

# Caring

Headlines

January 10, 2013



## New practice in Neonatal ICU

No central-line-associated blood-stream infections in 365 days

See story on page 7

Neonatal ICU staff nurse, Jeanne Gilbert, RN, connects IV tubing in accordance with the unit's new central-line policy. A key part of the policy is signage alerting staff and visitors not to enter while line-change is in progress.

# A princess, a prank, and a tragic breach of privacy

We go to great lengths to protect patients from falls, infections, pressure ulcers and the like; we must bring that same level of commitment and diligence to protecting their right to privacy.

Those of us who work in health care were especially distressed by the news of London nurse, Jacintha Saldanha's, death after being duped by a prank phone call. The call, made by two radio DJs seeking information about the Duchess of Cambridge's highly publicized pregnancy, resulted in details of her condition being broadcast over the air. Days later, the nurse who put the call through (apparently) took her own life. Like the rest of the world, we were saddened and appalled that this senseless hoax came to such a tragic end. Our thoughts and prayers go out to Saldanha's family, friends, and colleagues.

If we as a healthcare community are to take anything away from this situation, it is to make sure we understand the role we each play in protecting patients' privacy. We go to great lengths to protect patients from falls, infections, pressure ulcers and the like; we must bring that same level of commitment and diligence to protecting their right to privacy.

I don't mean to imply this is a simple undertaking—it *isn't*. In an age of instant messaging and electronic communication, protecting *any* information is a challenge. And with media outlets using any and all tactics to gain access to high-profile patients, it becomes even more difficult. That's why we employ such stringent strategies for encrypting computers, laptops, workstations, and personal devices (used to access Partners information). It's why we painstakingly draft, update, and share policies and procedures



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

related to patient privacy and protected health information. And it's why all employees need to know what to do should they find themselves on the receiving end of a fraudulent phone call.

According to our Limited Patient Access Policy and to ensure patients receive the level of protection most appropriate for their needs, the hospital offers three levels of restricted access available to every patient who comes through our doors. Patients can request that any of the following restriction levels be applied to their records at any time:

- **Clinical restriction** triggers a reminder in clinical systems (such as CAS, EDIS, etc.) that information is confidential and access to the record is being monitored
- **Partial restriction** triggers a response whereby:
  - the patient's name appears in the hospital census, but room and bed information are not displayed
  - staff may disclose to callers or visitors that the patient is in-house

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Jacintha Saldanha's tragic death reminds us that failing to protect patients' privacy can have dramatic consequences. Whenever you have questions, feel unsure, or suspect something's just not right, trust your instincts. Call Police & Security (617-726-2121), call Public Affairs (617-726-2206), or consult your manager or supervisor.

- unit nursing staff keep a list of approved visitors and work in cooperation with Police & Security to maintain the desired level of privacy
- *Full restriction* triggers a response whereby:
  - the patient's name does not appear in the hospital census
  - staff do not reveal to callers or visitors that the patient is in-house
  - deliveries for patient are refused
  - the patient is not contacted for demographic or insurance updates (unless self-pay)

Any employee who is contacted by the *media* to comment on a patient's condition should refer the call to the Office of Public Affairs. A representative from Public Affairs is on-call 24 hours a day through the page operator (617-726-2206). While Public Affairs is responsible for overseeing all media relations for the hospital, they rely on employees to notify them if/when they're contacted by the press.

If an employee should receive a call, and there is any question about the veracity or legitimacy of the caller, the employee should terminate the call in a civil and timely manner without disclosing any information. The best course of action is to take the caller's name and telephone number and let the caller know you'll inform the patient (or family) of their interest. This allows you to verify whether the caller is who he says he is and whether the call is welcome by the patient and/or family.

It's important to note that *no one* outside of a patient's family or approved circle of contacts has a right to that patient's health information. Don't be bullied or intimidated by callers claiming to be lawyers, police, FBI, or any other figure of authority. We're all gatekeepers when it comes to protecting patients' privacy.

The best defense against fraudulent inquiries is a strong relationship with patients and families. Staff should work with families to compile a list of acceptable visitors, callers, and contacts especially in cases where patients are on limited-access restrictions.

Jacintha Saldanha's tragic death reminds us that failing to protect patients' privacy can have dramatic consequences. Whenever you have questions, feel unsure, or suspect something's just not right, trust your instincts. Call Police & Security (617-726-2121), call Public Affairs (page operator: 617-726-2206), or consult your manager or supervisor. If you know that a high-profile patient or a patient requiring special security precautions is coming to your unit, be proactive—alert Police & Security ahead of time. Err on the side of caution.

