

Caring

Headlines

April 18, 2013

Occupational Therapy

*Working with the first
MGH hand-transplantation patient*



*See story
on page 4*

Pain-management

an integral part of Excellence Every Day and a key component of hourly rounding

In most of the domains tracked by HCAHPS, MGH fares in the top quartile; as high as the 90th percentile in some domains. But our pain-management scores lag behind our performance in other areas.

Perhaps the intervention that invokes The Golden Rule more than any other healthcare intervention, is pain-management. As caregivers, we strive to control pain the way we'd want it controlled if one of our loved ones or we ourselves were patients. For many of us, it's the reason we chose a caring profession in the first place—to ease the suffering of others.

Pain-management is one of the nine areas measured and publicly reported as part of the HCAHPS survey. HCAHPS, you recall, is the standardized patient-experience survey designed to provide comparable data to consumers so they can compare hospitals based on aspects of care important to them. The pain-management rating combines the responses of two questions. Patients who require pain medication during their stay are asked:

- How often was your pain well controlled?
- How often did staff do everything they could to help you with your pain?

Of the choices: Never, Sometimes, Usually, or Always, only the Always responses count toward a hospital's HCAHPS scores.

In most of the domains tracked by HCAHPS, MGH fares in the top quartile; as high as the 90th percentile in some domains (discharge information, overall rating, and likelihood to recommend). But our pain-management scores lag behind our performance in other areas.



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

From 2010 to 2012, our scores for pain-management were consistently between 70.9 and 71.9. So far this year, our score is 70.7. Compared to hospitals across the country, this puts us just above the national average.

When I think of our commitment to Excellence Every Day and the outstanding work we're doing on Innovation Units and elsewhere, I can't help think we can do better when it comes to pain-management. Not only do these scores put us at risk for reimbursement, they don't reflect the caliber of care I know is being delivered at this hospital every day.

Our colleagues in the Knight Nursing Center, Service Improvement Department, and collaborative governance are exploring ways to ensure staff are trained and educated in the nuances of pain-management—recognizing the signs and responding appropriately. The goal is to expand the Pain Committee to include representation from all units, ensuring every unit has a pain champion.

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We've always put our patients' safety, comfort, and needs above all else. I urge you to make pain-management a personal priority as we continue to try to improve the hospital experience for patients and families. It's so important for these efforts to be visible in our HCAHPS scores as well as at the bedside and in all our interactions with patients.

Pain-management is an integral part of hourly rounding. We know that regular rounding contributes to greater understanding of patients' expectations, improves our ability to anticipate their needs, and enhances communication. Each rounding visit should encompass:

- pain-management—no one should experience on-going pain
- positioning—re-position patients frequently to prevent pressure ulcers, ensure comfort, and place items they may need (telephone, call button, etc.) within reach
- personal needs—offer assistance with simple activities such as going to the bathroom, combing their hair, or any other needs that may add to their comfort or peace of mind
- presence—be fully present to the patient and his/her needs while at the bedside

Studies show that regular rounding has a positive impact on many things, including reducing falls and pressure ulcers, improving pain-management, increasing overall patient-satisfaction, and engendering loyalty to the hospital.

The Joint Commission stipulates that hospitals conduct a comprehensive pain assessment consistent with their scope of care, services, and patients' conditions. It defers to each organization's individual

policies. The MGH policy states (briefly):

- Pain is assessed upon admission and is included in the nursing dataset
- Pain is assessed within an hour after an invasive procedure requiring procedural sedation or anesthesia, and the assessment is documented on the appropriate flow sheet or progress note before transfer or discharge
- Pain is re-assessed after interventions to alleviate pain
- For inpatients, pain re-assessment is documented on the flow sheet, electronic medication administration record, or progress note by the end of the shift
- For outpatients, pain is re-assessed and the response to treatment is documented before discharge for those whose pain is treated as part of the care rendered during the outpatient visit

We've always put our patients' safety, comfort, and needs above all else. We strive for excellence in every detail of our daily practice. I urge you to make pain-management a personal priority as we continue to try to improve the hospital experience for patients and families. It's so important for these efforts to be visible in our HCAHPS scores as well as at the bedside and in all our interactions with patients.

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First MGH hand-transplantation

April is National Occupational Therapy Month

—by occupational therapists, Gae Burchill, OTR/L, and Carol Mahony, OTR/L

Hand-transplantation recipient, Joseph Kinan, works with occupational therapist, Gae Burchill, OTR/L, six months post-surgery.

