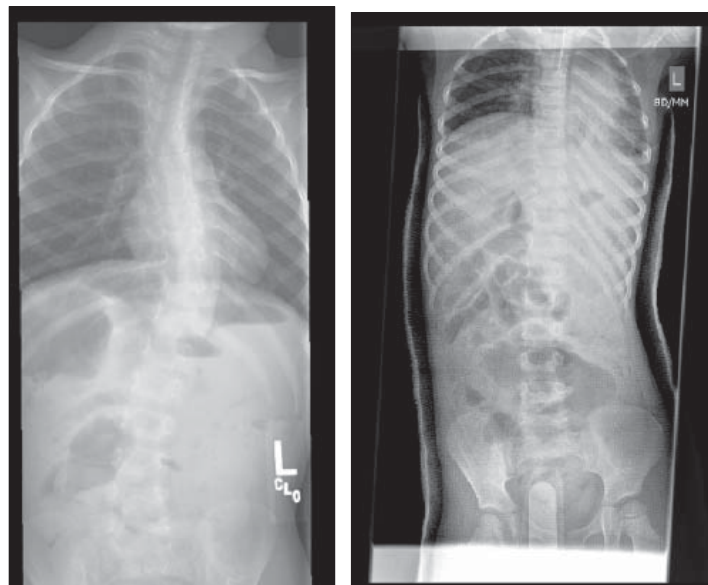
Risser casting involves the application of a cast using cervical and pelvic traction. It's had great success in controlling and often correcting curves in very young patients who otherwise would need extensive surgery. In the operating room under general anesthesia, the spine is manipulated to maximize de-rotation (correct scoliosis) and the position is maintained through casting. The cast is left on for six to eight weeks, then the procedure is repeated to obtain even greater correction.

More than a year ago at age 18 months, Nicole Pierce was referred to the Pediatric Orthopaedic Clinic with infantile idiopathic scoliosis and a spinal asymmetry of 32 degrees. Despite full-time bracing, the curve progressed to 42 degrees. It turned out that Nicole was a candidate for Risser casting. Her first cast was applied at age 3, and she tolerated it very well. Six other casts were applied over the next 18 months to progressively improve the curvature of her spine. (Usually, young patients are left out of the cast during summer months, and a full-time brace is worn instead). Nicole's most recent X-ray shows near-complete correction of the scoliosis.

Two years after starting the Risser casting program, the team considers Nicole their first 'graduate.' She now wears a daytime scoliosis brace to maintain her fully corrected spine. She will come in for follow-up examinations every six months to ensure there's no progression of the curve.

Special thanks to Chris Sweeney, RN, at Shriners Hospital in Portland for her guidance and hospitality. For more information on this innovative new technique, call Mark Tlumacki at 6-2950, or e-mail mtlumacki@partners.org.

Above: Tlumacki applies one final correction.
At right: before and after X-rays show straightening of the spine pre-casting and post-casting.



ESOL Celebration of Achievement

Bulfinch tent 'bursting with pride'

Family, friends, and colleagues gathered under the Bulfinch Tent, Friday, June 1, 2012, for the 17th annual Celebration of Achievement for the English for Speakers of Other Languages (ESOL) program. This year's event honored 82 employees. In his opening remarks, senior vice president for Human Resources, Jeff Davis, said, "This is one of my favorite events. Every time we come together here on the Bulfinch terrace, I can feel the tent bursting with pride."



Among the speakers was unit service associate, Liana Teixeira, who was recognized for completing the high-intermediate class. Teixeira spoke about the many opportunities MGH has given her. She thanked her co-workers and supervisor, Patricia Galvin, saying, "They're always there when I need them, and they make it possible for me to attend class. I'm so proud to work at MGH." She acknowledged Stephanie Cooper, Jennifer Lassonde, Kim Chelf, Dan Dolan, David Cohen, Stella Moody, and George Reardon for their continued support.

Smiling faces were the order of the day as honorees stepped to the podium to accept their certificates along with a roar of applause from the standing-room-only crowd. Representing their classes, Ana Bonilla of Nutrition & Food Services, Evandro Silva of the Center for Comparative Medicine, and Ben Graciani of Central Supply, spoke about the positive impact the program has had on their lives and work. Keynote speaker, Felicita Aponte, patient liaison in Speech, Language & Swallowing Disorders, shared her story of triumph at becoming the first member of her family to graduate from college. And she plans to continue working toward a master's degree.

