

Caring

Headlines

October 4, 2012

Our journey to a
common clinical system
has begun!

(See Jeanette Ives Erickson's column on page 2)



Conversion to a common clinical system is gonna be *epic!*

But the real reason we're moving to an integrated health information system and the reason we're committing a considerable amount of time, money, and resources to do so, is that it will ultimately *improve care for our patients.*

We've thought about it. We've talked about it. We've studied it at length. And now, we're doing it. We have officially committed to, and begun laying the groundwork for, the design and implementation of a fully integrated, Partners-wide, health information system. It's called Partners eCare. The vendor we'll be working with is Epic, and believe me, it's a fitting name—because this undertaking is going to be nothing short of epic!

Having an integrated system across the Partners network will revolutionize our ability to share and access health information; it will give us a common database on which to base scientific investigation; and it will enable us to learn from a greater repository of clinical experiences across the continuum. But the real reason we're moving to an integrated health-information system and the reason we're committing a considerable amount of time, money, and resources to do so, is that it will ultimately *improve care for our patients.*

I know you can appreciate the magnitude and complexity of this project—developing one system to serve all Partners entities. Be assured that representatives from all Partners hospitals are part of this discussion, and every voice is being heard. We've created a system-wide schematic to chart the numerous teams and committees that will be necessary to coordinate and com-



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

plete this work. And I'm not going to lie—as organizational charts go, this one is formidable. But it provides valuable insight into the scope and flow of the work that needs to be done.

To give you a sense of the time frame, we're looking at a five-year implementation plan that would see Partners eCare up and running at all Partners sites and practices by mid-2017. Beginning in 2014, every few months, certain locations (hospitals and ambulatory practices) will go live with clinical and revenue-cycle applications. Then, on a particular date in 2017, the entire Partners HealthCare System will have access to Partners eCare. In order to make that happen, Epic has provided us with a set of key milestones that need to be met between now and then, and each milestone is tied to a very tight time line. Even though we're still five years from implementation, failure to meet these early deadlines would be costly, so we're making every effort to ensure deadlines are met in a timely fashion.

continued on next page

But perhaps the most daunting challenge in creating an integrated health information system will be the need to standardize clinical and administrative data in a way that will be useful and effective for all Partners entities... We want to be able to continue to meet the local needs of each institution while minimizing the number of variables involved in capturing patient data.

As we work to achieve a unified system, we'll need to hire a number of employees to serve as full-time staff to support this project. We'll need to identify subject-matter experts to ensure our work is in the best interests of (primarily) patients, families, and staff. We'll need on-site nurse and physician champions, and we'll need to commit resources for budget analyses, team-building, training, communication, and implementation.

But perhaps the most daunting challenge in creating an integrated health information system will be the need to standardize clinical and administrative data in a way that will be useful and effective for all Partners entities. And I want to be clear, we're not talking about standardizing the way we *deliver care*—we're talking about standardizing the way we collect and input data. We want to be able to continue to meet the local needs of each institution while minimizing the number of variables involved in capturing patient information.

We're fortunate to have the lessons we learned from our Acute Care Documentation project, which went a long way toward demonstrating that standardization is possible, even preferable, when designing an integrated system spanning several institutions. And standardizing processes fits with the work we're doing around care re-design and patient affordability. We're

going to great lengths to ensure there's no duplication of efforts as we work to develop a unified system.

I wasn't kidding when I said we're doing this *now*. Work has already begun. Relationships are being forged. People are being asked to fill key roles. We're having crucial conversations about what we want our post-implementation world to look like and what will and won't work to get us there. In February of 2013 (just four months from now) we'll come to our first major milestone. We'll present our proposed 'model' system, at which time subject-matter experts and other key stakeholders will have an opportunity to red-light or green-light proposed ideas. And then our work begins in earnest.

I don't want to overwhelm you with details. I just want you to be aware that this conversion to an integrated health-information system is happening. Many decisions will have to be made along the way, and we'll make sure that the best minds and most invested stakeholders are at the table when those decisions are made. Every phase of the journey will come with its own set of challenges. But I've worked with you before in times of great change, and I know we're up to the challenge.

If you'd like to be more involved in this work, either as a subject-matter expert or on-site champion, please call my office at 6-3100.

In this Issue

Our Journey to a Common Clinical System.....	1	Case Management Celebrates 17 Years.....	11
Jeanette Ives Erickson.....	2	Fielding the Issues I.....	12
• Conversion to a Common Clinical System		• Service Animals at MGH	
Raising Awareness about DVT and PEs.....	4	Fielding the Issues II.....	13
Gil Minor and Norman Knight Scholarships.....	6	• Understanding Clostridium Difficile	
AMMP Scholarships.....	7	New Offerings from the Blum Center.....	14
Clinical Narrative.....	8	Announcements.....	15
• Janice Tully, RN		Announcements.....	16
Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy.....	10		

Innovative partnering to raise awareness about DVT and PEs

—by Lynn Oertel, RN, clinical nurse specialist

You may be at moderate risk for blood clots if you:

- are older than 65
- travel by plane, train, or bus for more than four hours at a time
- are currently receiving chemotherapy
- have a bone fracture or cast
- use birth-control pills, patch, or ring
- have had hormone-replacement therapy
- are pregnant or recently gave birth
- have a personal or family history of blood clots
- have heart failure
- are obese
- have been on bed-rest for more than three days
- have genetic or acquired blood-clotting disorder

On September 8, 2012, patients, families, and staff from throughout the MGH community participated in a special educational forum called, Stop The Clot,[®] sponsored by the National Blood Clot Alliance (NBCA) with funding from an educational grant from the Centers for Disease Control and Prevention (CDC). The NBCA is a national patient-led organization dedicated to advancing the prevention, early diagnosis, and treatment of life-threatening blood clots such as deep-vein thromboses (DVTs), pulmonary embolisms (PEs), and clot-provoked strokes.

Every year, 600,000 Americans develop blood clots, and approximately one-sixth of them die. That's more than the annual number of deaths from breast cancer, yet most people are unaware of the symptoms and risks associated with deep-vein thrombosis and pulmonary embolism. Stop The Clot[®] Forums were designed to educate patients and families about the risks, prevention, and treatment of these life-threatening conditions.

Lynn Oertel, RN, clinical nurse specialist in the Anticoagulation Management Service (AMS) serves on the Medical Advisory Board for the NBCA. She recognized an opportunity to collaborate with them to supplement traditional education in anticoagulation-management for patients and families in surrounding communities. Oertel and AMS staff nurse, Diane DeTour, RN, coordinated the program with the NBCA, and the entire staff of AMS contributed, informing patients about the forum and volunteering to help on the day of the program.

continued on next page



(Photos provided by staff)

Patient Education (continued)

Presenters included MGH physicians, Daniela Krause, MD; Michael Jaff, MD; and Katy Goodarzi, MD; and BWH pharmacist, Ronelle Stevens, RPh.

Attendees learned how to recognize signs and symptoms of DVT and PE and were reminded to, “seek medical help without delay.”

The common signs and symptoms of deep-vein thrombosis include swelling, pain or tenderness in the affected leg, and reddish or bluish skin discoloration that can feel warm to the touch. Deep-vein thrombosis can also occur in veins other than in the legs, which is another reason it’s important to raise awareness—most people assume it only affects the legs.

Signs and symptoms of pulmonary embolisms are sudden shortness of breath and pain in the chest that can be sharp or stabbing and may get worse with deep breaths. Pulmonary embolisms may cause rapid heart rate or an unexplained cough that can be accompanied by bloody mucus. Another important message delivered at the forum was the importance of knowing your risk for developing deep-vein thrombosis or pulmonary embolisms (see sidebars).

Krause likened the complicated cascade of blood clotting to a speedometer with a target speed of 65mph. He talked about special proteins in the blood or changes in the blood flow or vessels that can speed

or slow the process. Said Krause, “Risks for blood clots can be acquired and inherited. And people can have multiple risk factors, so it’s important to know what they are.”

Jaff spoke about treatment and prevention of blood clots and emphasized the importance of, “listening to your warfarin manager and following his or her instructions closely.”

Goodarzi spoke about risk factors specifically associated with women. He focused primarily on contraceptives and pregnancy, including the increased probability of having multiple risk factors.

Stevens shared some practical and myth-busting safety tips. She emphasized the importance of, “being your own best advocate.”

Perhaps the highlight of the forum was an interactive panel discussion where patients of the AMS shared personal stories about the impact blood clots have had on their lives. Said DeTour, who moderated the session, “Hearing the personal stories of others can have a tremendous impact. It can make you stop and think about whether you or someone you know may be at risk.”

Deep-vein thromboses and pulmonary embolisms are preventable with increased awareness and education. As one patient panelist said, “I know my risks and know what I need to do to stay healthy.” Know *your* risk factors and what you can do to decrease them. By recognizing symptoms early and quickly seeking medical treatment you can minimize the likelihood of a poor outcome.

For more information, go to: www.stoptheclot.org or call Lynn Oertel at 6-6955.

Opposite page: Forum organizers (l-r): Cynthia Sayers, NCBDDD, Centers for Disease Control and Prevention; JoAnn Thierry, NCBDDD, Centers for Disease Control and Prevention; Judi Kaplan Elkin, NBCA; Diane DeTour, RN, AMS staff nurse; Lynn Oertel, RN, AMS clinical nurse specialist.

This page: patient panel participants: Blair Brettman, Wat Tyler; Ellen Plapinger; Caitlin Martin, and Shawn David.

You may be at high risk for blood clots if you:

- were recently hospitalized
- had major surgery
- had a knee or hip replacement
- suffered a major trauma, such as a car accident or fall
- live in a nursing home
- have leg paralysis



Gil Minor and Norman Knight scholarships

—by Julie Goldman, RN, professional development program manager

On August 16, 2012, the Gil Minor Scholarship to Advance Workforce Diversity and the Norman Knight Nursing Scholarship were presented at an informal reception in the Institute for Patient Care. The Knight Scholarship supports nurses as they advance their education at the bachelor's, master's, or doctoral level, and this year's recipients were Erin Evans, emergency department registrar; Erin Keefe, RN, Psychiatry; and Ryan Sullivan, grant manager in the Yvonne Munn Center for Nursing Research.

