

# Caring

Headlines

November 21, 2013

## Innovation in Care Delivery Symposium

*Advancing a  
Professional Practice  
Environment*

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

Keynote speaker, Ed O'Neil, an expert in healthcare policy, leadership-development, and change-management, speaks about the socio-political factors prompting the need for innovation to make care more efficient and effective across the continuum.

# Innovation in Care Delivery Symposium

*sharing our work on Innovation Units  
with the world*

On October 28 and 29, 2013, Patient Care Services welcomed healthcare professionals from across the United States and (seven countries) around the world for a two-day, educational colloquium on innovations in care delivery.

**W**hen we began our innovation journey in 2011, we were driven by a social, economic, and moral imperative to make health care better. That meant making it more efficient, more affordable, and more accessible. It meant examining how we cared for patients and identifying opportunities to improve systems, improve practice, and improve the patient experience. We created testing grounds for change and called them Innovation Units. We closely evaluated our care-redesign efforts, learned from our mistakes, and implemented the interventions that showed the most promise. Today, we have 41 Innovation Units, all using some form of those interventions for the betterment of their respective patient populations.

Not surprisingly, word of our success spread. We began receiving inquiries about what we were doing, how we were doing it, and whether the interventions we introduced would be transferable to other hospitals. We decided the best way to share what we were learning was to bring these interested parties together and discuss our journey in a thoughtful and coordinated manner. And that's how the Innovation in Care Delivery Symposium was born.



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

On October 28 and 29, 2013, Patient Care Services welcomed healthcare professionals from across the United States and (seven countries) around the world for a two-day, educational colloquium on innovations in care delivery. Sponsored by the Institute for Patient Care, the symposium explored the transformational change we've experience from conception, to design, to implementation of our Innovation Units.

We were fortunate to have an incredible keynote speaker, Ed O'Neil, a specialist in healthcare policy and change-management, who spoke about the macroeconomics and socio-political factors affecting the healthcare environment. His presentation underscored the volatility of the current healthcare landscape and the dynamics that are driving our own efforts in care re-design. One thing he said really struck me: "To see the glass as half full, *all* nurses

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Not only was the Innovation in Care Delivery Symposium a great success, it validated our conviction that there is a way to make health care better. There is a way to make care more efficient, affordable, and accessible. We've unlocked the door to a new realm of innovative thinking, and others are as eager to exploit the possibilities as we are.

must see themselves as leaders.” I couldn’t agree more. Mr. O’Neil was extremely impressed with our work, saying time and again that we’re leading the industry with our pioneering work.

Nursing directors, Adele Keeley and Barbara Cashavelly, spoke about the shift to relationship-based care, highlighting the importance of staff-led change and centering care around the patient.

A panel discussion facilitated by nursing director, Lori Pugsley, focused on how Innovation-Unit interventions have enhanced teamwork and increased staff’s confidence in the continuity of care.

It was heartening to see every session resonate with attendees. From discussions about the patient journey, to building a just culture, leveraging technology, inter-disciplinary care, metrics, and the poster sessions—the excitement was palpable.

A highlight of the symposium was the session devoted to the attending nurse. There was great interest in this new role and the impact it’s having on patient care. Attending nurses, Michelle Anderson, RN (General Surgery); Sarah Ballard Molway, RN (Thoracic Surgery); Kelly Brown, RN (Orthopaedics); and Claire Paras, RN (Medical-Surgical), spoke eloquently about their experience practicing in this role and the pride they take at being able to influence the patient journey. They spoke about their increased ability to prevent gaps in care, to interface with pa-

tients throughout the care episode and follow up with post-discharge phone calls, and their own sense of excitement at ushering this new role into being. Several attendees expressed interest in working with us to see if the attending-nurse model can be replicated at their institutions.

I was acutely aware of a sense of anticipation, even hope, among attendees as they learned about our innovative work. And that sentiment permeated the feedback we received, with one nurse saying she was so excited to go back to her hospital and focus on ‘the patient journey’ as they implement care-delivery changes. Another saying it was the best conference she ever attended—every session gave her something important to think about.