April is National Occupational Therapy Month. To celebrate, the MGH Occupational Therapy Department would like to share our journey in the development of a hand-transplantation rehabilitation program and treatment regimen for the first hand-transplantation patient at MGH.

The new MGH Hand-Transplantation Service is one of only eight programs in the United States, including one at Brigham and Women's Hospital. Approximately 78 hand-transplantations have been performed (worldwide) since 1998, when the first one was performed in Lyon, France.

The process began over a year ago when the Hand-Transplantation Team, led by Curtis Cetrulo, MD, began meeting to establish the program. As key members of the team, occupational therapists needed to become knowledgeable about hand-transplantation, so they embarked on a focused effort to absorb all they could through literature, conferences, and discussions with colleagues who had experience treating hand-transplantation patients. We used our own clinical knowledge and expertise gleaned from treating hand-replantation and revascularization patients for the past 38 years.

We incorporated this information into a hand-transplantation protocol. Hand-transplantation involves the use of donated tissue, known as vascularized composite allotransplantation (VCA). The surgery involves two teams of surgeons, one working on the donor limb as the other works simultaneously on the recipient limb. Tissues need to be connected throughout the forearm bones, tendons, nerves, arteries, veins, and skin. Presently, hand-transplant recipients at MGH need to use conventional immunosuppressive therapy, but there's hope that a treatment involving bone marrow will eventually eliminate the need for anti-rejection medications, which can have serious long-term side-effects.

The MGH Hand and Upper Extremity Therapy Service is comprised of board-certified hand therapists who bring expert clinical skill and a passion for treating hand and upper-extremity patients. We worked together to develop a draft protocol. To address certain questions and concerns, we divided into

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With our hand-transplantation protocol and therapy regimen in place and our clinical skill set enhanced, we waited for the call.

small groups to explore these topics in greater detail. We talked about the type of splint the patient would need immediately after surgery and how complex it would need to be. We decided on the 'Crane splint' and created a plan to become proficient in its fabrication. We practiced fabricating the splint so we'd all be prepared when the time came to use it. It was new to us, and we spent many weeks perfecting the fabrication process, the fit, and the many nuances of the design.

Two other concerns we had were limited forearm rotation and whether to include electrical stimulation in our protocol. We felt we should start forearm rotation early in his rehabilitation to improve motor recovery and functional use of the new limb. We committed to start forearm motion early with the physicians' approval and work progressively to achieve the best outcome.

We looked at whether electrical stimulation would help maintain or stimulate intrinsic muscle function until nerve regeneration could occur. Some hand-transplantation programs use electrical stimulation, but we found no evidence in the literature that supported the use of electrical stimulation on

intrinsic muscles, so we eliminated it from our protocol.

Treatment focused on protective joint motion using the Crane splint to prevent soft-tissue adhesions, joint stiffness, and to maintain tendon glide. We would work to integrate the transplanted limb into the patient's body schema early. Stimulation to the sensorimotor cortex would be an integral part of treatment. Changes in cortical representations occur with motor-skill acquisition and the repetitive practice of basic movements. Use of the transplanted hand would improve cortical plasticity in the brain. It would be important to incorporate all of the patient's senses, such as vision, touch, verbal cuing, proprioception, movement, motor imagery, and kinesthesia into the treatment regimen.

With guidance from a therapist, the patient would select an activity of daily living, such as feeding or writing, and be asked to imagine doing the activity before actually doing it. The therapist would break the functional goal down into smaller components; provide adaptive equipment, then let the patient perform the task. With feedback as the patient progresses through the task, sensorimotor input to the brain increases. Studies show that aerobic exercise can enhance neural plasticity, cognitive function, and motor recovery, so aerobic exercise would also be part of the treatment regimen as the patient is able to tolerate it.

Intrinsic muscle innervation and sensation are slow to return, so as part of the treatment regimen, we would splint the hand using a lumbrical block splint. This will help prevent muscle imbalances and contractures and enable the patient to perform functional tasks. We would teach skin protection and safety techniques to compensate for the lack of sensation in the hand. As occupational therapists, our primary goal is to improve the patient's functional independence. The use of therapeutic exercise, splinting, positioning, cortical reintegration, sensory and motor re-education, and training in activities of daily living are all means by which we guide the patient through rehabilitation.