Evans, currently enrolled in the nursing program at Salem State College, says, "I'm competitive. I like to set goals. I want to be prepared to be a nurse. Just as in sports, you practice. If I don't practice as hard as I can, how am I going to be an asset to any hospital?"

In 2009, Gil Minor established the Gil Minor Nursing and Health Professions Scholarship to Advance

Workforce Diversity. Since its inception, 21 MGH employees have been supported in their efforts to pursue careers in nursing and other health professions.

This year's recipients of the Gil Minor scholarships were: Manisha Agarwal; Farah Andre; Renata DeCarvalho, RN; Michelle Farrell, RN; Kenia Giron; and Jane Martell, RN.

Kenia Giron, anesthesia technologist, has always wanted to make a difference. She believes she can do that best as a nurse. In her narrative, Giron wrote, "Every day I tell myself I'm going to be a nurse some day. That gives me the motivation I need to tackle each day with a smile."

Professional development program manager, Julie Goldman, RN, presented recipients with certificates. Said Goldman, "We're grateful to Mr. Knight and Mr. Minor for funding these programs that help increase the pipeline of diverse nurses and healthcare professionals. For more information about either of these scholarships, contact Goldman at 724-2295."

Scholarship recipients (l-r): Manisha Agarwal; Renata DeCarvalho, RN; Farah Andre; Kenia Giron; Erin Evans; Jane Martell, RN; Ryan Sullivan; and Erin Keefe, RN. (Not pictured: Michelle Farrell.)



AMMP scholarships

breaking barriers, building a stronger workforce

—by Waveney Cole, staff assistant

The Association of Multicultural Members of Partners (AMMP) has a long-standing commitment to helping recruit, retain, and develop multi-cultural professionals throughout the Partners community. Among its many programs, AMMP offers an annual scholarship to help eligible employees pursue educational and training opportunities. On September 6, 2012, this year's AMMP scholarships were presented to:

- Christa Brutus, senior medical technologist, MGH Core Lab
- Ferrimy Fatimazahra, patient care associate, Blake 11
- Chantal Kayitesi, refugee women's access coordinator at MGH Chelsea
- Farhiya Mohamoud, histology specialist, MGH Pathology

- Christine Marmen, educational development specialist and Lunder 9 patient care associate
- Tirza Martinez, patient service coordinator, Ambulatory Care Center
- Abdulwahab Musanur, distribution associate, Materials Management
- Ijeoma Nwankwo, financial analyst, MGH/MGPO Finance
- Christopher Roddick, senior analyst, Imaging & Informatics
- Henry Seemore, senior financial analyst, MGH/MGPO Finance
- Robyn Stroud, staff assistant, Institute for Patient Care
- Gureline St.Vil, clinical assistant, Clinical Genetic Research Facility
- Sandra Thomas, staff assistant, Central Resource Team



AMMP scholarship recipient, Christine Marmen, educational development specialist and future nurse (left) with AMMP scholarship program chair, Waveney Small Cole.

(Photo by Paul Batista)

In his opening remarks, Jeff Davis, senior vice president for Human Resources, emphasized the importance of education in terms of both employment and income potential. Dee Dee Chen, manager of professional staff benefits and chairperson of AMMP, shared a quote from Nelson Mandela, "Education is the most powerful weapon which you can use to change the world." She encouraged recipients to better themselves so that they, too, could one day go out and change the world.

Past AMMP recipient, Evelyn Abayaah, performance improvement coordinator for the Center for Quality & Safety, offered words of encouragement, saying, "We're lucky to belong to an organization that cares about its employees and their professional development. This scholarship is a testament to that fact."

Scholarship program chair, Waveney Small Cole, congratulated recipients and presented them with their certificates of completion. For more information about the AMMP

Inter-disciplinary collaboration in the cardiac care setting

One recent patient, RH, whom I worked with on the Cardiac Telemetry Unit, was admitted for severe right-sided heart failure and acute worsening of her pulmonary hypertension.

My name is Janice Tully, and I have been a nurse case manager for 14 years at MGH. I am consulted in the Cardiac Intensive Care Unit (CICU) and the Cardiac Telemetry Unit, for a variety of issues, from referrals to VNAs, rehabs, or hospice, to transfers to other acute-care settings. I often meet with families at a time when their loved ones are critically ill to assist them in navigating the health-care system. I do my best to support them, answer their questions, and collaborate with them for a safe transition of care.

One recent patient, RH, whom I worked with on the Cardiac Telemetry Unit, was admitted for severe right-sided heart failure and acute worsening of her pulmonary hypertension. She was volume overloaded and needed diuresis (help eliminating urine). Although she had been followed in the Pulmonary Hypertension Clinic, her condition had deteriorated, and she was being evaluated for IV epoprostenol. (IV flolan, a medication used to treat high blood pressure in the lungs). Her past medical history was significant; she had endured a very long hospitalization and rehab stay in the recent past. She had been living on her own but recently moved into her sister's home to be closer to MGH.