Not only was the Innovation in Care Delivery Symposium a great success, it validated our conviction that there is a way to make health care better. There is a way to make care more efficient, affordable, and accessible. We’ve unlocked the door to a new realm of innovative thinking, and others are as eager to exploit the possibilities as we are.

I’m convinced that the work we’re doing on Innovation Units will alter the future of health care. We’ll continue to learn from this important work and talk about it with anyone and everyone who shares our commitment to making health care better for all.

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(Cover photo by Paul Smith)

# First annual Trauma-Informed Care Conference

—by Heather Comak

**H**undreds of clinicians and administrators from throughout Partners HealthCare came together last month for the first annual Trauma-Informed Care Conference, hosted by Brigham and Women's Hospital. Featured speakers included Boston City Councilor, Ayanna Pressley, and keynote speaker, Carole Warshaw, MD, director of the National Center on Domestic Violence.

Studies show that 63% of the population have had at least one traumatic childhood experience. The Trauma-Informed Care Conference offered at-

tendees an opportunity to learn more about the latest research on trauma and gave those who work in domestic-violence treatment and prevention a chance to network and share best practices.

"Today is about recognizing your work, coming together as a group across Partners, and taking it to the next level," said Matt Fishman, vice president for Partners Community Health. "Years ago, it was a challenge to find people doing this kind of work. Seeing you all here today, a room full of people who know how vital this care is, is a dream come true."

Warshaw spoke about what defines trauma, research into the effects of trauma, the importance of caregivers supporting one another, and advice on

how to help individuals work through trauma without letting it take over your own life.

Said Warshaw, "When dealing with trauma, we need to feel there's something we can do to change it. When we're connected to others who are also dealing with trauma, it keeps us going. Clinicians are affected by trauma, too. We share the fear and uncertainty when one of our patients goes back to a dangerous situation. How do we keep from burning out?"

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A packed house at the Bornstein Amphitheater for the first annual Trauma-Informed Care Conference



(Photos provided by Lightchaser Photography)

## Trauma Care (continued)

Warshaw shared some methods for treating patients that take into account the effect trauma can have on their health. Trauma theory attempts to normalize the human response to trauma. It shifts our conceptualization from, “What’s wrong with you?” to “What happened to you?” Trauma-informed organizations recognize the pervasiveness of trauma on survivors, on staff, and on organizations themselves.

Pressley, a leading advocate for women’s rights and trauma-prevention, talked about her own experience with sexual abuse. “This is not abstract rhetoric,” she said. “It’s rooted in painful personal experience. Stable families equal healthy communities. That’s not a political position; it’s a moral imperative.”

Pressley outlined key methods for combating trauma in the community:

- Investing in social-emotional learning. If kids aren’t ready to learn, there’s no point. We need wrap-around education in schools to help prepare children

- Empowering girls and women, especially survivors of sexual assault and/or violence
- Helping communities understand that domestic and sexual violence and the health of our community are inextricably linked

A panel discussion featured clinical leaders from various Partners hospitals. Robin Cunningham, RN, from Newton-Wellesley Hospital, Wendy Macias Konstantopoulos, MD, from MGH, and Erica Veguilla, MD, from Brigham and Women’s Faulkner Hospital, shared how they’ve used trauma-informed care in their practice.

Posters created by researchers throughout Partners reflected the findings of a number of domestic-violence studies and activities.

MGH, Brigham and Women’s Hospital, Brigham and Women’s Faulkner Hospital, Newton-Wellesley Hospital, Neighborhood Health Plan, North Shore Medical Center, Partners Community Health, and Partners Employee Assistance Program were among the Partners entities that participated in the conference.

HAVEN at MGH participated in the planning of this event. Links to posters, slides, and videos will soon be available at [www.havenatmggh.org](http://www.havenatmggh.org). For more information contact social worker, Elizabeth Speakman, LICSW, at 617-726-7674.