The on-site ESOL program at MGH is the longest running, employer-sponsored program of its kind in the country. It is made possible through a partnership between the MGH Office of Training and Workforce Development and Jewish Vocational Service, a local non-profit employment-development organization. This year, the program expanded to include college-preparatory classes in Math and English. Next year, the program will offer classes in basic computer skills.

For more information, contact Beth Butterfoss, coordinator of the ESOL program, at 6-2388.



Top: unit service associate, Liana Teixeira delivers her graduation speech. Above left: unit service associate, Isabel Ramos is congratulated by Jerry Rubin, president of JVS (left) and Jeff Davis, senior vice president for Human Resources. Above right: a future MGH employee 'cruises' into the celebration. Below: ESL students before the ceremony.

Innovation in the perioperative services

Question: What's happening with perioperative services since they moved into the Lunder Building?

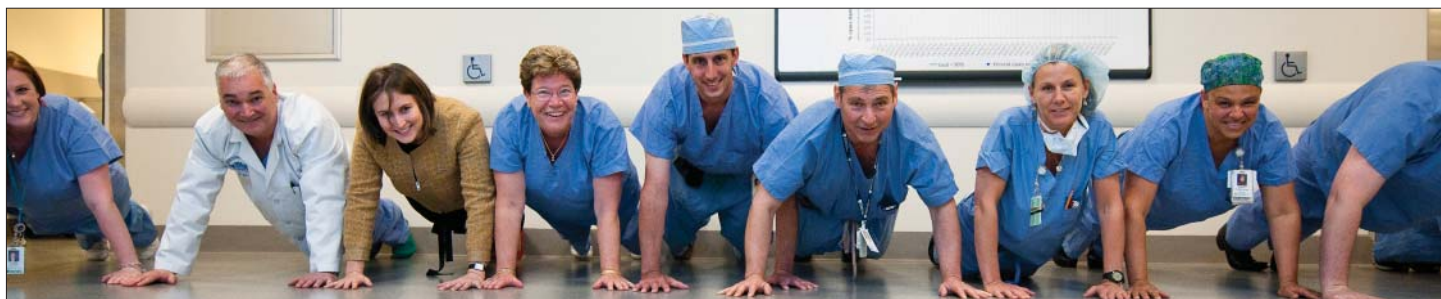
Jeanette: Several OR teams within Perioperative Services moved to the Lunder Building last summer. The goal was to improve patient- and staff-satisfaction, quality, and operational efficiency by optimizing the new space and new technology. So, under the guidance of an executive steering committee, a multi-disciplinary process-improvement team was formed comprised of orthopaedic surgeons, anesthesiologists, nurses, and support staff. The process-improvement initiative selected by the Orthopaedic Team was on-time starts for the first surgery of the day in hopes it would set the tone for subsequent surgeries to begin on schedule.

Question: What was different about this initiative?

Jeanette: Several innovative approaches were taken. In addition to weekly meetings of the process-improvement team to discuss next steps, open forums were held to provide all members of the service an opportunity to comment and make suggestions. The process-improvement team collected data and shared it on a large board at the entrance to the OR suite. The board was updated daily and provided a dynamic view of the progress they were making in improving on-time starts. They also shared the data with individual caregivers so they could make changes to improve their start times.

Question: What's this I hear about push-ups?

Jeanette: The process-improvement team came up with an innovative way to foster teamwork, acknowledge success, and, incidentally, help build upper-body strength. They decided that for every on-time start each day, the team would do ten push-ups. With 12 operating rooms, that could end up being 120 push-ups! This is where that team approach comes in handy. Members of the team can be relieved by their colleagues if necessary to meet the push-up requirement for the day. And members of the executive steering committee have joined in on occasion to help celebrate the extraordinary work of this innovative team. For more information, call 4-2508.



Above: Stephanie Weilert, Peter Dunn, Lauren Lebrun, Dawn Tenney, Jim Barone, Mark Vrahas, Suzanne McCarthy, and Barbara Clemons celebrate Orthopaedic team's first-case on-time starts by doing ten push-ups for each OR that started on time.
Above right: Mark Vrahas and Rob Peloquin demonstrate team approach.

Priest shortage spurs new strategies for MGH Chaplaincy

The growing shortage of Roman Catholic priests has impacted the number of priests available to serve as hospital chaplains. In most hospitals, round-the-clock access to a Roman Catholic priest can no longer be guaranteed.

