

Caring

Headlines

July 11, 2013

Ricardo Diaz Memorial Award



See story on
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Ricardo Diaz Award recipient, Halim Laanani (second from left), with (l-r): MGH president Peter Slavin, MD; director of PCS Clinical Support Services, George Reardon; and senior vice president for Administration, Jean Elrick, MD.

Emergency-management

*every disaster is an opportunity
to learn and improve*

Inherent in all disasters is one thing you can't plan for—unpredictability. Typically, there is little or no warning before a fire, flood, tsunami, earthquake, shooting, bombing, or any other catastrophic event that thrusts us into a state of emergency.

It's always advisable to prepare for disasters—contingency plans, drills, rehearsals—all increase our chances of surviving a disaster with minimal damage or loss of life. But inherent in all disasters is one thing you can't plan for—unpredictability. Typically, there is little or no warning before a fire, flood, tsunami, earthquake, shooting, bombing, or any other catastrophic event that thrusts us into a state of emergency. Add to that the fact that no two disasters are exactly the same, and you begin to get a sense of the challenges faced by those responsible for our local, state, federal, and MGH emergency-management plans.

The Marathon bombings are still fresh in our minds. No one expected that day to unfold the way that it did:

- At 2:50pm, two explosions went off near the finish line
- At 2:55pm, area hospitals were notified of the explosions
- At 3:03pm, Code Disaster was activated; the Trustees Room became the Emergency Operations Center for the hospital
- At 3:04pm, the first patient arrived at MGH

Talk about unpredictable. Less than 15 minutes after the first blast, we were treating casualties. That doesn't happen without planning, practice, and a highly coordinated, multi-disciplinary response.

When I asked our colleague, Maryfran Hughes, RN, nursing director in the ED, what went right that day, this is what she said.



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

“Police and Security secured the entrances to the ED. The Trauma Service responded immediately. Supervisors and unit staff mobilized to help decompress the ED. (95 patients were in ED when the incident occurred.) Individual nurse-physician teams were assigned to patients as they arrived. The OR quickly readied rooms; six patients were in surgery less than a half hour after arriving in the ED. Social workers and chaplains immediately began supporting patients and families. A support center was established where family members and loved ones could congregate, make calls, and support one another. Despite an unprecedented turn-out of people wanting to give blood, the Blood Bank remained available and responsive to the needs of patients arriving in the ED. Every discipline and ancillary service responded to support and expedite the work of those caring for the injured.”

By anyone's standards, our city's and our hospital's response to the Marathon bombings was exceptional. But if we truly want to maintain a state of meaning-

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As long as MGH employees continue to respond with care and compassion, skill and professionalism, teamwork and dedication, I have complete confidence that we're prepared to respond to any disaster with the same speed and efficiency we brought to the Marathon bombings.

ful readiness, we need to examine that response, ask what we can do better, and incorporate that into our emergency-management plan for the future.

Communication is a key area of focus in any emergency planning. It's been ten years since the Rhode Island nightclub tragedy, and communication has changed enormously in that time. Social media (Twitter, Facebook, blogs, etc.) has revolutionized the way information is shared, personally and in the media. People no longer have to wait for an official hospital announcement to learn about a patient's condition—that information is part of the blogosphere almost instantaneously.

The challenge is to ensure that accurate information is being disseminated both within and beyond the walls of the hospital, and at the same time that we are protecting the privacy of our patients. We've learned that timely, consistent messaging is essential. Our ability to share information effectively during a disaster requires vigilance and the utilization of all available modes of communication.

We know that in times of trouble, all employees want to help. The best thing staff can do is be *aware* of the emergency-management plans in their areas and work with managers and supervisors to assess the best way to support our colleagues providing direct patient care. Going to the ED or operating room on

your own only adds to a sense of confusion; know and abide by the emergency plan for your area.

Our participation in the Conference of Boston Teaching Hospitals Emergency Preparedness Coalition and numerous multi-disciplinary training exercises throughout the year continue to inform our planning efforts. We've developed collaborative relationships with city and state agencies as well as other Boston teaching hospitals, all of which played a major role in our ability to respond as efficiently as we did on Marathon Monday.

We've learned the importance of recognizing and addressing the impact disasters have on staff. Offering opportunities to de-brief, talk openly, come together to pray, or seek counsel from the Employee Assistance Program are all strategies we embrace.