MGH adheres to the requirements of HIPAA to ensure privacy of medical records and promote trust between patients and healthcare providers. For more information, call the MGH Privacy Office at 617-726-6360. Thank-you for all you do to keep patients safe.

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# The inaugural Connell Family Lecture Series

—by Dorothy Jones, RN, director, The Yvonne L. Munn Center for Nursing Research

**N**ovember 26, 2012, marked the inaugural lecture of the, “Impacting the Delivery of Care Today and in the Future” series, created to celebrate the William F. Connell family’s generous support in funding the Connell Nursing Research

Scholars Program and the Connell Ethics Fellowship.

Senior vice president for Patient Care, Jeanette Ives Erickson, RN, opened the celebration by recognizing Connell family members in attendance and reflecting on William Connell’s legacy and influence on staff at MGH. Ives Erickson expressed her gratitude to Mrs. Margot Connell and the family for their support of nursing research and their commitment to the delivery of ethical, humane care. A video was

shown highlighting the work of the research scholars and ethics fellows; each had an opportunity to discuss his/her program and provide insight as to how the work will impact care at MGH and beyond.

Gaurdia Banister, RN, executive director of The Institute for Patient Care, reflected on the importance of the Connell’s contributions, noting that the programs give nurses a voice with which to link nursing care to clinical outcomes; foster respect and advocacy; and assist patients and families in navigating the challenges of the healthcare system.

Keynote speaker, Sister Callista Roy, professor of Nursing at the Boston College William F. Connell School of Nursing, presented, “Innovators: Nurses Creating Excellent and Ethical Care. Now, is the time. Here, is the place.” Roy referred often to the importance of the Connell programs during this time of change and re-design in health care. She stressed

how the work of the Connell scholars and fellows directly aligns with the 2010 Future of Nursing Report from the Institute of Medicine, which stresses the need for nurses to advance their knowledge, promote care re-design through collaborative partnerships, and lead programs designed to foster optimal

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Below (l-r): speakers, Gaurdia Banister, RN, executive director, The Institute for Patient Care; Jeanette Ives Erickson, RN, senior vice president for Patient Care; and Sister Callista Roy, RN, professor of Nursing at the Boston College Connell School of Nursing.



(Photos by Paul Batista)

## Nursing Research (continued)

patient and family-centred care. Said Roy, “The time is right for a new vision and direction.”

Dorothy Jones, RN, director of The Yvonne L. Munn Center for Nursing Research and project advisor to the Connell Nursing Research Scholars Program, explained that the program offers nurse scholars the time and resources they need to seek external funding and design research to advance care at MGH and beyond. Jones introduced this year’s scholars: Susan Lee, RN, who will focus on care of the elderly and palliative care; Peggy Settle, RN, who plans to study nursing interventions that impact growth and development of premature newborns during the first month of life; Jeff Adams, RN, who will focus on the workforce environment and leadership; and Paul Arnstein, RN, whose research will address the management of chronic pain.

Ellen Robinson, RN, project advisor to the Connell Ethics Fellowship, described the pro-

gram as a means to provide space and mentorship to master’s or doctorally prepared nurses and allied health professionals. Ethics fellows integrate their learning into the clinical fabric of MGH as they engage in activities such as ethics consultations, ethics rounds, and the Harvard Ethics Consortium. Connell ethics fellow, Caitlin Merrill, RN, will be exploring the ‘best-interests’ standard as it applies to treatment decisions for neonates and young children with serious illness.

The event concluded with a panel discussion facilitated by Ives Erickson where scholars and fellows had an opportunity to respond to questions about their respective programs. Attendees left with a feeling of great anticipation at the prospect of what these programs can help achieve.

For more information about the Connell Nursing Research Scholars Program, call 3-0431. For information about the Connell Ethics Fellowship, call 4-1765.

Speakers, scholars, fellows, and members of nursing leadership come together for kick-off of the Connell Family Lecture Series, November 26, 2012, in O’Keeffe Auditorium.



# Connell Nursing Research Visiting Scholars

—by Diane L. Carroll, RN, Yvonne L. Munn nurse researcher

In recognition of the important contributions of nursing research, the Connell Nursing Research Program welcomed inaugural Connell visiting scholars, Patricia Stone, RN, on October 18, 2012, and Mary

Sullivan, RN, on November 15th. These visits marked the beginning of the Connell Nursing Research Program, which includes consultations, presentations, and discussions with Connell nursing research scholars, the doctoral forum, and nursing leaders over a two-day period.