Clockwise from left: Carole Warshaw, MD, presents; Boston City Councilor; Ayanna Pressley, speaks to the assembly; social workers, Mary Susan Convery, LICSW (left), and Jennifer D’Alotto, LICSW, view posters.



# October was National Physical Therapy Month

My first experience with PT started more than a year ago when I experienced a 'frozen' shoulder. The worst part was the pain. I listened to my physician ("Let's wait and see"), took some meds, and tried to wait it out.

A

lex Johnson, vice president for Academic Affairs and provost at the MGH Institute for Health Professions as well as a speech-language pathologist, posted the following narrative chronicling his experience with physical therapy as part of his blog ([www.provostmghihp.blogspot.com](http://www.provostmghihp.blogspot.com)).

*It's National Physical Therapy Month, and I'd like to take this opportunity to give a public thank-you to physical therapists everywhere. I've worked with some PTs for most of my clinical and academic life, but over the past year I was the recipient of some world-class physical therapy. I was and continue to be, 'the patient.' I've experienced the continuum of care in a highly individualized and focused manner. I'd like to take this opportunity to share a bit of what I've learned about PT and why I'm so grateful.*

*My first experience with PT started more than a year ago when I experienced a 'frozen' shoulder. The worst part was the pain. I listened to my physician ("Let's wait and see"), took some meds, and tried to wait it out. It improved enough to function but hurt all the time. When I finally got around to seeing physical therapist, Jon Hagan, at the MGH Charlestown Community Center, I was amazed. Boom! — a few sessions — no more pain, increased range of motion, and a few follow-up visits to make sure all was on track. I was so grateful for the relief and the rehab. I hope Jon knows how much I appreciate him and the great care he gave me. His talent and encouragement were remarkable*

*The lessons I learned from Jon were the preface for a story that's still unfolding. Last February, I had neurosurgery at MGH for an acoustic neuroma. I knew be-*



Alex Johnson, vice president for Academic Affairs and provost at the MGH Institute for Health Professions, speech-language pathologist, and blogger

*forehand that I'd be deaf in my left ear and 'might' experience other problems. Unfortunately, due to the size of the tumor, complications did include a number of those 'mights.' Among them: double vision, balance problems, facial weakness, and some speech and swallowing issues. My benign tumor had hit the sweet spot where all those nerves come together. The trifecta for a speech-language pathologist, wouldn't you say?*

*The first post-surgery chapter of PT was the part where you say to yourself, "Dude, you're in the Neuro ICU at MGH and you can't get out of bed!"*

*Physical therapists, Lauren O'Donoghue and Kristen Parlman, came to my rescue. They were amazingly skilled. They knew how to get me up (gently at first), help me into the chair, start me walking around the unit even though I was attached to all kinds of bells and*

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## Physical Therapy (continued)

whistles. They educated me and the staff about what I needed to do. Their knowledge of my condition, the environment, and the connection between my health and what I needed to accomplish in order to get home was amazing. These skills may be basic and routine for physical therapists in the acute-care setting, but they're far from routine for the patient. These neuro-PT experts helped me every day, pointed out little (and I mean tiny) steps, all with the goal of discharging me safely from the ICU and then the hospital. They reassured me every 'step' of the way.

One of the most impressive things was the way the PT team communicated with each other as I progressed. They kept each other aware of all the details and didn't keep asking me the same questions every time I saw them.

To all the physical therapists at MGH, especially my therapists in the Neuroscience Unit, thanks for helping me get home safely and with a bit of confidence. You're all stars in my book.

Chapter II takes place at home. About a week before my operation, I was contacted by two of our faculty members, both neurology PT specialists (Janet Callahan, PT, and Anne McCarthy Jacobson PT). They volunteered to check in on me after discharge to see if there was anything I needed. I was grateful for the attention, but assumed that after surgery I'd need to rest; why would I need PT? The first thing I said to my wife on the way home from the hospital was, "Can you see when Janet or Anne can come over?"