As long as there are disasters, there will be reason to re-visit, revise, and update our emergency-management plans. But as long as MGH employees continue to respond with care and compassion, skill and professionalism, teamwork and dedication, I have complete confidence that we're prepared to respond to any disaster with the same speed and efficiency we brought to the Marathon bombings. Still, I hope it's a long, long time before we have to put that statement to the test.

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(Cover photo by Brian Wilson)

ESOL Graduation

a celebration of achievement

Photos on this page (l-r): senior vice president for Human Resources, Jeff Davis; director of the Employee Education and Leadership Department, Carlyene Prince-Erickson, with unit service associate, Maria Jimenez; keynote speaker, Hanna Kim Gaggin, MD; and president and CEO of JVS, Jerry Rubin.

It must have been a hundred degrees under the Bulfinch tent, but five minutes into the program, no one seemed to care. Such was the level of excitement, Friday, May 31, 2013, at the graduation ceremony of the MGH Workplace Education Program, also known as the English for Speakers of Other Languages (ESOL) Program. Nearly 140 students, all MGH employees in various departments throughout the hospital, all at different stages in their English education, were honored for their commitment and perseverance in achieving this important milestone in their professional journeys.

In his remarks, senior vice president for Human Resources, Jeff Davis, noted that 138 employees rep-

resenting 26 countries and 12 languages had participated in the program. One student, Liana Teixeira, unit service associate, had received the Anthony Kirvilaitis Jr. Partnership in Caring Award; seven students had received Partners in Excellence awards; six became United States citizens; and one passed the High School Equivalency Diploma Exam.

Jerry Rubin, president and CEO of JVS (co-sponsor of the program) called the event, “one of the most impressive graduation ceremonies in the city,” which is saying something considering Boston is home to some of the most impressive schools in the world. Rubin gave a special shout-out to Allen Guerrero, the first student of the ESOL College Prep Class to graduate from college.

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Education/Support (continued)

Keynote speaker and MGH physician, Hanna Kim Gaggin, MD, came to the United States from Korea as a young girl, so she was well versed in the challenges and obstacles faced by employees whose knowledge of English is limited. She shared her own journey and lessons learned, saying, “Life may not take you where you think it will. Be open to the adventure—even if it may look like a dead end or wrong turn, you may ultimately like where you end up. She spoke about the importance of working hard, asking questions, and taking whatever time it takes to master challenges. Gaggin acknowledged the people in her own life who had helped her along the way and how important they were to her success. She encouraged students to remember to give back and help others as it engenders confidence, self-esteem, and a desire to succeed.

A number of students read aloud stories they’d written in English, each one met with cheers of encouragement from family, friends, and co-workers. Lead instructor, Beth Butterfoss, along with Davis, Rubin, and director of Employee Education & Leadership Development, Carlyene Prince-Erickson, presented students from all classes with certificates of completion; many were recognized for perfect (or near-perfect) attendance.



Environmental Services; and Melinda Veress, manager, Nutrition & Food Services Training.

For more information about ESOL or Computer Learning Classes, or to enroll, please call 617-726-2388.

Clockwise from bottom left: Allen Guerrero, first student from the ESOL College Prep Class to graduate from college; unit service associate, Isabel Ramos, hugs director of Environmental Services, Bill Banchiere; patient care associate, Marie Cayo, reads her narrative aloud to the gathering; Prince-Erickson congratulates enthusiastic unit service associate, Francisco Pizarro.



(Photos by Brian Wilson)

Ricardo Diaz Memorial Award

Pride and smiles were the order of the day, June 10, 2013, under the Bulfinch tent, as the MGH community came together to celebrate Operations Support Staff Day and Halim Laanani, unit service associate on Ellison 16, the recipient of this year's Ricardo Diaz Memorial Award. In his remarks, MGH president, Peter Slavin, MD, praised the hospital's support staff, saying, "We have the finest, most dedicated employees in Boston, and that's what makes MGH the truly wonderful place it is." He cited just a few of the many contributions made by support staff, including:

- more than 49,000 inspections of medical devices by Biomedical Engineering last year
- approximately 6 million square feet of property maintained by Buildings and Grounds
- the scheduling of 21,500 conference rooms and special set-ups by Environmental Services
- the sorting of mail into more than 500 mailboxes for MGH and Partners affiliates by Mail Services

- the re-stocking of more than 100 areas a day with clean linens by Linen Services

The Diaz award commemorates the life of Ricardo Diaz, a loved and respected Buildings & Grounds employee who died in 2003 as he cleared snow from the sidewalks around MGH. The award recognizes employees who demonstrate the same qualities Diaz exemplified—dedication, hard work, and a strong commitment to the hospital and his co-workers.