Janice Tully, RN, case manager

When I first met RH, I saw a critically ill woman who was very guarded and barely made eye contact. She deferred my questions to her mother and sister, so I told her I'd be back when they were present. I understood she was tired from the admission process, and I encouraged her to rest—my assessment could wait. Over the next week, I got to know RH and checked in with her daily. Prior to becoming ill, she had enjoyed gardening and photography, but the progression of her medical issues had limited her ability to engage in these activities. Over the next two weeks, RH's heart-failure medications were carefully titrated, and she improved, gaining strength. When I went to see her, I was thrilled to see a smiling RH ambulating in the hallway with her portable IV flolan at her side. RH was at a point where she could begin to learn about the CADD pump (an ambulatory infusion pump), IV-flolan mix-

continued on next page

ing, and the care necessary to independently manage her medication at home.

IV-flolan administration can be challenging. Patients need to be able to mix the drug daily, know how the CADD pump works, and demonstrate the ability to troubleshoot and problem-solve as the half-life of the drug is less than five minutes. If therapy is interrupted, it can cause rebound hypertension and a potentially critical situation.

RH was referred to a specialty pharmacy for help managing her medication at home. Teaching sessions offered by the pharmacy nurse were very focused and intense. I noticed that RH was having trouble following along; the sessions weren't progressing as we had hoped. Many discussions followed to try to figure out what the problem was.

RH said she was nervous about her mother, who was asking questions and trying to be part of the process. Other family members were present, as well, wanting to hear the teaching session and trying to be supportive. Despite several attempts at instruction, RH struggled with the basic techniques. I conferred with her nurses to see if there would be a better time for teaching when she might be more able to absorb the material. We looked at factors such as the activity of a double room and the effect of her medications.

Our assessment was that her medications might be increasing her somnolence in the morning, so we asked her physician to adjust the medication regimen accordingly. We restricted her teaching sessions to one-on-one with RH and her nurse, and provided a quiet room where they could talk without interruption. It seemed to help. Slowly, RH began to make progress.

I shared with RH an experience I'd had with another IV-flolan patient who had also felt frustrated and overwhelmed learning about the CADD pump and mixing her medication. I assured her that the patient's anxiety had faded over time. It was like driving a car—after a while, the process would become second nature. I told her about a 17-year-old patient with a learning disability who had been able to learn the process and went on to go to her senior prom.

With encouragement and patience, RH became more confident. Her physicians suggested that she go to rehab for continued teaching, as she wasn't quite able to demonstrate her ability to manage in the home setting. She didn't have any physical- or occupational-

therapy needs, so I advocated for her to be given more time to learn here at MGH. RH had had a difficult time in the past with a long rehab stay, and she confided that she didn't want to go back to rehab. Very few rehab facilities accept patients on IV-flolan. (I've only ever successfully moved one patient with IV-flolan to a rehab setting). I agreed that it wouldn't be in RH's best interest to go to rehab. I advocated for her to stay on Ellison 10 until she was able to go directly to her sister's home. I reminded the team that RH had been quite ill when she first arrived, which had delayed initiation of her teaching sessions. After much discussion among the team, RH's family, and myself, we decided against a transfer to rehab.

RH continued to improve with one-on-one teaching sessions. She got to know and trust the team on Ellison 10. She became more focused and proficient at preparing her medications, and she practiced on her own throughout the day. Her confidence really started to emerge.

The pharmacy nurse coordinated a pre-discharge visit to the sister's home to review things with the family. Before being discharged, RH thanked me for my role in helping her get healthy and more comfortable managing her healthcare needs.

I believe partnering with RH, her family, the team, and the pharmacy was vital to her successful transition to her sister's home. Her hope was to return to her own home out of state after a period of time. I'm confident RH has the ability and determination to live independently and will succeed at reaching that goal, as well.

A follow-up call with RH's nurse in the outpatient setting confirmed that she is managing quite well in her own home.

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

Janice's experience with IV-flolan and more importantly, her knowledge of RH, had a profound effect on the outcome in this clinical situation. Janice recognized the stress RH was feeling and the impact it had on her ability to process critical information. She advocated to create a setting that was optimal for RH's learning and recovery. She focused on RH's long-range needs and goals and tailored her care to do what was best for her patient.

Thank-you, Janice.

I believe partnering with RH, her family, the team, and the pharmacy was vital to her successful transition to her sister's home. Her hope was to return to her own home out of state after a period of time. I'm confident RH has the ability and determination to live independently and will succeed at reaching that goal, as well.

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

—by Julie Goldman, RN, professional development manager

On September 12, 2012, Quetlie Cadet, nutrition service coordinator for Phillips 21 and Lunder 9, received the 2012 Paul W. Cronin and Ellen S. Raphael Award for Patient Advocacy. The award was established by the Raphael and Cronin families in 1999 to recognize the contributions of a clinical and/or support-staff member on Phillips 21 who consistently demonstrates excellence in identifying and addressing the individual needs of patients and families through advocacy and empowerment.

Award recipient, Quetlie Cadet (holding framed certificate), with colleagues and friends at award ceremony.