Question: I understand there's a shortage of Roman Catholic priests in the area. Is this having an impact on our Chaplaincy?

Jeanette: The growing shortage of Roman Catholic priests has impacted the number of priests available to serve as hospital chaplains. In most hospitals, round-the-clock access to a Roman Catholic priest can no longer be guaranteed. So patients are encouraged to receive the Sacrament of the Sick in their home parishes prior to scheduled hospitalizations.

Roman Catholic patients are reminded that the Sacrament of the Sick can be administered at any time and need only be given once during any given hospitalization. A priest does not need to be present at the time of death for a patient who has already received the Sacrament of the Sick.

Multi-faith chaplains are trained to provide spiritual, end-of-life care to individuals and families of all faiths and to those who don't subscribe to any formal religious tradition. Multi-faith chaplains are available 24/7 at MGH.

Question: What can we do to help minimize the effects of the shortage?

Jeanette: The Chaplaincy is employing a number of strategies to respond to the priest shortage:

- Our full-time and per-diem priests are working extra time to fill in when they can after hours

- Roman Catholic priests are available on-site daily from 8:30am–5:00pm. Please be proactive in requesting the Sacrament of the Sick during these hours to ensure administration of the sacrament by a Roman Catholic priest
- The MGH Chaplaincy is communicating with the Archdiocese of Boston to recruit additional Roman Catholic priests (full-time and per diem). One per diem priest has already been hired
- In addition to the MGH website, Human Resources is advertising for full-time priests with the National Association of Catholic Chaplains and other outlets
- The Chaplaincy has reduced the number of masses offered in the Chapel to make priests more available to minister to the acute spiritual and sacramental needs of patients and families. We've also added Boston Catholic TV to the hospital cable package so patients can watch daily mass in their rooms (also available in Spanish). And Eucharistic ministers continue to provide Holy Communion upon request.

Question: How do we go about requesting a Roman Catholic priest or multi-faith chaplain?

Jeanette: The MGH Chaplaincy is committed to meeting the spiritual needs of all patients, families, and staff. For more information, or to request a chaplain, call 6-2220.

Professional Achievements

Karp honored

Rosanne Karp, RN, case manager, was recognized as one of The One Hundred at an award ceremony at MGH, May 10, 2012.

Maclean receives scholarship

Julie Maclean, OTR/L, occupational therapist, received the Mary Forshay Scholarship Award in April, 2012.

Milton honored

Lucy Milton, RN, clinical nurse specialist, Post Anesthesia Care Unit, received the Make a Difference Award, from Northern Essex Community College, in Haverhill, April 27, 2012.

Ahern honored

Richard Ahern, RN, nurse practitioner, Infectious Diseases, was awarded the Judith A. Fong Nursing Faculty Prize at the 32nd commencement ceremony of the MGH Institute of Health Professions, May 10, 2012.

Kennedy certified

Ann Kennedy, RN, nursing director, Neuroscience, became a certified nurse executive by the American Nurses Credentialing Center in May, 2012.

Healey presents

Lauren Healey, PT, physical therapist, presented, "Get Moving! Tips for Adopting and Maintaining an Exercise Routine," at the 2nd annual patient seminar of the North American Thrombosis Forum, in Foxboro, May 12, 2012.

Miller certified

Brenda Miller, RN, nursing director, Pediatrics, became a certified nurse executive by the American Nurses Credentialing Center in May, 2012.

Social workers present

Social workers, Julie Berrett-Abebe, LICSW; Mary Susan Convery, LICSW; and Jocelyn Walls, LICSW, presented, "Social Workers as Psychosocial First Responders: Addressing Secondary Traumatic Stress in the Oncology Setting," at the 2012 national conference of the Association of Oncology Social Workers, May 30, 2012.

Inter-disciplinary team presents poster

Mary Orencole, RN; Daniel Friedman, MD; Gauray Upadhyay, MD; Robert Altman, MD; Conor Barrett, MD; Theofanie Mela, MD; E. Kevin Heist, MD; and Jagmeet Singh, MD, presented their poster, "Left-Ventricular Lead Electrical Delay and Anatomic Re-Position Predict Ventricular Arrhythmia in Cardiac Resynchronization Therapy," at the 2012 scientific session of the Heart Rhythm Society, May 10, 2012.