In her remarks, Jean Elrick, MD, senior vice president for Administration, noted that 40 people had been nominated for the award. Said Elrick, "That's the most we've ever had. It's a testament to how wonderful our staff is and how hard you work to ensure a positive experience for our patients and families."

Said George Reardon, director, PCS Clinical Support Services, "It's my honor to present Halim Laanani with the Ricardo Diaz Award. As I understand it, Halim was working at the Holiday Inn a while back when some MGH employees took note of his outstanding customer service and encouraged him to apply for a position at MGH. We're extremely glad they did, as Halim is now an outstanding member of our own MGH team."

Reading from a letter of nomination submitted by operations manager, Jen Kambegian, and clinical nurse specialist, Jacqueline Collins, RN, Reardon said, "No matter what is asked of Halim, he responds willingly and with a positive attitude. He puts the needs of Ellison 16 and everyone on the unit first. He's self-directed, takes on many responsibilities, assists with special projects, and looks for creative solutions to challenges on the unit."

We can only assume that Ricardo Diaz would approve of this choice as those qualities truly exemplify the spirit of the Ricardo Diaz Memorial Award. From Patient Care Services and the entire MGH community, Congratulations, Halim.



(Photo by Brian Wilson)

Ricardo Diaz Memorial Award recipient, Halim Laanani (third from left) with MGH president, Peter Slavin, MD, and some of his Ellison 16 co-workers.

An unexpected journey

Liz Walker's message to MGH

—by Wendy Venti, MGH Senior HealthWISE

"I'm hopeful,"
said Walker. "I'm
hopeful despite
terrorism. I'm
hopeful despite
poverty. I'm
hopeful despite
the cruelty I see
in the world. If
we're not the
hope, who
will be?"

It was standing-room-only in O'Keefe Auditorium, Tuesday, June 11, 2013, as the MGH community gathered to hear award-winning television news anchor, ordained minister, and humanitarian, Liz Walker, present, "After the Marathon: Thoughts on Change," hosted by MGH Senior HealthWISE. Walker spoke vividly about her personal journey working with under-served populations in war-torn Sudan, but her underlying message was one of hope, and it resonated with all in attendance.

It began when Walker was assigned to cover a story in Sudan 12 years ago. What she saw changed her. She met people who had been living in a state of war for decades. Widespread violence was the norm. Said Walker, "We heard stories that were so far beyond our reality they didn't even make sense. This drama was unfolding in the world, and we knew nothing about it."

Walker said she experienced a shift—from seeing the world through the lens of a news reporter to wanting to do something on a personal level. That desire

soon took the form of organizing an effort to build a school for girls in Sudan.

She spoke about, "crossing that line in the sand to help others. It's about feeling connected to the larger drama going on in the world." She related her experience in Sudan to what we all experienced after the

Marathon bombings. "People stepped up. People stepped outside their comfort zone to help others. We saw the best of what people are capable of—like the clinicians and volunteers right here at Mass General Hospital."

Walker concluded her talk by reminding us that you don't have to wait for a disaster to help others. You don't have to go to Sudan. There are opportunities to serve every day. "We all have a calling. The important thing is to do *something* and to give it your all. I'm hopeful," said Walker in closing. "I'm hopeful despite terrorism. I'm hopeful despite poverty. I'm hopeful despite the cruelty I see in the world. If we're not the hope, who will be?"



(Photo by Brian Wilken)

Liz Walker, news anchor,
ordained minister, humanitarian

Knowledge, experience, and having the right information are key to OT care plan

My name is Jennifer McAtee, and I am an inpatient occupational therapist. I met 'Jimmy' for the first time two days after he was admitted for a left-side embolic stroke. He was 65 years old. After reviewing his chart, I learned he'd scored an eight out of 42 on his National Institutes of Stroke Scale (NIHSS). Though eight is low, it's not a reliable predictor of function post-stroke. His follow-up head imaging report showed a hemorrhagic conversion of his stroke, so I knew I could anticipate more prominent neurological impairment.

I made a list of impairments I could expect to encounter during my evaluation, including: impaired communication, apraxia (inability to perform purposeful movement), and right-sided motor and sensory impairments. I've learned that patients affected by left MCA (middle-cerebral artery) strokes can demonstrate variable levels of functioning that don't correspond with traditional neurological assessment. Experience has taught me to use activities-of-daily-living (ADL) tasks during my evaluation to highlight potential impairments and establish an appropriate intervention plan.