(Photo by Michelle Rose)

In her opening remarks, Barbara Cashavelly, RN, nursing director for Lunder 9, observed, “Today is a day of remembrance and celebration. I’m sure there are many contributions and memories that accompany the legacy that Paul and Ellen have left. One of those contributions is this wonderful award, and this year, we honor Quetlie Cadet. I also want to acknowledge all the support staff on Lunder 9 for their advocacy on behalf of patients and families.”

Cadet has worked at MGH for 22 years. She has been the nutrition service coordinator for Phillips 21/Lunder 9 for the past six years. Cadet takes pride in her work and give her best to patients and families every day. She was nominated by her colleague, Renee Reynolds, and other co-workers who describe Cadet as a caring and committed staff member. “Quetlie reassures patients with her genuine concern and compassion. She pays attention to all the patients on the unit, checking on them and making sure she knows their food preferences so she can arrange to bring any special items they may want.”

When asked what she likes best about her role as nutrition service coordinator, Cadet says, “I enjoy getting to know and assist patients. I take pride in providing support to staff whenever they need it.”

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

Case Management celebrates 17 years at MGH

—by Jackie Lally, RN, and Maria Sweeney, RN

When you think of the many stressors associated with hospitalization, there's a lot for patients to deal with. Case managers guide patients and families through hospitalization, help navigate the team through the admission process, and plan for a safe transition through discharge.

What an amazing year for MGH. The hospital was ranked number one by *US News & World Report*, we had a successful Joint Commission survey, we launched 12 inpatient innovation units, and we opened a new short-stay unit on Bigelow 7 (to name just a few of our accomplishments). And this month, we're celebrating another important milestone. Case Management is celebrating its 17th year as a department providing quality patient care at MGH.

The case manager's role is to positively affect patient outcomes and improve a patient's well-being. When you think of the many stressors associated with hospitalization—illness, concern over diagnoses, tests, insurance, hospital routines, discharge, etc.—there's a lot for patients to deal with. Case managers guide patients and families through hospitalization, help navigate the team through the admission process, and plan for a safe transition through discharge.

The role of case managers will become even more valuable in the era of accountable care. Accountable care organizations link payment to quality care metrics and reductions in the cost of care. Case managers are knowledgeable about available resources and level of care and are skilled in after-care planning. Through patient advocacy and teamwork, case managers play a vital role in guiding patients and families through these changing times in health care.

The Case Management Department has undergone some major changes recently. Three nurse managers

have joined our ranks. The clinical knowledge and expertise they've brought have been an asset to our department and to the hospital. We've also added staff as part of our Case Management Project (CMP). CMP case managers follow Medicare patients in the outpatient setting to promote health, streamline services, and help control costs.

In the spirit of saving the best for last, our outstanding support staff bring the highest level of dedication and customer service to their roles. Our mission as a department is to effect a seamless transition from admission to discharge with follow-up after patients have left the hospital to ensure continuity. Our committed support staff assist in making sure patients are screened in a timely manner before transitioning to the next level of care. The contributions of our support staff cannot not be overstated.

October 8–12, 2013, is Case Management Week. Case Management will have an information booth in the Main Corridor on Tuesday, October 9th, from 8:30am–3:30pm, and on Friday, October 12th, from 8:30am–noon. Representatives from the department will be available to answer questions, and SHINE (Serving Health Information Needs of the Elderly) pamphlets will be available, as well. On Wednesday, October 17th, Case Management will present, "Case Management: at the Heart of Healthcare's Future," by Nancy Skinner RN, from 12:30–1:30pm in O'Keefe Auditorium. CEUs and CCMs will be awarded.

For more information about Case Management Week or the work that case managers do to help keep patients safe, contact Laurene Dynan, RN, at 4-9879.

Service animals at MGH

understanding their rights, and yours

Service animals are (most often) dogs specially trained to work with, or perform tasks for, people with disabilities... Patients who use service animals are responsible for all aspects of their animals' care while in the hospital.

Question: What is a service animal?

Jeanette: Service animals are (most often) dogs specially trained to work with, or perform tasks for, people with disabilities. For example, they may guide people who are blind, alert people who are deaf or hard of hearing, calm a person with post-traumatic stress disorder during an anxiety attack, or protect a patient having a seizure.

Question: How can you tell if a dog is a service animal?

Jeanette: Most of the time, service animals are on a harness, trained to perform services related to their owner's disability. If it's not obvious, you can ask if the dog is a service animal. But as stipulated in the Americans with Disabilities Act of 1990, you may *not* ask what the person's disability is or request any documentation, identification, licensing, or certification for the dog.

Question: Who is responsible for providing care to service animals when their owners are hospitalized?

Jeanette: Patients who use service animals are responsible for all aspects of their animals' care while in the hospital. That includes walking them, controlling them, providing food and water for them, and cleaning up after them. In cases where patients are unable to perform those duties, they're responsible for making ar-

rangements with family, friends, the dog's trainer or breeder, or anyone else in their support network. If no help is available, a list of resources, dog-walkers, and boarding options will be provided to the patient, and it's their responsibility to make arrangements. (This list is an appendix to the Revised Service Animal Policy, which can be found in Trove.)