Multi-disciplinary team publishes

Mary Orencole, RN; Robert Altman, MD; Kimberly Parks, MD; Christopher Schlett, Mi Young Park, MD; Quynh Truong, MD; Peerawut Deeprasertkul, MD; Stephanie Moore, MD; Conor Barrett, MD; Gregory Lewis, MD; Saumya Das, MD; Gauray Upadhyay, MD; E. Kevin Heist, MD; Michael Picard, MD; and, Jagmeet Singh, MD, authored the article, "Multi-Disciplinary Care of Patients Receiving Cardiac Resynchronization Therapy is Associated with Improved Clinical Outcomes," in the *European Heart Journal*, May, 2012.

Knab presents

Mary Knab, PT, physical therapist, presented, "PhD—Reflection I Physical Therapy Practice: a Phenomenological Inquiry into Written and Oral Narratives," at the School of Education of Lesley University, in May, 2012.

Brown presents

Carol Brown, RN, cardiac nurse practitioner, presented, "12-Lead ECG Interpretation," at the Northeast Regional Nurse Practitioner Conference, in Manchester, New Hampshire, May 2, 2012.

Peterson and LaSala appointed

Gayle Peterson, RN, staff nurse, Gynecology/Oncology, and Cynthia LaSala, RN, clinical nurse specialist, General Medicine, were appointed, members of the Code of Ethics Task Force for the American Nurses Association in June, 2012.

Callahan presents

Janet Callahan, PT, physical therapist, presented, "Physical Therapy Management of Concussion," at the special interest group introductory meeting of the American Physical Therapy Association of Massachusetts, at Boston University, May 16, 2012.

Myers and Taylor Pedro present

Kathleen Myers, RN, nursing director, Orthopaedics, and Jill Taylor Pedro, RN, clinical nurse specialist, Orthopaedics, presented, "IHI STAAR Collaborative Overview of the Institute for Healthcare Improvement: Reduce Avoidable Hospital Re-Admissions," at the annual congress of the National Association of Orthopaedic Nurses, in New Orleans, May 21, 2012.

Sullivan honored

Dana Sullivan, RN, staff nurse, Emergency Department, was named the MGH/C Nurse of the Year by the pediatric residents in June, 2012.

Miguel publishes

Karen Miguel, RN, staff nurse and patient safety officer for Radiology, authored the chapter, "Teamwork and Communication in Radiology," in *Quality and Safety in Radiology*, in 2012.

Nurses publish

Jennifer Spina, RN, clinical educator, Obstetrics and Gynecology; C. Lynne McIntyre, RN; and Joyce Pulcini, RN, authored the article, "An Intervention to Increase High-School Students' Compliance with Carrying Auto-Injectable Epinephrine: a MASNRRN Study," in *The Journal of School Nursing*, in June, 2012.

Orencole presents

Mary Orencole, RN, adult nurse practitioner, Cardiac Arrhythmia Service, presented, "CRT and HF: Playing Nice in the Sandbox," at the 2012 scientific sessions of the Heart Rhythm Society, May 11, 2012. Orencole also presented, "A Novel Approach to CRT Response: Applying What We Now Know," at the 12th Essentials of CRM Therapy and Patient Management conference, May 8, 2012.

Chang presents

Lin-Ti Chang, RN, staff specialist, presented, "Detecting and Managing Intra-Abdominal Hypertension: a Lethal Complication of Critical Illness," at the Zhejiang & Jiangsu Emergency Medicine Congress, part of the West Lake International Forum on Disaster Medical Response and Trauma, in Hangzhou, China, April 20–22, 2012.

Professional Achievements (continued)

Peterson appointed

Gayle Peterson, RN, staff nurse, Gynecology/Oncology, was appointed, a member of the Board of Directors for the American Nurses Association, in June, 2012.

Silva certified

Judy Silva, RN, nursing director, Cardiac Interventional Unit and Cardiac Access Program, became a certified nurse executive by the American Nurses Credentialing Center in May, 2012.

Nurses publish

Paul Arnstein, RN, clinical nurse specialist, Pain Relief; Hannah Lyons, RN, clinical nurse specialist, Oncology; and Yasmin Khalili, RN, clinical nurse specialist, Surgery, authored the chapter, "Pain" in *Practice Nursing of Adults in Acute Care*.

Mannix certified

Catherine Mannix, RN, Radiation Oncology, became a certified nurse executive by the American Nurses Credentialing Center in May, 2012.