Left MCA strokes can affect the ability to comprehend verbal and written information and the ability to verbally express information. Patients with expressive language impairments often exhibit some impairment in receptive language, and I anticipated that might be the case with Jimmy.

Research suggests that in left MCA strokes, motor apraxia occurs bilaterally (on both sides), but typically more prominently on the right side of the body. Patients with ideational apraxia often reach for the wrong object, such as a comb to brush their teeth; or demonstrate clumsy motor patterns, such as being unable to rotate a hairbrush appropriately. These patients may appear to 'neglect' the af-



Jennifer McAtee, OTR/L, occupational therapist

ected side because it's too difficult to formulate or perform the movements required. So the patient simply doesn't use that side of his body.

I made a plan to engage Jimmy in three common tasks: combing his hair, putting on pants, and putting on socks. I chose these tasks because even if he exhibited receptive communication impairment, I'd be able to demonstrate what I was asking him to do.

As an occupational therapist, I rely heavily on information known as an 'occupational profile' to learn how an individual's prior roles, routines, and daily contexts are impacted by their illness or injury. There was very little documentation about Jimmy's social history or prior function. The only information I had was that he was right-hand dominant and lived with his niece. Jimmy's nurse reported that he was neglecting his right side. I was starting to build an understanding of who Jimmy was prior to his stroke and what kind of impairments he was exhibiting even before I entered his room.

When I met Jimmy, he was lying on his back against the bed rails on the right side of the bed. His sheets were tan-

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Clinical Narrative (continued)

gled in his legs, and the right sleeve of his hospital gown had fallen off his shoulder. He appeared somewhat guarded when I sat in the chair beside him but willing to engage with me. I wanted to ensure I had a basic understanding of any communication impairments he might have so that I could establish an effective mode of communication.

After introducing myself and my role, I asked Jimmy to perform some basic commands to ensure he understood me. I asked questions that could be answered by nodding, 'Yes' or 'No,' as research shows this to be an effective way to communicate with patients with impaired expressive communication. For non-Yes/No questions, I provided options, interpreted his gestures, and validated the information back to him. The fact that he was able to communicate beyond a simple Yes or No showed me that Jimmy was able to integrate all the things I was saying, and it also gave me a way to establish a rapport with him by allowing us to communicate with one another.

As I continued to ask questions about his life, he grew more relaxed; he smiled when communicating about his likes and interests, he made eye contact, even gestured for me to sit beside him. All these non-verbal signs affirmed that we had begun to establish a level of trust. I learned that Jimmy lived with his niece in a walk-up apartment and that she worked full-time. He had retired within the last year and liked to eat out. He drove when needed, but preferred to walk when he could. I soon learned that Jimmy was actually left-dominant for all tasks except handwriting. He conveyed that he had learned to write with his right hand in elementary school when a teacher made him sit on his left hand.

Knowing Jimmy's dominance was key in engaging him in activities of daily living. Occupational therapists use activity-analysis to break down functional tasks to accurately identify any neurological impairment. Learning that Jimmy was naturally left dominant changed the lens through which I would assess his performance. I could anticipate he'd perform right-handed tasks with more difficulty regardless of any motor impairment he may exhibit.

I felt I had the appropriate context to assess Jimmy's level of functioning. In observing him perform tasks such as dressing and hair-combing, I noted he acknowledged his right upper extremity consistently, but required intermittent cues to engage it. He appropriately chose a comb for the task, but once he was finished he kept the comb in his hand while reaching for the socks. His movements were clumsy and inaccurate, which frustrated him. He attempted to hold garments with ineffective grasps, and his right hand was notably worse than his left. Each time his dominant left upper extremity crossed the midline of his body, his motor performance and control of his arm deteriorated.

I combined these observations with the data I'd gathered during my evaluation that showed Jimmy had intact strength, coordination, and sensation. My analysis revealed two important findings. First, based upon my understanding of neuroanatomy, I knew it

would be very rare for him to demonstrate a right spatial or body neglect. And second, right spatial or body neglect doesn't exist in conjunction with functional communication impairments because those two neurological deficits are housed in opposite hemispheres of the brain. Since I knew Jimmy's stroke damage was limited to the left hemisphere, I felt confident that it wasn't right neglect he was exhibiting but motor apraxia.