Question: What if a patient is unable to communicate when he or she is admitted?

Jeanette: The person listed as emergency contact should be called as soon as possible. Explain the situation and ask for their assistance with the service animal. If there's no emergency contact or assistance available, contact Police & Security (6-2121) and ask them to page the emergency service animal representative. Provide your name, the patient's name, and the location.

Question: Besides service dogs, are other animals allowed at MGH?

Jeanette: Service dogs and pet-therapy dogs are allowed in patients' rooms at MGH. The Pet Therapy program is coordinated through the Volunteer Department.

For more information about service animals at MGH, contact Zary Amirhosseini, disability program manager, at 6-3370.

What you need to know about C. difficile

Question: What Is Clostridium difficile?

Jeanette: Clostridium difficile (C. difficile) is a spore-forming* bacterium that lives in or 'colonizes' the intestinal tract. Some strains of C. difficile produce a toxin (toxigenic strains). Under the right conditions, toxigenic C. difficile bacteria multiply in the intestine producing a toxin that can cause antibiotic-associated diarrhea or pseudomembranous colitis. These syndromes are known as C. difficile infection or C. difficile-associated disease (CDAD).

The incidence and severity of healthcare-associated C. difficile infections have increased in the United States since 2000, particularly in older patients. Studies indicate that 20-50% of adults may contract C. difficile during hospitalization; some of those patients develop infections, others remain asymptomatic.

Question: What are the main symptoms of C. difficile?

Jeanette: Symptoms typically include:

- watery diarrhea
- blood or pus in stool
- abdominal cramping/pain/tenderness
- fever
- loss of appetite/nausea
- dehydration/weight loss

Question: Who is at increased risk for C. difficile infection?

Jeanette: Conditions or treatments that alter the normal flora (beneficial organisms) of the intestine can set the stage for C. difficile, increasing the risk of C. difficile-associated disease in patients who:

- have antibiotic exposure
- receive proton-pump inhibitors
- undergo gastrointestinal surgery/manipulation
- are receiving chemotherapy
- have a serious underlying illness
- have immunocompromising conditions
- are of advanced age

* C. difficile bacteria within the body are in a vegetative state. Outside of the body, vegetative C. difficile bacteria quickly dry on environmental surfaces and form spores. These spores can persist in the environment and are not easily killed.

Question: Which laboratory tests are used to diagnose C. difficile?

Jeanette: Stool culture for C. difficile is the most sensitive test available, but it can be associated with false-positive results due to the presence of non-toxigenic C. difficile strains.

At MGH, a new test was recently adopted that detects both C. difficile antigen and toxins A and B and provides significantly higher sensitivity than testing for the toxin alone. Because of the increased sensitivity of this test, it is not necessary to repeat testing.

Question: How can C. difficile infection be prevented?

Jeanette: C. difficile can be present on hands, equipment, and environmental surfaces in patients' rooms. *Some* measures you can take to help prevent the transmission of C. difficile include:

- Judicious use of antibiotics
- Contact Precautions Plus for patients with known or suspected C. difficile infection. (If private rooms are not available, patients may be placed in rooms with other patients with C. difficile infection)
 - Perform hand hygiene and don gloves when entering patients' rooms and during patient care
 - Don gown on entry if you might contact the patient or environment in the room. Tie gown to secure it and pull gloves over cuffs
 - Upon exiting, remove gloves first then gown
 - Perform hand hygiene. Because alcohol does not kill C. difficile spores, use soap and water to remove spores then dry hands and use Cal Stat to destroy organisms that may remain
- When possible, assign medical equipment to individual patients. Place stethoscope in the room; avoid shared commodes. Equipment removed from the room must be thoroughly cleaned and disinfected with hospital-approved, bleach-based disinfectant
- Perform daily cleaning and disinfection of all 'high-touch' surfaces with hospital-approved, bleach-based disinfectant.
- Patients should wash their hands after using the bathroom, bedpan, or commode and when leaving their room. Families should be educated to wash their hands when leaving patient's room

At MGH, precautions are maintained for duration of hospitalization. Patients hospitalized for more than 30 days after a positive test may be evaluated by Infection Control for removal of precautions.

For more information, call 6-2036.

New offerings from the Blum Patient & Family Learning Center

—by Jen Searl, health education project specialist

Starting this fall, the Blum Center is expanding its offerings, both in the type of programs being offered and the medium in which they can be accessed. For information, call 4-3823.

In the past, The Maxwell & Eleanor Blum Patient and Family Learning Center has offered a number of educational series for patients, families, and staff—Book Talk, Shared Decision Making, and the National Health Observance Series, to name a few. Starting this fall, the Blum Center is expanding its offerings, both in the type of programs being offered and the medium in which they can be accessed.

Popular programs like the National Health Observance Series, the Healthy Living Series, Book Talk, and Shared Decision Making will continue to be offered. Paul Arnstein, RN, kicked off the fall season with his presentation, “Prescription and Non-Prescription Pain Medications,” as part of the National Health Observance Series.