Stone is director of the PhD Program, director of the Center for Health Policy, and centennial professor in Health Policy at Columbia University School of Nursing. Her research is geared toward understanding cost and quality outcomes. Stone's current interest is healthcare-associated infections. Her presentation, "Prevention of Healthcare-Associated Infections: a Program of Inter-Disciplinary Research Focusing on Comparative Effectiveness," was thought-provoking and illuminating.

Sullivan is professor and interim dean of the University of Rhode Island School of Nursing. Her inter-disciplinary research focuses on the biological, psychological, social, and environmental factors of the developmental trajectories of pre-term infants. She leads of the longest-running NIH follow-up study in the United States of premature infants in adulthood. Her presentation, "Health and Development of Pre-Term Infants from Birth to Young Adulthood," was illuminating.

The Connell Nursing Research Program was established in 2011 to advance inter-disciplinary patient- and family-centered care through collaborative practice and to support research to assist patients and families to cope with difficult decisions.

The current Connell nursing research scholars are Jeff Adams, RN, who's focusing on workforce, environment, and patient outcomes; Paul Arnstein, RN, who's focusing on pain management; Peggy Settle RN, who's focusing on growth in pre-term infants; and Susan Lee, RN, who's focusing on older adults and palliative care. These scholars met with Stone and Sullivan to discuss their research programs and generate ideas on how to advance inter-disciplinary health care.

For more information about the Connell Nursing Research Program, call 617-643-0431.



At right: Dorothy Jones, RN (left), with Connell visiting scholar, Mary Sullivan, RN. Below: Connell visiting scholar, Patricia Stone, RN (seated, right), with Connell nursing research scholars (standing): Peggy Settle, RN, and Jeffrey Adams, RN, and (seated): Susan Lee, RN, and Paul Arnstein, RN.



# Neonatal ICU and level II nurseries achieve patient-safety milestone

—by Janet Madden, RN, clinical nurse specialist

Central-line-associated blood-stream infections (CLABSIs) increase morbidity, mortality, length of stay, and costs for all patients, but in newborns, CLABSIs can also affect neuro-development. So preventing these infections among the newborn population is critically important as they can have life-long implications. On December 16, 2012, staff of the Newborn ICU and level II nurseries celebrated a significant milestone—no central-line-associated blood-stream infections for *one year*.

This accomplishment is the direct result of staff's commitment to best practices, a willingness to believe they

could effectively prevent central-line-associated blood-stream infections, and a complete revision of all aspects of central-line care. We reviewed the literature for evidence-based practices around CLABSI-prevention. This led us to standardize and carefully articulate processes for the set-up and revision of central-line tubing and dressing changes. And we implemented a closed system for accessing central lines during blood-sampling and medication-administration.

We realized that a complete overhaul of practice all at once would be too disruptive. As we considered individual changes, it quickly became clear that a 'tiered approach' would be the best option, introducing small changes every couple of weeks over a two-month period. A one-page description of new practices preceded each change, providing staff with a concise explanation of the changes to come and the rationale behind them.

Staff embraced both the didactic and hands-on education, constantly expressing their desire to, "get it right." Our clinical scholars, advanced clinicians, and resource nurses championed practice changes, making themselves available on all shifts. Night staff developed a signage system alerting people to keep from entering patients' rooms to ensure aseptic technique was observed. Staff truly took ownership of central-line care, skillfully integrating changes into their daily practice.

Most rewarding are the benefits to patients. We are keenly aware of the need to sustain this level of excellence. Toward that end, the daily central-line checklist has been revised to reflect current practice and promote compliance. And we're in the early stages of a multi-disciplinary project focusing on central line-removal. For more information on the efforts to prevent central-line-associated blood-stream infections in the NICU, contact Janet Madden, RN, at 4-4308.



Clinical nurse specialist, Janet Madden, RN (center front), and staff of the Blake 10 Neonatal ICU and level II nurseries celebrate big milestone—no central-line-associated blood-stream infections for one year!

# Swallowing concerns remedied by skill, experience, and a good old-fashioned tea party

'Mary' was a 90-year-old woman with a history of advanced dementia. She was admitted to MGH due to acute changes in her mental status accompanied by pneumonia.

**M**y name is Danuza (Danny) Nunn, and I am a speech-language pathologist. 'Mary' was a 90-year-old woman with a history of advanced dementia. She was admitted to MGH due to acute changes in her mental status accompanied by pneumonia. Speech-Language Pathology was consulted to evaluate her ability to swallow and her risk for aspiration (taking fluid into the lungs). She had been in the hospital for nearly a week, her stay complicated by her worsening mental status and concern about failure to thrive.