After completing Jimmy's evaluation, it was clear he'd require further rehabilitation of his motor apraxia and communication impairments. Jimmy's prior level of independence, motivation to improve, and cognitive status told me he had an excellent chance at full recovery. I collaborated with his physical therapist and speech-language pathologist to ensure we were in agreement about his post-hospital rehabilitation needs. We agreed Jimmy should be discharged to an acute inpatient rehabilitation program. I gave his nurse some suggestions on how to assist Jimmy with daily self-care, including verbal reminders to use both hands during tasks and placing the spoon or fork in his left hand with a normal grasp at mealtime.

After identifying Jimmy's primary neurological impairments, I formulated a treatment plan with short-term goals focused on ADL tasks. I integrated verbal and tactile cues to facilitate motor planning of his upper extremities. Jimmy showed improvement in his motor planning and was able to feed himself independently with his dominant left hand by the end of our second treatment session. His progress not only confirmed the effectiveness of the treatment intervention, it facilitated a level of independence for Jimmy that he hadn't experienced since his stroke.

Gathering accurate information from Jimmy's occupational profile allowed me to employ an advanced evaluation process and accurately interpret the results. By integrating my knowledge of the information with my observations of his functional performance, I was able to tailor my evaluation method to incorporate the information he gave me about his left-hand dominance. This allowed me to create the most effective plan to facilitate his recovery.

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

Jennifer's narrative beautifully captures her assessment of the physiological changes caused by Jimmy's stroke and the impact those changes would have on his ability to function in his daily life. Jennifer identified potential limitations and predictors of recovery through stroke scores and exams then integrated those findings into her own evaluation using Jimmy's occupational profile. Jimmy recognized Jennifer as a partner on his road to recovery. The trust they established was key to Jennifer learning about his true dominance, which ultimately enabled her to craft a meaningful, effective plan of care for him. This is a wonderful example of the importance of 'knowing' your patient.

Thank-you, Jennifer.

Clinical Leadership Collaborative for Diversity in Nursing reaches milestone

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care

The Clinical Leadership Collaborative for Diversity in Nursing (CLCDN) recently reached a significant milestone, surpassing 100 recipients of its scholarship funding. You may recall the Institute of Medicine's 2004 report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, that noted, "Evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health-professions students, among many other benefits." And the recent IOM report, *The Future of Nursing*, supports increased diversity among students to create a workforce prepared to meet the demands of an increasingly diverse patient population.

Patient Care Services, in conjunction with several other Partners institutions; UMass, Boston; and the Boston College of Nursing and Health Sciences, joined forces to help minority nursing students make a smooth transition into clinical practice upon graduation.

The CLCDN supports socio-economically disadvantaged students as they progress through their undergraduate nursing programs. Recently accepted students who demonstrate academic excellence and exhibit a potential for success

in leadership positions are invited to participate. Components of the program include scholarship support, leadership development, NCLEX preparation, pairing with diverse mentors for coaching and problem-solving, and educational opportunities.

Beginning in 2011, the CLCDN expanded to include an advanced-practice component, offering graduate students working within the Partners network the same benefits offered in the undergraduate program. Partners HealthCare has invested nearly \$3 million in the program and is ready to support 84 new undergraduates, 34 new graduates, and a new administrative fellowship program. MGH currently employs 12 advanced-practice nurses who came through the CLCDN.

A number of studies are currently in place or being developed to evaluate the leadership-development, networking, educational, financial, transition-to-practice, and mentorship components of the program. Some findings have been published in the *Journal of Nursing Administration* and presented at various professional organizations and forums.

Special thanks to Jariza Rodriquez, at UMass, Boston, who is instrumental in communicating the progress of the CLCDN. For more information, call Gaurdia Banister, RN, at 617-724-1266.



Students, mentors, and advisory committee members commemorate first anniversary of the CLCDN initiative, dedicated to increasing the diversity of the nursing workforce throughout Partners HealthCare.

(Photo provided by staff)

Vaz first USA to receive Orren Carrere Fox Award

—by Mary Ellin Smith, RN, professional development manager

“She’s always happy to do anything that will help the family.” It was that sentiment that a colleague captured in her nomination of Belmira Vaz, unit service associate in the Newborn Intensive Care Unit (NICU), that led to her being selected the 2013 recipient of the Orren Carrere Fox Award. The award was created by Libby DeLana and Henry Fox to recognize the compassionate, holistic, family-centered care they received when their own son, Orren, was a patient in the NICU 16 years ago.