On September 18th, Steve Schlozman, MD, became the first Book Talk presenter to talk about a work of fiction with his book, *The Zombie Autopsies*. In the well-attended session, Schlozman assured attendees that *he* knew that *they* knew that, “Zombies aren’t real.”

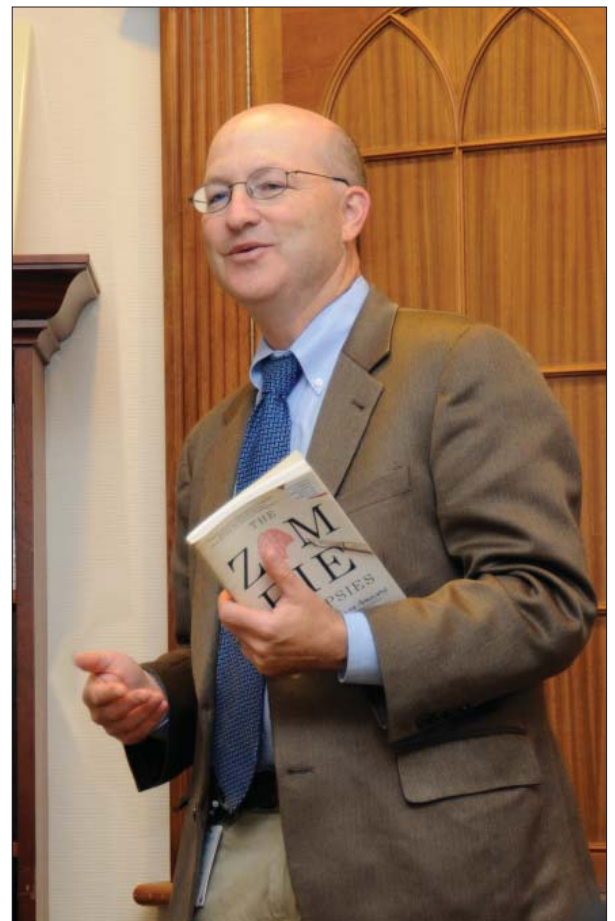
On September 27th, as part of the Healthy Living Series, Barbara Moscovitz, LICSW, presented, “Caring for Loved Ones with Alzheimer’s Disease.”

In response to feedback from staff, two programs have been added that offer a mind-body focus. On September 12th, relaxing harp music was played for patients, families, and staff. And as part of a collaboration with the Benson-Henry Institute for Mind Body Medicine, beginning October 19th, Laura Malloy, LICSW, will lead a bi-monthly chair yoga session.

In an attempt to reach more people, video recordings of many of the Blum Center programs will be available on the Blum Center website. The Blum

Center has also recently launched Facebook and Twitter accounts, enabling us to connect with patients, families, and staff in new ways.

For more information on Blum Center programs, call Jen Searl, health education project specialist, at 4-3823.



Steve Schlozman, MD, author of *The Zombie Autopsies*, presents at recent Book Talk.

Announcements

The Inaugural Blum Visiting Scholar Program

Inter-Disciplinary Grand Rounds

"Becoming a Health-Literate Organization: Soup to Nuts Strategies"

presented by
Cindy Brach, senior health policy researcher, AHRQ

Thursday, October 18, 2012
1:30–2:30pm
O'Keefe Auditorium

For more information,
call 4-7352.

Infection Control honors Carole DeMille

The MGH Infection Control Unit will host a special presentation to honor infection control pioneer, Carole DeMille, RN. DeMille was the first infection control nurse at MGH and a founder of the international Association for Professionals in Infection Control (APIC).

October 15, 2012
2:00pm
Ether Dome

The event marks the 40th anniversary of the APIC and the first day of Infection Control Week, 2012. Reception to follow in the newly dedicated Carole DeMille Conference Room on Bulfinch 3.

For more information,
call 6-6330

October is Domestic Violence Awareness Month

The Domestic Violence Working Group will host events throughout the month:

"In Her Shoes"

An interactive event to increase understanding of domestic violence. Discussion to follow.

October 11th
11:45am–1:30pm

Light refreshments. Social Work CEUs pending.
Please RSVP to: 617-726-6976

"The Commercial Sexual Exploitation of Children"

Social Work Grand Rounds with Lisa Goldblatt-Grace, LICSW, of My Life, My Choice

October 18th
10:00–11:30 am
O'Keefe Auditorium

Light refreshments.
1.5 Social Work CEUs

For more information,
call 6-7674.

An update on healthcare reform

The Upsilon Lambda Chapter of Sigma Theta Tau International presents:

"The Only Constant is Change: an Update on Healthcare Reform and Implications for Practice

October 15, 2012
6:00–8:30pm
MGH Institute of Health Professions
Conference Room 305 A/B

Includes dinner and panel presentation featuring:
Stephanie Ahmed, RN
and Alex Hoyt, RN

Registration deadline: October 8th
\$10 for chapter members, alumni,
and current student
\$15 for all others
1.5 contact hours

For more information,
call 617-724-5158.

Blum Center Events

Shared Decision Making
"Women's Health"

Thursday, October 4, 2012
Join Karen Carlson, MD, and Kathleen Ulman for an in-depth discussion about women's health issues.