Mary had two devoted daughters who were by her side every day. They were very concerned they may have inadvertently done something to contribute to their mom's aspiration. They were eager to find out if they needed to change her diet or learn a new way to feed her. She had been prescribed pureed and honey-thick liquids but was either refusing to eat or was too somnolent to be fed. The daughters reported that at home she'd had a good appetite and loved to eat. Despite her advanced dementia prior to admission, she'd been able to feed herself. They hadn't noticed any coughing or choking, no recent vomiting, and no recent changes in her weight. They did note that she had become more somnolent and sounded congested, and hadn't eaten or drunk anything the day before being admitted. Mary had spiked a fever and was brought to MGH.



Danny Nunn, CCC-SLP  
speech-language pathologist

Mary's daughters reported that since being admitted, she wasn't 'behaving like herself,' appearing agitated and/or lethargic. Because of her refusal to eat and drink she was placed on IV fluids and IV antibiotics. The team had tried to place a nasogastric tube but Mary was too agitated to tolerate it.

Mary was fidgety. When her daughters left the room she would try to remove her IV (which she managed to do three times). She experienced increased agitation at night requiring sedation, which made her somnolent the next day, affecting her ability to participate in her care. She had been able to walk at home but hadn't been out of bed since being admitted.

My initial session with Mary was spent gathering information, trying to learn as much as I could about her likes, dislikes, and typical routine. We discussed how just being in the hospital can cause behavioral changes—being in an unfamiliar environment, having her routine disrupted, taking medications, and being exposed to unfamiliar people and situations.

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While I know part of Mary's improvement was due to antibiotics and the eventual resolution of her pneumonia, I felt honored to be involved in her care. I think sharing my personal and professional experience with dementia had an impact on Mary's outcome, and tapping into the pool of expertise and resources that MGH has to offer was key.

Mary's daughters were concerned that she was still refusing to eat or drink. I suggested we try offering her some familiar foods and let her try to eat on her own (instead of feeding her). The daughters were concerned because doctors had mentioned that their mom had aspirated. I still had hope that her pneumonia might be unrelated to aspiration. I reminded them that Mary had been independent with feeding, hadn't lost weight prior to admission, and hadn't had any prior pulmonary infections. She hadn't shown any typical signs of aspiration or feeding issues usually observed with dementia patients (like pocketing, decreased chewing, or forgetting to swallow).

I could see they were distraught and afraid Mary might decline further, or worse, that she might not be able to eat anymore. I reminded them I'd been consulted to make sure Mary was able to eat and drink safely and evaluate whether she was aspirating or not. I assured them I wouldn't do anything to harm or aggravate their mother. I felt the best way to proceed was to allow her to do what she did naturally.

I had learned that Mary loved cookies and tea. So instead of conducting a typical evaluation where I would observe Mary eating or drinking, I arranged a little 'tea party.' We set up a table beside her bed, complete with cookies and tea cups. I invited Mary's daughters to join in and partake of the snacks. Mary, who still hadn't eaten anything, hesitated briefly, but when she saw her daughters grab a cookie, she promptly reached for one, too.

The tension in the room evaporated as we all laughed. Mary ate the whole cookie with no difficulty, then asked for ice cream. Her daughters were shocked at the change in Mary's behavior. I reminded them that Mary had presented with no signs of deterioration of her feeding skills or aspiration. Just being hospitalized was a challenge for her.

I shared that both my grandmothers had suffered from dementia and their abilities had deteriorated when they were hospitalized. This has made me more attuned to the impact of care on patients with dementia. I explained that Mary's abilities would probably fluctuate during her hospitalization, and it would be important to try to normalize her routine as much as possible. Identifying factors that led to agitation would be helpful. I acknowledged how lucky Mary was to have daughters who were so devoted to her and how important they were in assisting us in caring for her.

I stressed the importance of minimizing things that might further disrupt her routine and/or agitate her. I advised them that our geriatric team and/or psychiatric CNS teams would be good resources in this area.

It was very rewarding to come in the next day and see everyone working together. The team had spoken with some of the resources and were given some very helpful suggestions. Nurses on the unit were key in implementing those suggestions. Mary's bed was moved closer to the window so she could tell whether it was day or night. They didn't check her vital signs at night so she could get a good night's sleep. Mary was assigned the same nurses and PCAs for consistency and to increase her familiarity with her caregivers. Staff posted a list of her favorite foods so they could be requested for her. She was allowed to wear some of her own clothes, and her daughters brought in a few things from home to make the room more familiar.

Mary's agitation was managed with de-escalation techniques such as looking at family pictures, playing cards, and listening to music.