(L-r): Henry Fox; Orren Fox; Stephanie Cooper; award recipient, Belmira Vaz; Vaz’ sister; and Libby DeLana. Vaz’ mother is seated.

On June 20, 2013, surrounded by family, friends, and her NICU colleagues, Vaz became the first unit service associate to receive this cherished award since its inception. Peggy Settle, RN, nursing director, expressed her gratitude to the Fox family for their support of the award and thanked Vaz for her commitment to creating a safe and welcoming environment for families.

Presenting the award, Stephanie Cooper, associate director, PCS Support Services, recalled how Vaz had heard on the news about a product recall of a piece of equipment typically stocked in the NICU.

She immediately contacted her supervisor to alert him that the equipment needed to be removed. Said Cooper, “It’s that commitment to her patients that makes her such a deserving recipient of this award.”

Vaz expressed her gratitude and love to her family and colleagues. “They’re the best nurses I’ve ever worked with. I love them like my family.”

The Fox family expressed their thanks that even though years have passed, Orren is still strong and healthy. “We think of you and all you did for him, and we are truly grateful.”

For more information about the Orren Carrere Fox Award, call Mary Ellin Smith, RN, professional development manager, at 617-724-5801.



(Photo by Paul Batista)

Product Value-Analysis Committee

We've created a Product Value-Analysis Committee (PVAC) within Patient Care Services to ensure a coordinated approach to reviewing clinical products. This enables us to use a standardized process to guide product-evaluation and decision-making.

Question: Is there a new committee focusing on product-review?

Jeanette: Yes, we've created a Product Value-Analysis Committee (PVAC) within Patient Care Services to ensure a coordinated approach to reviewing clinical products. This enables us to use a standardized process to guide product-evaluation and decision-making.

Question: How does the committee impact existing structures and resources?

Jeanette: The Product Value-Analysis Committee is an adjunct to collaborative governance and the work of clinical nurse specialists in leveraging new product selection. Representatives from the PCS Policies, Products, & Procedures Committee are members of Product Value-Analysis Committee.

Question: Who else is on the committee?

Jeanette: The committee is co-led by George Reardon, director of PCS Clinical Support Services, and Theresa Gallivan, RN, associate chief nurse, with representation from Nursing, the health professions, Clinical Support Services, the Knight

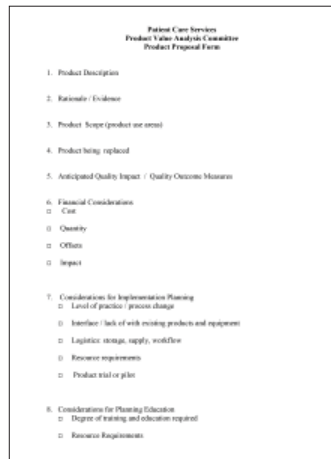
Nursing Center, MGH and Partners Materials Management, and MGH and Partners Finance. Ad-hoc members are consulted as needed, including individuals from Biomedical Engineering and Infection Control.

Question: How do you go about requesting a product review?

Jeanette: The Product Value-Analysis Committee is reachable by e-mail at: MGHPCSPVAC@partners.org. Once your e-mail is received, you'll be asked to complete a Product Proposal Form describing the product, the rationale or clinical evidence supporting its use, and the anticipated impact on quality and outcomes. You'll also be asked to share planning, implementation, education, and financial expectations. You may not have all this information at the time of your request; you may be writing to ask the committee for help with this kind of analysis.

Question: Whom can I contact for more information?

Jeanette: For more information, please contact Chris Annese, RN, staff specialist, at 6-3277.



E-cigarettes included in No-Smoking Policy

Question: What is an electronic cigarette?

Jeanette: Electronic cigarettes or e-cigarettes were invented in China and most are still manufactured there. E-cigarettes are obtained primarily at convenience stores, shopping-mall kiosks, or on-line. They were designed to simulate the appearance and sensory experience of a real cigarette.

Question: How does it work?

Jeanette: The cartridge contains liquid nicotine and propylene glycol (the ingredient used to create theatrical smoke) or glycerin. Inhaling activates a battery that vaporizes the liquid nicotine. It's then inhaled along with the propylene glycol, which looks like cigarette smoke when exhaled. Essentially, e-cigarettes allow users to inhale nicotine vapor without inhaling carbon monoxide or any other by-products created when real cigarettes are smoked.