Once we had a working draft of our hand-transplantation protocol and treatment regimen, we shared it with the surgeons. After incorporating their feedback, we were ready to evaluate candidates.

During the winter of 2011, the team had selected a number of potential candidates to undergo the first hand-transplant. Comprehensive evaluations were conducted, and the assessments were shared with the

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Kinan with occupational therapist, Carol Mahony, OTR/L



It has been a privilege to work with Joe and be part of this amazing journey. We've learned so much as individual clinicians and as a department. We hope to contribute to the OT literature as we reflect back on what went well with this case and what we might do differently for future hand-transplantation candidates.

transplant team so the best candidate could be chosen.

The primary goals of hand-transplantation are to enhance the patient's quality of life while addressing the aesthetic, social, and psychological impact of having a new hand. Part of the rehabilitation process is to successfully integrate the transplanted hand into the patient's body and self image and for the recipient to be satisfied with the sensation and function of the new hand. It became evident while evaluating candidates that 'normalcy' was very important to them. The ability to be 'whole' was, to some candidates, more important than functional use of the hand. We had many discussions about patients' goals for hand-transplantation as well as ethical issues associated with treating this population. We hoped we had a good understanding of the issues and concerns, which would help us be more empathic when we started treating our first recipient.

We asked candidates their goals for hand-transplantation, and the team discussed whether the goals were realistic. We informed candidates of the commitment they'd need to make to their treatment. Therapy would start one to two days after surgery and continue for a year or more. The recipient would need to spend the first six months close to MGH—rehabilitation would be their full time job.

With our hand-transplantation protocol and therapy regimen in place and our clinical skill set enhanced, we waited for the call.

On October 7, 2012, the first MGH hand-transplantation was performed on Joseph Kinan, a survivor of the Rhode Island Station nightclub fire who had lost the fingers of both hands and could only minimally use the thumb of his right hand for lateral pinch. He was originally left-handed and had very poor function of his left residual hand. During his evaluation, Joe reported that his goals for a new hand included

being able to perform activities of daily living, feed and dress himself, work out, and do push-ups.

Now, six months post-surgery, Joe has made tremendous gains in the functional use of his hand. Daily progress is slow, but steady. His gains are more discernible during monthly re-assessments when he realizes the remarkable progress he's made. Joe has full forearm rotation. His long extrinsic muscle function is strong, and he's experiencing numbness and tingling in his hand, a sign of nerve regeneration. He can sense hot and cold in his palm, and with his new hand, he's able to feed himself, drink from a cup, and help prepare meals. Perhaps most important, he can hold his fiancée, Carrie's, hand.

Joe's therapy is on-going. With hard work and commitment from Joe and his therapists, we're confident he'll achieve gains that will continue to enhance his quality of life.

It has been a privilege to work with Joe and be part of this amazing journey. We've learned so much as individual clinicians and as a department. We hope to contribute to the OT literature as we reflect back on what went well with this case and what we might do differently for future hand-transplantation candidates.

For more information about hand-transplantation or any of the services provided by the Occupational Therapy Department, call 617-726-2960.



Burchill, Kinan, and Kinan's fiancée, Carrie Pratt.

Commemorating the March on Washington with ‘virtual walk’

—by Deborah Washington, RN, director, PCS Diversity

This year marks the 50th anniversary of the 1963 civil rights March on Washington, DC. MGH will commemorate this historic event with a civil-rights event of its own in partnership with: Biogen Idec, AARP Massachusetts, the Old South Church, Krokidas & Bluestein, City Mission Society, Members of Leslie Saul & Associates, the Downtown Boston Rotary, the New England Regional Black Nurses Association, the MGH Institute of Health Professions, and Zion Church Ministries. The event will be a ‘virtual walk,’ scheduled for April 26, 2013.

Every year, the YWCA sponsors, *Stand Against Racism*, a program that strives to raise awareness about, and ultimately eliminate, racism. Patient Care Services

and the Emergency Department have joined with the YWCA to make *Stand Against Racism* an annual event at MGH. Says Robert Seger, executive director of the ED, “We’re committed to sending a message of inclusion to all patients, families, staff, and employees.”

Invitations were extended to leaders of other organizations. Says Ryn Miake-Lyn, one event organizer, “Just by wearing pedometers and T-shirts, we’ll be renewing the philosophy of inclusion and civility.”

Mike Festa, state director of AARP Massachusetts, observes, “The event is an opportunity to join others who care about these issues as we do.”