She was upgraded to a regular diet with thin liquids, and she was able to eat uneventfully.

Mary was discharged a few days later when she was able to transition to oral antibiotics.

While I know part of Mary's improvement was due to antibiotics and the eventual resolution of her pneumonia, I felt honored to be involved in her care. I think sharing my personal and professional experience with dementia had an impact on Mary's outcome, and tapping into the pool of expertise and resources that MGH has to offer was key. They say it takes a village, and in this case, it certainly did.

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

As Danny well knows, hospitalization poses many risks for elders. But she didn't let fear or statistics cloud her judgment. Danny helped Mary's daughters and the team focus on the evidence—stable weight, lack of pulmonary infections, and disorientation due to unfamiliar surroundings. Danny restored 'normalcy' for Mary in the form of a tea party, and behold, Mary responded. We should all hope to have a speech-language pathologist with the same knowledge, skill, and expertise that Danny brought to this case.

Thank-you, Danny.

# Health Literacy Month and the Blum Visiting Scholar Program

—by Jessica Saad, health educator; Cara Hefner, RN; and Nancy Davis, RRT

In recognition  
of Health Literacy  
Month, The Maxwell  
& Eleanor Blum  
Patient & Family  
Learning Center,  
the Maxwell V. Blum  
Cancer Resource  
Room, and the PCS  
Patient Education  
Committee held  
the inaugural Blum  
Visiting Scholar  
Lecture with  
visiting scholar,  
Cindy Brach.

The Affordable Care Act defines health literacy as, “the degree to which individuals have the capacity to obtain, communicate, process, and understand basic health information and services needed to make appropriate health decisions.” Limited health literacy can be linked to poor disease-management, medication errors, otherwise avoidable hospitalizations, and poor health outcomes. Even those with advanced literacy skills can feel overwhelmed by the complexity of health information.

In October, in recognition of Health Literacy Month, The Maxwell & Eleanor Blum Patient & Family Learning Center, the Maxwell V. Blum Cancer Resource Room, and the PCS Patient Education Committee held the inaugural Blum Visiting Scholar Lecture with visiting scholar, Cindy Brach. Brach is a nationally recognized expert in health literacy and senior health policy researcher at the Agency for Healthcare Research and Quality (AHRQ).

As leading author of the IOM report, *Attributes of a Health Literate Organization*, Brach discussed ways to meet patient’s educational needs. She noted that according to the National Assessment of Adult Literacy, only 12% of patients feel proficient in health literacy. That means that to some degree, most people feel they lack the skills necessary to manage health and prevent disease.

Brach recommends that all hospitals become health literate organizations—making it easier for

people to navigate, understand, and use information and services. She describes health literate organizations as those that employ:

- organizational assessments
- universal precautions
- the teach-back/show-back method
- the re-engineered discharge

Also during Health Literacy Month, the Patient Education Committee staffed an educational booth in the Main Corridor, disseminating information about health literacy. Materials highlighted what patients can do to improve their own health literacy and what staff can do to ensure patients’ educational needs are met. A ‘Wheel of Fortune’ game was used to trigger questions and answers about health literacy.

The Maxwell & Eleanor Blum Patient and Family Learning Center and the Maxwell V. Blum Cancer Resource Room are committed to making MGH a health literate organization by working with staff and helping patients find reliable health information.

For more information about patient education or being a health literate organization:

- visit the Blum Center website at: [www.massgeneral.org/pflc](http://www.massgeneral.org/pflc)
- visit the Blum Cancer Resource Room website at: [www.massgeneral.org/Cancer/resourceroom.aspx](http://www.massgeneral.org/Cancer/resourceroom.aspx)
- access the Health Literacy Universal Precautions Toolkit at: <http://www.ahrq.gov/qual/literacy/>
- go to: [www.medlineplus.gov](http://www.medlineplus.gov)
- call 4-3823

The Blum Center is located off the Main Corridor in the White Building.

# Changing practice at the micro-system level

—by Barbara Blakeney, RN; Barbara Cashavelly, RN; Betty Ann Burns-Britton, RN; and Kristen Patrick, RN

Are attending nurses in the right place, organizationally, to lead process- and practice-improvement? That's the question Barbara Blakeney, RN, innovations specialist, set out to answer in her role as CMS innovation advisor. But how? Lunder 9 nursing director, Barbara Cashavelly, RN, and attending nurses, Betty Ann Burns-Britton, RN, and Kristen Patrick, RN, recognized a need to shorten the amount of time cancer patients spend waiting for chemotherapy to begin. And behold, a research project was born.