Question: Can patients use e-cigarette while at MGH?

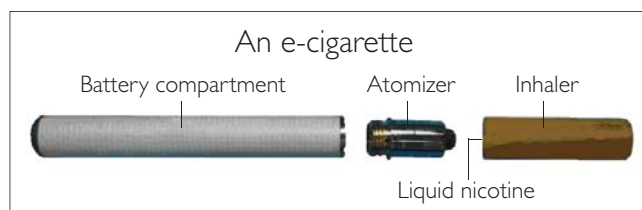
Jeanette: No. E-cigarettes are banned as part of the hospital's No-Smoking Policy. Just as cigarettes, chewing tobacco, and pipes are not permitted, e-cigarettes are not permitted, either. The policy applies to everyone: patients, visitors, employees, and vendors.

Question: Are e-cigarettes safe?

Jeanette: We don't know. Unlike nicotine-replacement products (patches, gum, lozenges, and nicotine inhalers) e-cigarettes have not been studied or approved by the FDA. The FDA considers them tobacco products and will be regulating them in that category. The chemicals used in the manufacture and vaporization process are unknown. It's likely that e-cigarettes are less harmful than cigarettes because they don't expose users to the same cancer-causing tar or carbon monoxide as tobacco smoke. But we know very little about the effects of regular exposure to e-cigarettes. They have been banned in a number of countries, including Australia, Brazil, Canada, Denmark, Norway, the Netherlands, Panama, and Singapore.

Question: Are e-cigarettes considered nicotine-replacement therapy products (NRTs)?

Jeanette: No. NRTs available at MGH include nicotine patches, nicotine gum, nicotine lozenges, and nicotine inhalers, all of which are approved by the FDA. E-cigarettes are not. Since e-cigarettes have not been tested in clinical trials, their safety and efficacy have not been determined.



Question: What can I say to patients who request e-cigarettes?

Jeanette: We should encourage patients to use FDA-approved, NRT products available at MGH, and use those requests as an opportunity to educate patients about the unknown effects of e-cigarette utilization.

For more information, call the MGH Tobacco Treatment Service at 617-726-7443.

Announcements

Hausman Program

Summer mentoring opportunity

Do you want to influence the youths of today in making important career choices? Do you want future MGH employees to be well-skilled, educated, and informed?

Please consider dedicating at least one hour a week in July to help mentor minority children of operations associates, patient care associates, and unit service associates.

Through the generous donation of the Hausman Foundation, a stipend will be offered to all participants.

For more information, contact Alicia Williams at: anhysman@partners.org.

Today's youth. Tomorrow's leaders.

ACLS Classes

Certification:

(Two-day program)

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

Day one:

September 9, 2013
8:00am–3:00pm
O'Keefe Auditorium

Day two:

September 23rd
8:00am–1:00pm
Their Conference Room

Re-certification (one-day class):

August 14th
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.

SAFER Fair

Join collaborative governance champions (representing the Diversity, Ethics in Clinical Practice, Fall Prevention, Informatics, Pain Management, Patient Education, Policy, Procedure and Products, Research and Evidence-Based Practice, Restraint Solutions, and Skin Care committees)

to see how they're working to make a SAFER environment for patients, families, and the entire MGH community.

September 24, 2013
11:00am–2:00pm

under the Bulfinch tent

Food, games, and prizes!

For more information, call Mary Ellin Smith, RN, at 4-5801.

Mind Body Spirit Nursing

on-line certificate programs

The MGH Institute of Health Professions is offering on-line Mind Body Spirit Nursing certificate programs:

- 9-credit certificate of completion in Mind Body Spirit Nursing
- 15-credit post-master's certificate of advanced study

Classes begin September 9, 2013. Full-time employees of Partners HealthCare may take one 3-credit course at half-price.

Vouchers may be used to cover the cost of tuition.

For more information, call 617- 643-6432, or visit: www.mghihp.edu/mbs.

New Global Health certificates from the IHP

The MGH Institute of Health Professions School of Nursing, in conjunction with Partners In Health, is offering two certificate programs in Global Health Nursing beginning in the fall. A 9-credit, on-line certificate of completion is available for nurses with a baccalaureate degree or higher; a 15-credit certificate of advanced study is available for master's-prepared students.

Flexible schedules available to accommodate working professionals.

For more information go to: www.mghihp.edu/globalhealth.