Says Ruth Purtilo of the Old South Church, “We’re inspired by our dedication to social justice to participate in this wonderful event.”

Jaclyn White, of Krokidas & Bluestein, says, “I wanted this to be a meaningful event and something everyone could enjoy.”

On April 26th, individuals from participating organizations will wear pedometers as they go about their daily business. At the end of the day, each participant will log on to a website (www.PeopleAreDifferent.net) and report his/her mileage. The hope is to record a combined total of 450 miles, symbolizing the distance from Boston to Washington, DC.

Dr. King once famously said, “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

For more information, call Deborah Washington, RN, at 4-7469.

Members of the ‘virtual walk’ organizing committee (l-r): Mike Festa, June Cooper, Jaclyn White, Ruth Purtilo, and below, representatives from MGH and Biogen Idec.



True nursing is understanding the needs of a fellow human being

My name is Jesse MacKinnon, and I am an oncology nurse. 'John' had an abusive father, an absent mother, and was diagnosed with pancreatic cancer at the age of 30. His cancer was complicated by a surgical scar that opened repeatedly and developed fistulas that leaked bile into his stomach. This caused severe pain and left John with many tubes throughout his chest and abdomen.

John was angry. He had developed a reputation of yelling, swearing, and threatening staff. On my first day with John, he lived up to his reputation, calling me every name in the book. But something about him was likable. I saw he had a dry sense of humor.

I knew I needed a way to establish trust so he'd feel comfortable enough to open up to me. John's primary concern was pain—he was receiving pain medication every two hours. His biggest fear was that his medication would be forgotten and he'd be left in unbearable pain. I made sure to bring John his pain medication every two hours, on the hour. This allowed him to feel more at ease. He even commented that I, 'cared about his pain as much as he did.'

Over the next few weeks, John did open up to me. He talked about restaurants, fishing, and his favorite things in the world—his two dogs. Other than his sister, his dogs were the only living creatures he trusted. Overall, John was a sensitive, kind, caring person, but his severe pain and loss of hope and independence had masked those qualities. John didn't need anti-depressants as some suggested, he needed a trustworthy friend, coach, and nurse. So that's what I set out to be.

During his months in the hospital I urged him to take walks, shower, and even be a little less harsh with staff. I walked with him, even after my shift ended, and I was always present when a doctor had to deliver bad news. I listened to him when he talked about his care, or when he just wanted to talk about a movie. We scheduled his two-hour dressing changes for days when I was working. During those dressing changes, I rarely did any nursing tasks; I was just in the room for support and to help ease the burden.

After a month and a half on our unit, John went home to be with his sister and his two dogs. Unfortunately, he returned after a few weeks, this time with a systemic infection that was ravaging his body. John was in severe pain, couldn't eat, and had no quality of life to speak of. He confided in me that he was ready to die. All he wanted was to be comfortable and no longer pursue treatment.



Jesse MacKinnon, RN, oncology staff nurse

But John wasn't dying of cancer, it was the infection. Many of his doctors didn't want to give up. There was great disagreement among the team; some passionately wanted to try to save him, while some compassionately wanted to let him go.

I reminded them that John no longer wanted treatment. I called a meeting so the team could hear it directly from John. I arranged for John to meet with a representative from the Office of Patient Advocacy. At a second meeting, with my support, John explained why he no longer wanted to live 'this life.' The team finally understood. Treatment was stopped, and John spent a comfortable final two days with his sister and his beloved dogs.

This was a turning point in my career. John made me realize that true nursing care isn't elaborate or complicated, it's simply understanding the needs of a fellow human being. It's about connecting with another person and trying to lessen their suffering. We all have times of anguish and pain. We all need someone to trust and rely on, to instill hope, and connect to on a basic human level. John showed me that true nursing care doesn't occur between nurse and patient, it occurs between people. John will remain in my heart as a constant reminder of why I became an oncology nurse.

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

Short and simple. But, oh, so powerful. Jesse saw beyond the anger and aggressive behavior to the vulnerable person who was his patient. He treated John with compassion and respect, and John responded in kind. Most important, Jesse's advocacy to end treatment allowed John to pass peacefully, on his own terms, and in the company of his family and his beloved dogs.

Thank-you, Jesse.

GI Nurses and Associates Day

—by June Guarente, RN, endoscopy clinical nurse specialist

Endoscopy clinical nurse specialist June Guarente, RN (left), and staff nurse, Janet King, RN, staff educational booth outside Eat Street Café.