Janet spent several hours with me over the next few weeks. In terms of symptom-management for double vision and balance, she's a pro. In terms of kindness, humor, clinical skill, encouragement, and generosity, she is gifted. My progress was swift. Within ten days, I was starting to take walks outside. My gratitude to Janet is immeasurable. While some of the exercises seemed more tailored to the flying Wallendas, I learned so much about the neurological system, balance, and physical therapy. I'm still using what Janet taught me.

P.S. The day my double vision cleared was one of life's best rewards.

Chapter III: I mentioned my facial weakness (similar to Bell's Palsy). There was limited movement on the left side of my mug. My surgeons recommended I wait about six months before starting therapy on my facial muscles. That was a long six months. In July, I made an appointment to see Mara Robinson, PT, at Mass Eye and Ear Infirmary (MEEI). Mara is a facial PT specialist who sees patients in the Facial Nerve Department at MEEI. She is a star. Her knowledge of the facial musculature is beyond belief. She gave me some facial exercises. Doing these exercises in the mirror is somewhat comical, yet highly logical.

Sometimes when I'm doing them, I feel like a contortionist. However, within a few weeks, I saw improvement. Do you know what it feels like to lose a smile, then get it back? Do you know what it feels like to finally feel comfortable again when you go out or meet strangers? Do you know how good it is to hear family and friends say, "You look so much better!"

For all this and so much more, thank you, Mara.

And thanks to PT!

## MGH Physical Therapy Services

MGH physical therapists provide patient care; participate in community outreach, education, research, and wellness initiatives. During the month of October,

National Physical Therapy Month, MGH physical therapists provided a number of educational activities. They presented, "Meet your Neighbors," at MGH West, "Back-Pack Safety" and exercise information at the Revere Healthcare Center; and posture information and screenings on the main campus. Staff celebrated PT Month with a special presentation by Earnest Nalette, associate professor of Physical Therapy at Ithaca College, entitled, "Compassion in Physical Therapy: Coloring Outside the Lines."

MGH physical therapists:

- provide care on all inpatient units, including the Emergency Department and observation units
- provide outpatient services on the main campus and healthcare centers in Revere, Chelsea, Charlestown, and MGH West in Waltham
- boast 47 board-certified staff members in the specialties of: Orthopaedics, Neurology, Vestibular, Cardiovascular and Pulmonary, Pediatrics, Geriatrics, Hands, Sports, and Women's Health
- see patients of all ages, from newborn to geriatric

For more information about services provided by

MGH physical therapists, visit their website at:

[www.mghphysicaltherapy.org](http://www.mghphysicaltherapy.org),

or call 617-726-2961.

# Complex patient spurs multi-faceted, holistic approach for Revere therapist

**M**y name is Alissa Evangelista, and I've had the pleasure of working as a physical therapist in the MGH Revere Health Center for the past six years. Through educational opportunities and my practice, I've become more adept at evaluating and treating complex medical conditions and managing the socio-economic needs of my clients. I've learned to treat each patient as a 'whole person,' using connections within the community and the healthcare center to provide the best possible care.



Alissa Evangelista, PT, physical therapist

'Anna' presented with complaints of acute exacerbation of her chronic lower-back pain. Like many patients, Anna had numerous medical and social concerns, as well.

One patient, 'Anna,' is an 88-year-old woman I've treated through two episodes of care for orthopedic conditions. I've worked with Anna's son and granddaughter, as well as her late husband. Anna presented with complaints of acute exacerbation of chronic lower-back pain. Like many patients, Anna had numerous other medical and social concerns, as well.

Anna's husband had passed away suddenly a few months before. They'd been married more than 60 years, and she had been devoted to him. Anna had a history of vertigo, bilateral hearing loss, low blood pressure, vertebral artery aneurysm, and extensive, degenerative joint disease.

During my initial evaluation, Anna reported a high level of pain (10 out of 10) and disability. She said she was primarily limited in her ability to ambulate or stand for any length of time, which kept her from baking (her favorite hobby). She perceived the pain as caused by her spine and found it devastating and disabling. I delved into the social and emotional changes she'd gone through since the death of her husband. She revealed that she hadn't been leaving the house much. Prior to her husband's passing, she'd attended exercise classes at a senior

center, but due to transportation issues and sadness, she hadn't been able to go back there. Anna shared that her daughter would be retiring soon and she'd be able to spend more time with her and take her out into the community once that happened.