Inter-disciplinary team presents

Mary Orencole, RN; Neal Chatterjee, MD; Gauray Upadhyay, MD; Robert Altman, MD; Theofanie Mela, MD; and Jagmeet Singh, MD, presented their poster, "Echocardiographic and Clinical Outcomes in Patients Undergoing Cardiac Re-Synchronization Therapy: Differential Implications of Chronic Versus Paroxysmal Atrial Fibrillation," at the 2012 scientific sessions of the Heart Rhythm Society, May 10, 2012.

Inter-disciplinary team presents

Elyse Levin-Russman, LICSW, social worker; Heather Peach, CCLS, child life specialist; and Lorrie Kubrick, music therapist, presented their poster, "Fall for the Arts: Community-Building Through the Healing Arts," at the national conference of the Association of Pediatric Oncology Social Workers, in Portland, Oregon, May 16, 2012.

Banister presents

Gaurdia Banister, RN, executive director, The Institute for Patient Care, presented, "Nursing Leading and Transforming Care," as the visiting scholar for Nurse Recognition Week at Women and Infants Hospital in Providence, Rhode Island, May 7, 2012.

Inter-disciplinary team presents

Julie Berrett-Abebe, LICSW; Michele Gabree; Meredith Seidel; and Kristen Shannon presented, "Collaboration Between Oncology Social Workers and Genetic Counselors in Care Management of Cancer Predisposition Mutation Carriers," at the 2012 national conference of the Association of Oncology Social Workers, May 30, 2012.

Nurses present poster

Mary Hudson, RN; Jennifer Gray, RN; and Shelly Stuler, RN, presented their poster, "Wading Through the Complexity: Current-State Dataflow Analysis of Maternal and Newborn Documentation Requirements," at the annual symposium of the New England Nursing Informatics Consortium, in Waltham, May 11, 2012.

Anticoagulation team presents

Lynn Oertel, RN; Clemens Hong, MD; Fatima Rodriguez, MD; Yuchiao Change; Daniel Singer, MD; and Lenny Lopez, MD, presented their poster, "Limited-English-Proficient Patients and Time Spent in Therapeutic Range in an Anticoagulation Clinic," at the Thrombosis and Hemostasis summit of North America, in Chicago, May 3-5, 2012.

Oertel on panel of experts

Lynn Oertel, RN, clinical nurse specialist, Anticoagulation Management Services, participated in the Centers for Disease Control and Prevention expert panel meeting, "Prevention of Hospital-Acquired Venous Thromboembolism," in Atlanta, in August, 2011. The meeting summary is available electronically on the CDC web page: <http://www.cdc.gov/ncbddd/dvt/documents.html>.

Nurses present

Sandra Silvestri, RN, clinical nurse specialist, Operating Room; Jill Taylor Pedro, RN, clinical nurse specialist, Orthopaedics; and Kathleen Myers, RN, nursing director, Orthopaedics, presented, "A Multi-Disciplinary Approach to the Prevention of OR Positioning Injuries in the Orthopaedic Patient," at the annual congress of the National Association of Orthopaedic Nurses, in New Orleans, May 21, 2012.

McKenna Guanci presents

Mary McKenna Guanci, RN, clinical nurse specialist, Neuroscience Intensive Care, presented, "Educational Needs of Families with Traumatic Brain Injury," at the 44th annual meeting of the American Association of Neuroscience Nurses, in Seattle, April 29, 2012.

McKenna Guanci also presented, "Developing a Neuroscience Critical Practice Committee," at the Continuing Neuroscience Critical Care Education Course, at Harvard Medical School, May 19, 2012.

Health literacy team presents

Jennifer Searl, health education project specialist, The Maxwell & Eleanor Blum Patient and Family Learning Center; Katherine Fillo, RN, staff nurse, General Medicine; and Brian French, RN, director of The Maxwell & Eleanor Blum Patient and Family Learning Center, presented their poster, "A Systemic Multi-Faceted Approach to Staff Knowledge of Health Literacy," at the 11th annual Health Literacy Conference of the Institute for Healthcare Advancement, in Irvine, California, May 10, 2012.