Graph shows a reduction in average wait time per week for chemo patients, exceeding Lunder 9's goal of 20% improvement.

Attending nurses spent two weeks tracking the process of preparing patients for chemo. The goal was to reduce the time from 'admit to chemo' by 20%. While the aver-

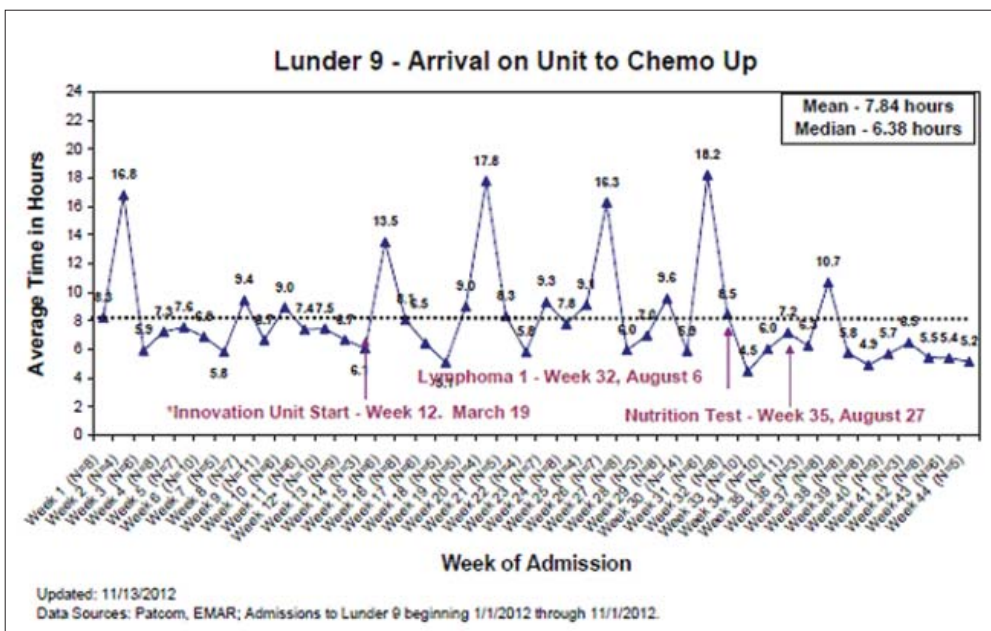
age wait time was 'long,' it was noted that some patients were able to initiate their treatments sooner than others. An in-depth review of these cases revealed some similarities: they all had blood results and medication orders in their charts; they all arrived prior to 2:30pm; they were all well hydrated; and they all had already had ports placed for medication administration.

Armed with this information, Patrick and Burns-Britton began to identify steps to reduce delays. They met with oncology ambulatory-care providers to brief them on the project, the findings, and proposed next steps. With assistance from ambulatory providers, patients began arriving with blood results and chemotherapy orders in their charts. Attending nurses began calling patients prior to appointments to reinforce

the need for hydration and punctuality. This helped establish a personal connection between patients and attending nurses—patients already had a relationship with Patrick and Burns-Britton by the time they arrived.

The Pharmacy was asked to 'split' chemo orders so that pre-chemo medications and hydration could be administered while patients waited for chemotherapy. And thanks to collaboration with the IV team, PICC-line placement time was also dramatically reduced.

This is a good-news story for the Lunder 9 Oncology Unit, and a great-news story for patients receiving their care there. Lunder 9 exceeded their goal of achieving a 20% reduction in waiting time. For more information, call 617-724-7468.



# Electronic resources for patient education

—by Julie McCarthy, RN, and Katie Russo, OTR/L, for the PCS Patient Education Committee

Log on to HealthStream for a new tutorial on how to locate patient-education resources.

**H**ealthStream is offering a new tutorial designed to assist staff in locating patient-education resources found in Partners Handbook and through the MGH intranet. The goal is to help staff become more proficient at navigating these tools to ensure patients have access to appropriate educational materials when they're needed. Staff can access Partners Handbook and other edu-

cational resources a number of ways. A variety of resources are available, including videos, television channels, and handouts, all of which make teaching and educational interactions more reliable and effective. Many of the materials are available in a number of languages.

To access the HealthStream tutorial on your computer, go to:

- Start Menu —> Partners Application —> Utilities —> HealthStream

The screenshot shows the 'Partners Handbook' website interface. On the left, there is a 'My Links' sidebar with various categories like 'Quick Links', 'Drug Information', and 'Medical Literature'. A red box highlights the 'Patient Education Info' link in this sidebar, with a red arrow pointing to the 'Patient Education Information' section on the right. This section contains a list of links such as 'Care Notes/Drug Notes (Micromedex)', 'AAFP Conditions A to Z (2011) (STATRef)', and 'BWH Health-e-Weight for Women'. A red box at the bottom left of the screenshot contains the text 'Select desired resource'.