Master's in Health Professions Education

The IHP's Master of Science in Health Professions Education (MSHPEd) program is designed for expert clinicians who also teach. This unique program provides an opportunity to study educational best practices in an inter-professional setting. Participants attend two intensive, weekend seminars each year and complete the remainder of the course on-line, (full- and part-time options available).

Applications are reviewed on a rolling basis; next cohort starting in September. For more information or to apply, go to: <http://www.mghihp.edu/academics/center-for-interprofessional-studies-and-innovation>, and click on Academics. Full-time Partners employees receive a tuition discount; contact your Human Resources representative.

For more information, call 617-726-0968.

2nd annual Global Health Expo

presented by the MGH Center for Global Health

Wednesday, July 17, 2013
3:00–6:00pm
under the Bulfinch tent

The 2nd annual MGH Global Health Expo is an opportunity for the MGH community to learn more about the breadth of global health activities available for staff at all levels.

For more information, call Elizabeth 'Libby' Cunningham at 617-724-1215.

Senior HealthWISE events

All events are free for seniors 60 and older

Lecture Series

"Clear communication: how to get the most out of your health care visit"

Thursday, July 18, 2013
11:00am–12:00pm

Haber Conference Room
Speakers: Jen Searl and Jessica Saad, Blum Patient & Family Learning Center

"An Update on Parkinson's Disease"

Thursday, July 25th
11:00am–12:00pm

Haber Conference Room,
Speaker: Nutan Sharma, MD.

Hypertension Screenings:

Monday, July 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.

Garber named director, PCS Informatics

On June 9, 2013, Annabaker Garber, RN, became the new director of PCS Informatics. Garber had recently served as chief nursing officer for Informatics at the Swedish Medical Center, the largest non-profit health provider in Seattle, encompassing five campuses and more than 11,000 employees. In her role as chief nursing officer for Informatics, Garber supported clinical nursing practice through information technology and by aligning clinical standards, regulatory requirements, clinical education, and clinical-information technology. Her work around streamlining nursing care plans, admission screening, patient-education documentation, and progress notes earned national attention.

Garber's knowledge and experience fit perfectly with the work Patient Care Services is currently undertaking. Prior to her stint as chief nursing officer for Informatics, she served as administrative director of Clinical Transformation, where she focused on making care more efficient.

An experienced educator, Garber has also been the director of Education, Communications, and Support and education manager for Clinical Information Systems. She was responsible for on-site support and communication strategies during Swedish Medical Center's conversion to an integrated electronic medical record (similar to our Partners eCare initiative). She designed, implemented, and managed education on the system-wide implementation, including nursing and physician



Annabaker Garber, RN,
new director, PCS Informatics

documentation, CPOE and order sets, ADT and scheduling, imaging, laboratory, pharmacy, and surgical applications.

Says Garber, "I'm thrilled to be part of the MGH team. I'm excited to learn from my new colleagues here, and I look forward to contributing to the great work going on around Partners eCare and other clinical systems."

The MGH community thanks Sally Miller, RN, outgoing director of PCS Informatics for her many years of invaluable service during an era of unprecedented change, and welcomes Garber to her new role at MGH. Garber's office is located in the Professional Office Building (POB-420); she can be reached at 617-724-3561.

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Submissions

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

Next Publication

July 25, 2013

Inpatient HCAHPS Results

2012–June, 2013

| Measure | 2012 | 2013 YTD | Change (2012 - 2013 YTD) |
|------------------------------------|------|----------|--------------------------|
| Nurse Communication Composite | 81.0 | 80.7 | -0.3 |
| Doctor Communication Composite | 81.6 | 81.9 | +0.3 |
| Room Clean | 72.9 | 74.3 | +1.4 |
| Quiet at Night | 48.5 | 50.2 | +1.7 |
| Cleanliness/Quiet Composite | 60.7 | 62.3 | +1.6 |
| Staff Responsiveness Composite | 64.9 | 63.6 | -1.3 |
| Pain Management Composite | 71.9 | 71.0 | -0.9 |
| Communication About Meds Composite | 64.0 | 65.0 | +1.0 |
| Discharge Information Composite | 91.2 | 91.5 | +0.3 |
| Overall Rating | 80.1 | 80.2 | +0.1 |
| Likelihood to Recommend | 90.5 | 90.5 | Flat |

The hospital's performance on patient-experience metrics continues to improve.

Data complete through April 30, 2013
 All results reflect Top-Box (or 'Always' response) percentages
 Pull date: June 17, 2013



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