March 27, 2013, was GI Nurses and Associates Day. Staff of the Endoscopy Unit celebrated with an educational booth outside Eat Street Café to promote awareness of GI nursing. Staff made posters highlighting the work that goes on in the Blake 4 Endoscopy Unit; the Charles River Endoscopy Unit; and the Pediatric Endoscopy Suite on Gray 4.



Most people associate endoscopy with colonoscopies, but a number of other procedures, diagnostic tests, and treatments are also performed on endoscopy units. They include:

- Esophagogastroduodenoscopy (EGD)
- Endoscopic retrograde cholangiopancreatography (ERCP)
- Endoscopic Ultrasound (EUS)
- Esophageal Ablation
- Cryotherapy
- Dilation
- Endoscopic Mucosal Resection (EMR)
- Percutaneous gastrostomy tube (PEG)
- Liver biopsy
- Fecal transplant
- Esophageal Motility
- Impedance
- pH probe
- Anorectal Manometry
- Smart Pill
- Capsule Endoscopy
- Bravo pH

Staff produced a video of a mock patient from the time of arrival at CRP for a colonoscopy through discharge. Since March was Colon Cancer Awareness Month, staff hoped to raise awareness and help promote colon-cancer screenings.

Several staff members participated in the project: Janet King RN; Michael Pandolfi; Maureen Donovan, RN; Evelyn Shakes, RN; Lisa Sobczak, RN; Alice Sickey; Serey Vorn; Kayon Elliott; Tiffany Torres; Ivonny Niles, RN; Janice Amihan, RN; Cece Polchlopeck, RN; Christopher Robbins, RN; Shavonda Barte; Jane Wardrobe; and June Guarente, RN.

Preventing patient falls

It's everyone's responsibility

—by Patti Shanteler RN, staff specialist, PCS Office of Quality & Safety

The phrase, It takes a village, is appropriate in describing the MGH approach to keeping patients safe from falls.

According to the Institute for Healthcare Improvement, patient falls are one of the most common adverse events reported in hospitals. The Joint Commission, concerned about the potential for harm to patients, added prevention of patient falls to its list of National Patient Safety Goals in 2005. Hospital fall rates are now reported publicly on websites such as www.medicare.gov/hospitalcompare and www.patientcarelinkma.org.

Preventing falls and eliminating injuries related to falls are high priorities at MGH. In 2010, LEAF

(Let's Eliminate All Falls), the MGH fall-prevention program, was developed to introduce an evidence-based approach to fall risk-assessment and intervention. In 2011, the LEAF program was launched on all inpatient units using a team approach to keep patients from falling.

The team

The phrase, It takes a village, is appropriate in describing the MGH approach to keeping patients safe from falls. All staff who come into contact with patients have a responsibility to keep them safe. One of the best strategies for minimizing the risk of patient falls is good communication (effective handovers) among team members. Some of those team members include:

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Staff nurse, Brenda Ross, RN (left) and unit service associate, Nejoua Elhirech, talk fall-prevention outside patient room.



Staff nurse, Stephanie Sarcione, RN (left), reviews fall-risk information with physical therapist, Kirstie Hinsman, PT.



Staff nurse, Sanja Miljevic, RN, reviews fall-precaution strategies with patient, Robert Isbart.

Fall-Prevention (continued)

The Fall Prevention Committee continuously strives to reduce patient falls through staff awareness and education, evaluation of equipment, and feedback about strategies clinicians can use to keep patients from falling.

Nurses

Beginning with a fall-risk assessment by nurses, patients are classified according to their potential risk while in the hospital. On inpatient units, the risk of falling is measured by The Morse Falls Scale®, a validated tool that utilizes six categories of risk. The LEAF program includes prevention and protection strategies based on these categories. Nurses use these indicators, in addition to the patient's clinical findings, to create an individualized plan of care. The plan is then communicated to the rest of the team and updated if changes occur.

Physical and occupational therapists

Physical and occupational therapists are critical members of the team when the need for strengthening, balance, assistive devices, safe ambulation, and/or transfer techniques are necessary for a safe plan. Minimizing the effects of de-conditioning that can result from hospitalization is an important part of minimizing the risk of falling. Working collaboratively with nurses and other members of the team, therapists can provide important safety strategies for patients and families.