Inter-disciplinary team publishes

Mary Orencole, RN; Ravi Shah, MD; Robert Altman, MD; Mi Young Park, MD; Jodi Zilinski, MD; Jordan Leyton-Mange; Michael Picard, MD; Conor Barrett, MD; E. Kevin Heist, MD; Gauray Upadhyay, MD; Jagmeet Singh, MD, and Saumya Sas, MD, authored the article, "Usefulness of Hemoglobin A(1c) to Predict Outcome After Cardiac Re-Synchronization Therapy in Patients with Diabetes Mellitus and Heart Failure," in the *American Journal of Cardiology*, in May, 2012.

Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, presented, "Geriatric Pain Management," at the Chicago metropolitan area chapters of the American Society for Pain Management Nursing & Hospice/Palliative Care Nursing, in Lisle, Illinois, April 20, 2012.

Arnstein, also presented, "Balancing Concerns for the Control of Both Pain and Drugs," at the annual Long Island chapter conference of the American Society for Pain Management Nursing, in Greenvale, New York, June 1, 2012.

New brochure helps educate families about restraints

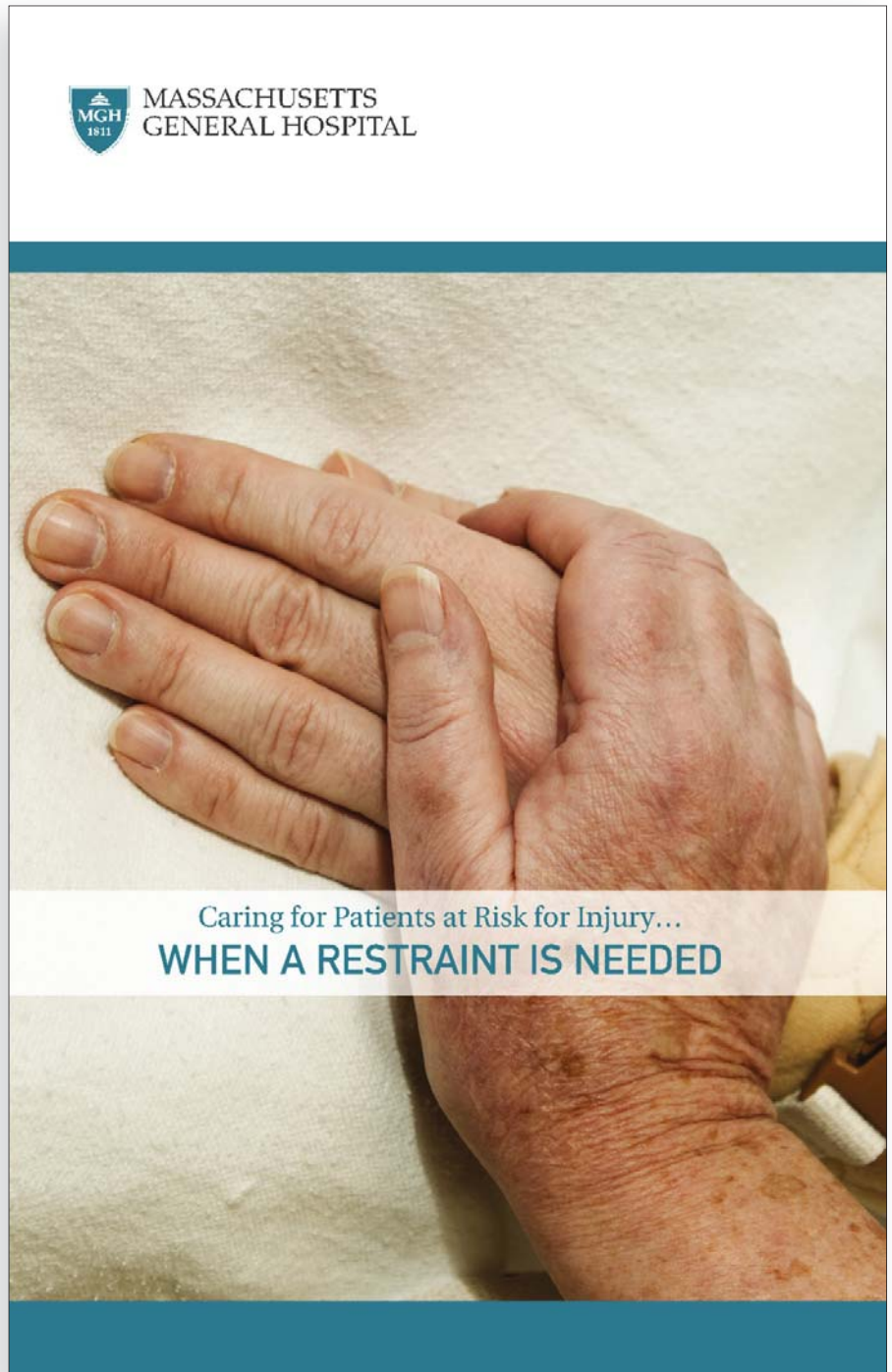
—submitted by the Restraint Solutions in Clinical Practice Committee