- In HealthStream, click on Catalog and type: "MGH PCS Patient Education Committee Resource for Patient Education" into the search box
- For more information, call The Blum Patient & Family Learning Center, at 617-724-7352, or contact the Patient Education Committee via e-mail at: <http://www.mghpcs.org/ipc/Programs/Committees/Education.asp>.

# A reminder about the importance of patient confidentiality

It may seem as though VIPs receive preferential treatment, but the truth is, because of their notoriety, there's usually more interest in their cases. Which means we may have to work a little harder to protect their privacy. But all patients, regardless of who they are, are entitled to have their health information protected.

**Question:** I know it's important to protect the privacy of our patients. Do VIPs get preferential treatment when it comes to privacy?

**Jeanette:** It may seem as though VIPs receive preferential treatment, but the truth is, because of their notoriety, there's usually more interest in their cases. Which means we may have to work a little harder to protect their privacy. But all patients, regardless of who they are, are entitled to have their health information protected.

Three levels of access are available for *all* patients. Patients can request one of the following privacy restrictions be added to their record at any time:

- **Clinical restriction** triggers a reminder in clinical systems (such as CAS, EDIS, etc.) that information is confidential and access to the record is being monitored
- **Partial restriction** triggers a response whereby:
  - the patient's name appears in the hospital census, but room and bed information are not displayed
  - staff may disclose to callers or visitors that the patient is in-house
  - unit nursing staff keep a list of approved visitors and work in cooperation with Police & Security to maintain the desired level of privacy
- **Full restriction** triggers a response whereby:
  - the patient's name does not appear in the hospital census
  - staff do not reveal to callers or visitors that the patient is in-house
  - deliveries for patient are refused
  - the patient is not contacted for demographic or insurance updates (unless self-pay)

Patients who choose full restrictions may include: victims of domestic violence, celebrities or high-profile individuals, or employees. Patients who choose partial restrictions may include: prisoners, some high-profile individuals, or employees.

**Question:** How do I know what to do when a high-profile patient is admitted to my unit?

**Jeanette:** Resources are available 24/7 to all MGH employees. If you're unsure about what is expected, call Police & Security (6-2121); your nursing supervisor; or page the Public Affairs officer on-call. These people all have experience managing patients who need extra privacy or security. They can assist you in developing a plan specific to each patient.

It's a good idea to ask high-profile patients to choose a spokesperson to be responsible for providing updates rather than clinicians fielding inquiries from friends and family members, taking them away from clinical care.

If you do receive a call and you're unsure of whether the caller is legitimate, you can always say, "Please give me your phone number and I'll have someone call you back." This buys you time and the ability to verify the caller's identity.

Work together. Be cautious. Be smart. And never worry alone. If you have concerns, call someone.

For more information, contact the MGH Privacy Office at 617-726-2465, visit their website at: <http://intranet.massgeneral.org/hipaa/index.html>, or go to the Trove library at: <http://library.partners.org/MGH1/trove.asp?HU=EmptyURL>.

# Announcements

## Back-Up Childcare Center welcomes families

Located in the Warren Building, the Back-Up Childcare Center provides on-going back-up child care; holiday and school vacation programs; and summer care for children of MGH employees and patients, aged 9 months–12 years old.

The center is open from 6:30am–5:45pm daily, offering a stimulating, caring, play environment.

Drop-in visits are welcome, or go to the Back-Up Childcare Center website for information and registration materials: [www.partners.org/childcare](http://www.partners.org/childcare)

## ACLS Classes

Certification:

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

Day one:  
February 11, 2013  
8:00am–3:00pm  
O’Keefe Auditorium

Day two:  
February 25th  
8:00am–1:00pm  
Their Conference Room

Re-certification (one-day class):  
January 9th  
5:30–10:30pm  
Founders 130 Conference Room

For information, contact Jeff Chambers at [acls@partners.org](mailto: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](http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf).

## The Connell Ethics Fellowship

Two ethics fellowships available (20 hours/week for one year)

Nurses, social workers, chaplains, and allied health professionals with master’s degree or higher may apply.

Application Deadline:  
Thursday, January 31, 2013

Interviews scheduled by appointment, February–March

Fellowship begins  
Monday, June 3, 2013

Submit CV and goal statement by e-mail to [erobinson1@partners.org](mailto:erobinson1@partners.org), or hand deliver to Founders 341.