Patient care associates

Assisting 'at-risk' patients to the bathroom, answering call lights, providing necessary care, and reinforcing the safety plan, patient care associates play a crucial role in minimizing the risk of falling. Patient care associates are instrumental in communicating concerns about changes in a patient's status to the care team or relaying information about adherence to safety teaching.

Unit service associates

Unit service associates are essential to maintaining a safe environment in and around the patient care area. Many falls are the result of items being moved by members of the care team or family members and not put back. Unit service associates can help scan the room while cleaning to make sure patient equipment and personal items have been returned to their proper places. They can also alert the clinical team if/when safety concerns arise.

Operations associates

Operations associates may be the first to respond to a request for help when answering a call from a patient's room. Communicating patients' requests for help to other members of the team in a timely manner is an important part of preventing patient falls.

The PCS Fall Prevention Committee

A dedicated group of clinicians from throughout Patient Care Services and Ambulatory Care participates on the PCS Fall Prevention Committee. Every month, the group assesses the effectiveness of the LEAF program, discusses case studies, and shares lessons learned from patient-fall scenarios. They review data related to patient falls, evaluate trends, and identify areas for potential improvement. The group continuously strives to reduce patient falls through staff awareness and education, evaluation of equipment, and feedback about strategies clinicians can use to keep patients from falling.

For more information about fall-prevention, call Patricia Shanteler, RN, staff specialist, PCS Office of Quality & Safety, at 617-726-2657.



Physical therapist, Katharine Kirsh, PT, helps patient, Gloria Calderone, ambulate safely.



Operations associate, Lourdes Charles, fields call from patient's room.



Members of the Patient Care Services Fall Prevention Committee

(Photo by Michelle Rose)

Seeking baby-friendly status

by providing exemplary infant care and optimizing a woman's ability to breast-feed

—by Saira Chaudary, administrative fellow

The Baby-Friendly Hospital Initiative (BFHI), created by the World Health Organization and the United Nations Children's Fund (UNICEF) in 1991, promotes and supports breast-feeding in healthcare facilities around the world. Hospitals earn baby-friendly

designation by providing exemplary infant care

and adhering to a ten-step program designed to optimize a woman's ability to breast-feed. Becoming recognized as a baby-friendly organization lets the public know we provide information and skills necessary for mothers to breast-feed in the hospital as well as at home. Information on how to safely give babies formula is provided to mothers who choose not to breast-feed.

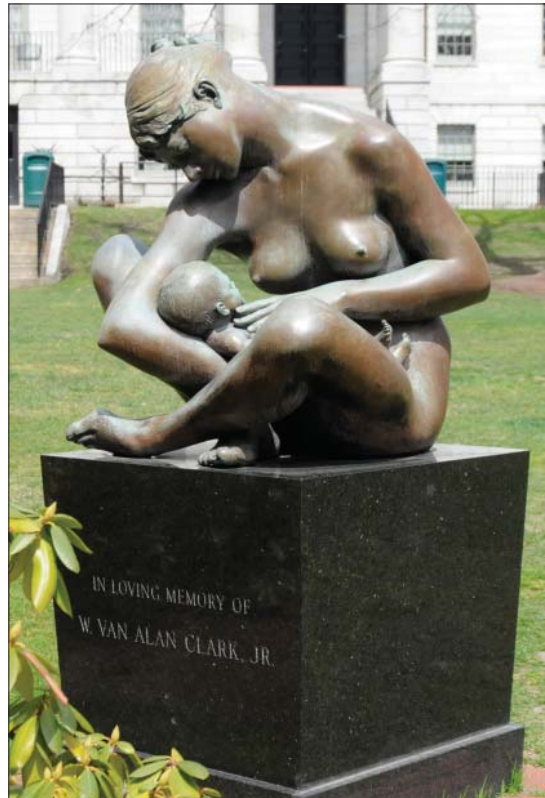
Studies show that the ten-step program helps in both the initiation and duration of breast-feeding—significant because the benefits of breast-feeding are numerous for both the mother and baby.

MGH Obstetrics has long encouraged mothers to breast-feed, but securing baby-friendly designation strengthens the practice and clearly identifies MGH as a hospital that provides complete obstetrical care of the highest quality.

To obtain the designation, MGH will embark on a four-stage process beginning with the submission of a registration form and ending with an on-site evaluation. The process typically takes two to three

years. To ensure our success, the Baby-Friendly Task Force has been created comprised of representatives from inpatient and outpatient Obstetrics and Pediatrics.