A new brochure called, *Caring for Patients at Risk for Injury... When a Restraint is Needed*, has been published by the Restraint Solutions in Clinical Practice Committee. The brochure was created to help educate and inform families about what restraints are, why they're needed, and what they can do to support family members who may be in restraints.

Committee champions recognized that while it's always preferable to employ the least restrictive means possible to keep patients safe, there are times when restraints must be used to keep patients from harming themselves or others. The committee identified a lack of educational materials for families, which was the impetus for this brochure. They worked in collaboration with The Blum Patient & Family Learning Center to ensure it was written in plain language.

Caring for Patients at Risk for Injury... When a Restraint is Needed is now available through Standard Register; it can also be accessed through the Excellence Every Day portal page: http://www.mghpcs.org/eed_portal/EED_restraints.asp.

For more information, call Jennifer Repper-



Announcements

One-stop intranet site for strategic priorities

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

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

<http://priorities.massgeneral.org>.

Collaborative Governance

Applications are now being accepted for collaborative governance committees.

Collaborative Governance is the multi-disciplinary decision-making structure of Patient Care Services.

Applications are due by October 5, 2012.

For more information about collaborative governance or to obtain an application, go to: <http://www.mghpcs.org/IPC/Programs/Governance.asp>, or call Mary Ellin Smith, RN, at 4-5801.

New MGPO website

The new MGPO website is now available. The look matches the *Fruit Street Physician*, the content has been rewritten, and the layout is more intuitive user-friendly. Check it out at: <http://mgpo.partners.org>.

Clinical Ethics Residency for Nurses

Applications now being accepted

Applications for year three of the Clinical Ethics Residency for Nurses (CERN), are now being accepted. The program begins in September; applications should be submitted by July 16, 2012.

Applicants will be notified of their acceptance during the week of August 6th.

Participants attend 10 eight-hour sessions from September, 2012, through May, 2013. To obtain an application or learn more, e-mail Rosemarie Lemole (rlemole@partners.org).

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

ACLS Classes

Certification:

(Two-day program)

Day one: lecture and review
Day two: stations and testing)

Day one:

September 10, 2012
8:00am–3:00pm
O’Keeffe Auditorium

Day two:

September 24
8:00am–12:00pm
Their Conference Room

Re-certification (one-day class):

September 29th
8:00am–1:00pm
Founders Training Room 130

October 10th
5:30–10:00pm
Founders Training Room 130

For information, call 6-3905 or go to: <http://www.mgh.harvard.edu/emergencymedicine/education/acls.aspx>

To register, go to: http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf

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For more information, call: 617-724-1746

Next Publication

July 19, 2012

Preventing Patient Elopement

—by Rosemary O'Malley, RN, staff specialist

Electronic alarms have been installed on the doors to stairwells on White 7 and 9 so that individuals exiting by way of the stairs are required to swipe an employee identification badge.

In order to reduce the risk of patient elopement (leaving patient care units without notifying staff), a pilot program is being conducted on White 7 and 9 that incorporates the use of audio alarms. Electronic alarms have been installed on the doors to stairwells so that individuals exiting by way of the stairs are required to swipe an employee identification badge. Signage has been posted at all exits. If anyone does try to exit via the stairwells without swiping a valid ID badge, the door will open and an alarm will sound (at the door, at the nursing station, and in Police & Security).

If a stairwell alarm is triggered, nurses on White 7 and 9 have been trained to make sure all patients are

accounted for and reset the alarm if necessary. If it's determined that a patient has exited the unit without notifying staff, Police & Security will be enlisted to locate the patient.

If this pilot program is successful, other units in the White Building will be fitted with alarms at stairwell entrances.

Also now in effect, all stairwell entrances to patient care units, White 6–12, are locked requiring badge access (White 7 and 9 are the only units with alarms). Staff who work in the White Building should have stairwell access with the swipe of a valid ID badge. If you have any issues, contact Bob Leahy at 4-5531.

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