Harp Music
Wednesday, October 10th
Enjoy relaxing music with harpist, Becky Wertz.

Chair Yoga
Friday, October 19th
Join Laura Malloy, LICSW, of the Benson Henry Institute for Mind-Body Medicine to learn healthful chair yoga techniques accessible to all levels.

Book Talk
Chicken Soup for the Soul: Boost Your Brain Power
Wednesday, October 24th
O'Keefe Auditorium
Learn how to be smarter; think faster; and have a better memory with author Marie Pasinski, MD

National Health Observances Talk
"Selecting the Right Shoe for You"
Tuesday, October 30th
Join Marie Figueroa, PT, for a discussion about the importance of selecting the right shoes.

Programs are free and open to MGH staff and patients.

No registration is required. All sessions held from noon–1:00pm in the Blum Patient & Family Learning Center unless otherwise specified.
For more information,
call 4-3823.

Published by

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

Publisher

Jeanette Ives Erickson, RN
senior vice president
for Patient Care

Managing Editor

Susan Sabia

Editorial Advisory Board

Chaplaincy
Reverend John Polk, DMin

Disability Program Manager
Zary Amirhosseini

Editorial Support
Marianne Ditomassi, RN
Mary Ellen Smith, RN

Medical Interpreters
Anabela Nunes

Materials Management
Edward Raeke

Nutrition & Food Services
Martha Lynch, RD
Susan Doyle, RD

Office of Patient Advocacy
Robin Lipkis-Orlando, RN

Office of Quality & Safety
Kevin Whitner, RN (interim)

Orthotics & Prosthetics
Mark Tlumacki

PCS Diversity
Deborah Washington, RN

Physical Therapy
Occupational Therapy
Michael Sullivan, PT

Police, Security & Outside Services
Joe Crowley

Public Affairs
Emily Lemiska

Respiratory Care
Ed Burns, RRT

Social Services
Ellen Forman, LICSW

Speech, Language & Swallowing Disorders and Reading Disabilities
Carmen Vega-Barachowitz, SLP

Training and Support Staff
Stephanie Cooper

The Institute for Patient Care
Gaurdia Banister, RN

Volunteer Services
Wayne Newell

Distribution
Ursula Hoehl, 617-726-9057

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

Next Publication
November 1, 2012

Announcements (continued)

Caring for the Caregiver

The stress of being a caregiver can be overwhelming. This four-week program from the Benson-Henry Institute for Mind Body Medicine is designed to help caregivers manage stress and regain resilience.

Programs start October 15, 2012 (MGH West) and October 24th (Merrimac Street, Boston).

\$125 for four weekly two-hour sessions.

For more information, or to register, contact Aggie Casey at 781-487-6101.

Connell Visiting Scholar Presentation

"Prevention of Healthcare-Associated Infections: a Program of Inter-Disciplinary Research Focusing on Comparative Effectiveness"

presented by Patricia Stone, RN, director of the Center for Health Policy at Columbia University School of Nursing

Friday, October 19, 2012
9:30–11:00am
Bigelow Amphitheater
Bigelow 4

For more information:
Call 617-643-0431

MGH Clinical Research Day

The Clinical Research Program invites you to the 10th annual MGH Clinical Research Day

Thursday, October 11, 2012.
8:00am

O'Keefe Auditorium
Keynote Address

"Genetics: Cycling to Better Care"
by James F. Gusella

9:00am
Bulfinch Tent
Poster Session

View 230 posters by researchers from across the institution

11:00am
O'Keefe Auditorium
Panel Discussion

"Integrating Genetics into Clinical Medicine: 'Sequencing' the Future of MGH"

moderated by Susan A. Slaughaupt with panelists:
Henry C. Chueh, MD
Mark J. Daly
James F. Gusella
Alexandra B. Kimball, MD
and Jordan W. Smoller, MD

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

Bereavement Support Group

An eight-week bereavement support group for patients and staff of the MGH and Partners community who have experienced the death of a loved one in the past year and a half will begin in mid-November.

For more information, to make a referral, or schedule a pre-group screening interview, call group leader, Susan Primm Thel, at 617-726-2636.

Senior HealthWISE Lectures

"What Do Gratitude and Forgiveness Have to Do with Living and Aging Well?"

October 4th and 18th, 2012
11:00am–noon
Haber Conference Room

In this two-part series on gratitude and forgiveness, Bob Weber will examine gratitude and forgiveness and show how they can enhance our lives as we age. He will share exercises that increase our capacity for both gratitude and forgiveness.

Thursday, October 4th (gratitude)
Thursday, October 18th (forgiveness)

Feel free to attend both or either program.

For more information,
call 4-6756.

ACLS Classes

Certification:

(Two-day program)

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

Day one: November 1, 2012
8:00am–3:00pm
Robbins Conference Room,
Founders 2

Day two: November 2nd
8:00am–3:00pm
Robbins Conference Room,
Founders 2

Re-certification (one-day class):
October 10th
5:30–10:00pm
Founders 130

ACLS Instructor Course
Wednesday, November 14th
5:30–10:30pm
Founders 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



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



First Class
US Postage Paid
Permit #57416
Boston, MA