For more information about becoming a baby-friendly hospital, or if you'd like to join the Baby-Friendly Task Force, contact Lori Pugsley, RN, nursing director, at 617-724-6753, or Tracy Ramondi, breast milk specialist, at 617-724-4831. For more information about the Baby-Friendly Hospital Initiative, please visit the Baby-Friendly USA website at <http://www.baby-friendlyusa.org/>.



Hospitals earn baby-friendly designation by providing exemplary infant care and adhering to a ten-step program designed to optimize a woman's ability to breast-feed.

Window for Joint Commission lab survey is open

Question: What is a Joint Commission lab survey?

Jeanette: Laboratory services are required to be surveyed biennially. The survey will include patient tracers reviewing all steps of laboratory testing and processes for storing and issuing blood products and tissues. Surveyors will look at practice and documentation of ordering tests, collecting specimens, managing results, point-of-care testing, and tissue management.

Question: What will the scope of the survey be?

Jeanette: Surveyors will want to visit most patient care areas including inpatient units, Emergency, procedure areas, and ambulatory sites. They may ask to meet with nurses and observe specimen collections, transfusions, point-of-care tests, and documentation related to managing tissues.

Question: When will they arrive and how long will they stay?

Jeanette: The Joint Commission lab survey could occur any time between now and the end of August. Three surveyors will spend five days performing patient tracers in all areas of the hospital involved in laboratory service and tissue-management.

Question: What kind of questions can we expect?

Jeanette: Questions will vary based on the setting and the patient. Be prepared to describe your practice related to:

- administering blood to a patient
- verifying and completing orders for laboratory testing
- managing critical values
- ensuring proper patient identification and specimen collection
- monitoring glucose levels
- following infection control procedures

Question: Will the surveyors be escorted?

Jeanette: Representatives from Patient Care Services and the laboratory will accompany surveyors and try to ensure unit leadership is available to meet with them. It's not always possible to anticipate how and where visits will take place.

Question: What's the best way to ensure optimal care from laboratory services?

Jeanette: Laboratory services suggests:

- collecting the best possible specimens by:
 - using two patient identifiers and labeling specimens:
 - in the presence of the patient
 - on all specimen containers and requisitions
 - on all point-of-care devices and slides even if the test is performed at the bedside or in the exam room with the patient
 - following the order of draw. The order of draw information is located in the on-line laboratory handbook, under Phlebotomy information. <http://mghlabtest.partners.org/PhlebotomyInfo.htm>
- recording the collection date and time on the requisition
- following all hand-hygiene and infection-control procedures
- documenting all information associated with laboratory or point-of-care tests including the:
 - provider order in the patient record
 - specimen collection on the flow sheet
 - communication of critical values

This is an opportunity for MGH to showcase the excellent care provided every day at MGH. For more information about the Joint Commission lab survey, call Cynthia Mansfield at 617-726-8172, or Mary Ann Walsh, RN, at 617-724-8763.

Nurse Recognition Week

May 2–8, 2013

Thursday, May 2

Chief Nurse Address
presented by Jeanette Ives Erickson, RN, chief nurse

2:00–3:00pm, O’Keeffe Auditorium
and Haber Conference Room

Staff Nurse Reception and Military Cake-Cutting Ceremony
3:00–4:30pm, Trustees Room, Bulfinch 2

Friday, May 3

“Relationship-Based Care: a Pathway to Extraordinary Practice
and Compassionate Care,”
presented by: Mary Koloroutis, RN,
vice president and consultant, Creative Health Care Management

1:30pm–2:30pm, O’Keeffe Auditorium

Sunday, May 5

Staff Nurse Breakfast
7:00–9:00am
Trustees Room

Monday, May 6

“Creating a Culture of Innovation,”
presented by Karen Drenkard, RN,
executive director, American Nurses Credentialing Center

1:30–2:30pm, O’Keeffe Auditorium

Tuesday, May 7

“Nurses and Comprehensive Care: the Answer
to the Healthcare Crisis,”
presented by Mary O’Neil Munding,
Edward M. Kennedy professor of Health Policy and
dean emeritus, Columbia University School of Nursing