Applicants will be notified of their acceptance via e-mail in spring of 2013.

For more information, call 4-1765.

## 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](mailto:ssabia@partners.org). For more information, call 4-1746.

## Magnet Site Visit scheduled

MGH has learned that the Magnet appraisal team will conduct its re-designation site visit, March 4–7, 2013. Details will be shared as they become available.

Congratulations on earning the opportunity to showcase our inter-disciplinary patient- and family-centered care during this important external review.

For more information, or to stay abreast of all our Excellence Every Day activities and Magnet preparations, go to: [www.mghpcs.org/PCS/Magnet](http://www.mghpcs.org/PCS/Magnet)

## Senior HealthWISE events

All events are free for seniors 60 and older

Lecture series  
“Exercise for Healthy Aging”  
Thursday, January 17, 2013  
11:00am–12:00pm  
Haber Conference Room  
Speaker: Alison Squadrito, PT, physical therapy geriatric clinical specialist.

“The Latest in Cardiac Tests”  
Thursday, January 31st  
11:00am–12:00pm  
Haber Conference Room  
Speaker: Dorothy Sullivan, RN, nurse practitioner, MGH Heart Failure and Transplantation Unit.

Hypertension Screenings:  
Monday, January 28th  
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.

## 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>.

## Blum Center Events

Clear Conversations:  
“Take Control of Your Health Visit”

Friday, January 11, 2013  
12:00–1:00pm

Speaker: Jen Searl, health education project specialist

Healthy Living Series:  
“Holiday Weight Loss”  
Wednesday, January 16th  
12:00–1:00pm  
Speaker: Mike Bento, personal trainer, The Clubs at Charles River Park

Harp Music  
Wednesday, January 23rd  
12:00–12:30 and 12:40–1:00pm  
Harpist: Becky Wertz

Shared Decision-Making:  
“Low Back Pain”  
Wednesday, January 30th  
12:00–1:00pm  
Speakers: Steve Atlas, MD, and Thomas Cha, MD

Programs are free and open to MGH staff and patients.

All sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

# Raskin Feldman retires

**A**fter 35 years of distinguished service to MGH, professional development specialist, Roberta Raskin Feldman, RN, has retired. At a reception in her honor, December 21, 2012, scores of well-wishers (and one simulation mannequin) came together to give her a heartfelt send-off.

Gino Chisari, RN, director of the Knight Nursing Center, calculates that Raskin Feldman

taught more than 50,000 students in the course of her career as professional development specialist and clinical educator before that.

A graduate of the MGH School of Nursing, Raskin Feldman began her career as a staff nurse on the old Baker 8, served as a Basic Life Support instructor for 30 years, and participated on the Critical Care PCA Orientation Team. Her positive attitude, quick wit, and nurturing teaching style will be missed, but the MGH community wishes her well in the next chapter of her life.



At left: friends, colleagues, and husband (guess which one's the husband?) bid Roberta Raskin Feldman, RN, a fond farewell.

Below left: guest of honor gets hug from Brian French, RN, director of The Blum Patient & Family Learning Center; Below right: with Gino Chisari, RN, director of the Knight Nursing Center; and Gaurdia Banister, RN, executive director of The Institute for Patient Care.



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

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**Distribution**  
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**Submissions**  
All stories should be submitted to: [ssabia@partners.org](mailto:ssabia@partners.org)  
For more information, call: 617-724-1746

**Next Publication**  
January 23, 2013

# Inpatient HCAHPS Results

## 2010 through December, 2012

Measure	2010 (Top Box Result)	2011 (Top Box Result)	2012 YTD (Top Box Result through December 9, 2012)
Nurse Communication Composite	78.8	79.4	80.7
Doctor Communication Composite	80.4	81.9	81.6
Room Clean	71.4	69.8	72.8
Quiet at Night	45.9	45.2	48.2
Cleanliness/Quiet Composite	58.7	57.5	60.5
Staff Responsiveness Composite	63.1	63.6	64.7
Pain Management Composite	70.7	71.5	71.8
Communication About Meds Composite	62.0	62.7	64.3
Discharge Information Composite	89.8	89.8	91.3
Overall Rating	78.4	79.1	80.0
Likelihood to Recommend	89.3	89.4	90.5

The hospital's performance on patient-experience metrics remained strong in 2012. Our scores on six indicators improved in December and were on track to meet all targets set for the year.

Data complete through 10/31/12  
 All results reflect Top-Box (or 'Always' response) percentages  
 Pull date: 12/17/12



January 10, 2013

Returns only to:  
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