1:30–2:30pm, O’Keeffe Auditorium

Wednesday, May 8

Research Day

Posters on display throughout Nurse Recognition Week
O’Keeffe Auditorium Foyer

Interactive Nursing Research Poster Session

10:00am–12:00pm, O’Keeffe Auditorium Foyer

Yvonne L. Munn Nursing Research Lecture
and presentation of the 2013 Yvonne L. Munn Nursing
Research Awards

“Communicating Nursing’s Impact on Patient Outcomes through the
Use of Standardized Nursing Terminologies,”
presented by: Sue Moorhead, RN, associate professor of the PhD
Program; director for the Center for Nursing Classification & Clinical
Effectiveness, University of Iowa College of Nursing

1:30–3:00pm, O’Keeffe Auditorium

High Tea Reception immediately following
in the Trustees Room

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>.

Financial Assistance Seminar

Thursday, April 25, 2013
12:00–1:00pm
Thier Conference Room

Representatives from the Harvard University Employees Credit Union and the MGH Institute of Health Professions will discuss options to help finance your education.

For more information, call 4-3241.

Higher Education Fair

Thursday, May 23, 2013
12:00–3:00pm
Bulfinch Tent

Fair provides one-stop-shopping for exploring certificate, undergraduate, graduate, clinical, and non-clinical programs in nursing, research administration, inpatient coding, healthcare policy, and administration. Featured schools include: Boston University; Bunker Hill Community College; MGH Institute of Health Professions; Simmons College; and UMass, Boston.

For more information, call 4-3241.

ACLS Classes

Certification:
(Two-day program
Day one: lecture and review
Day two: stations and testing)

Day one:
June 14, 2013
10:30am–5:00pm
Potts Conference Room
Bigelow 8

Day two:
June 17th
8:00am–1:00pm
Thier Conference Room
Re-certification (one-day class):
May 8th
5:30–10:30pm
Founders 130 Conference Room

For information, contact Jeff Chambers at acls@partners.org

Classes are subject to change; check website for current dates and locations.

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

Clarification

Last month's cover of *Caring Headlines* depicted two practices we wish to clarify. For patients on Contact Precautions, the patient's chart should not be brought into the room. Green books should only be handled with clean, ungloved hands and not taken into Contact or Contact Precaution Plus rooms. In general, they should remain outside patients' rooms to keep the surface free from contamination.

Also, a reminder that when gowns and gloves are worn together, gloves should always be pulled up over the cuffs of the gown.

For more information, call Infection Control at 617-726-2036.

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.

Senior HealthWISE events

All events are free for seniors 60 and older

"Depression: When is it More than Just the Blues?"
Thursday, April 25, 2013
11:00am–12:00pm
Haber Conference Room
Speaker, Anthony Weiner, MD, director of MGH Outpatient Geriatric Psychiatry, will talk about how to identify signs and symptoms of depression.

Hypertension Screenings:
Monday, April 22nd
1:30–2:30pm
West End Library
151 Cambridge St.
Free blood pressure checks with wellness nurse, Diane Connor, RN.

For more information, call 4-6756.

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

Next Publication
May 2, 2013

MGH celebrates National LGBT Health Week

—by Jared Ruckman, clinical engineer, Biomedical Engineering and PR coordinator,
MGH LGBT Employee Resource Group

The MGH Lesbian, Gay, Bisexual, and Transgender (LGBT) Employee Resource Group (ERG) began the year with re-energized leadership and renewed participation within the MGH community. One of many activities planned for 2013, the group celebrated National LGBT Health Week with an informational table in the Main Corridor, March 27th.

The mission of the ERG is to help educate the MGH community about LGBT health issues and create an environment supportive of LGBT employees, patients, families, friends, and allies. National LGBT Health Week provided an opportunity to share information about resources available at MGH and showcase LGBT-related research at MGH and other facilities, such as the Ragon Institute and Fenway Institute. It was also an opportunity to demonstrate the welcoming and inclusive environment we strive to create throughout the hospital community.

The ERG continues to be involved with many educational initiatives geared toward raising awareness about healthcare issues specific to LGBT patients. The group is strengthening its relationship

with the BWH LGBT employee group, which was instrumental in making BWH a leader in healthcare equality.

For more information about the MGH LGBT Employee Resource Group, e-mail: LGBTmgh@partners.org, or go to: www.massgeneral.org/lgbt.



Members of the MGH Lesbian, Gay, Bisexual, and Transgender (LGBT) Employee Resource Group staff informational booth in the Main Corridor during National LGBT Health Week.



Returns only to:
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