Due to her reported pain, I had to rule out any pathological causes. Anna is an older, thin, Caucasian woman with a history of osteoporosis, so I was concerned it could be a vertebral stress fracture. But her physician had ordered imaging, which revealed no fracture. It did reveal a severely degenerated lumbar and thoracic spine with marked curvature causing scoliosis. Due to the amount of degeneration, my assessment veered away from stress fracture; Anna's complaints were more consistent with arthritic symptoms. Because Anna's pain was mechanical versus pain that doesn't change with motion or re-positioning, I felt confident her degenerative changes were the primary cause of her dysfunction.

I was also concerned about Anna's balance, so I performed some tests to determine if she was at risk for falling. Anna had lost considerable strength in her legs and trunk muscles. She had multiple areas of bilateral, lower-extremity, muscle shortening and

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During Anna's final visits, she reported one or two days of increased pain, but she was much more adept at employing strategies to control it. She realized that if she addressed her pain early and modified her body mechanics, she could prevent high levels of pain for an extended period of time.

hypo-mobility throughout her lumbar spine. Testing showed a loss of protective reflexes and balance while walking or ambulating on uneven surfaces. Her sensory testing was normal. During Anna's history and evaluation, it became clear that her pain had a strong emotional component. She had become depressed as well as deconditioned.

I knew from working with Anna before that when educated on causes and treatment of injuries, she reported lower levels of pain and disability. I had to not only verbally explain my findings but use visual tactics and meaningful examples. I showed Anna the images of her spine compared to images of a normal, healthy spine. I used a model to demonstrate how compression from advanced arthritis can cause lower-extremity symptoms and pain.

We discussed realistic, outcome-based goals. I paid special attention to the activities Anna felt caused her pain and disability, including baking, walking, and housecleaning. I instructed Anna that she'd need to change her body mechanics to protect her lumbar spine and that because of her arthritic changes, the long-term outcome would not be 100% resolution. She'd need to take a proactive role in managing her arthritis to prevent flair-ups.

Anna had felt isolated since the death of her husband. Realizing that socialization and outside activities were important, I discussed ways to re-integrate her into the community. I'm active in the Senior Wellness Group at the Health Center, and I felt the program would be an excellent fit for Anna since it encompasses social, medical, and general well-being initiatives. Anna thought it was a great idea and looked forward to working out with people her age.

During subsequent visits with Anna, I used manual therapy to address her pain, and I addressed her balance issues with manual and visual feedback. I gave Anna a home exercise program, which we practiced together to make sure she was doing it correctly.

After three follow-up visits, Anna continued to complain of low-back pain at a 10/10 level. She would experience temporary improvement after manual therapy for about 48 hours. I realized she'd need more manual therapy, strength, and endurance training to see real gains in her pain and function. Anna, however, was upset that she didn't feel better. We decided to explore other options for pain-control until Anna was stronger and more flexible.

I spoke with Anna and her daughter about the use of heating pads and Lidoderm patches. We discussed when and how long to apply them and how to prevent skin irritation. I suggested bracing her spine during extended periods of standing and housework. We tried a standard

lumbar support, but Anna didn't have the upper-body strength to put it on and take it off. After a little brain-storming, we decided to try a girdle she had at home. Anna had used the girdle to help manage her pain before. I cautioned her that the girdle was only a temporary method, and she shouldn't become dependent on it.

Anna soon began to report a significant and lasting decrease in her level of pain. By now, Anna's daughter had retired and was able to spend more time with her. We developed a plan to promote endurance and combat feelings of social isolation by walking in the mall and visiting her friends. Anna also started to participate in Tai Chi and Yoga classes at the Health Center. Since Anna's pain was better controlled, I switched my focus from manual therapy and pain-management to strength and endurance training and balance re-training.

During Anna's final visits, she reported one or two days of increased pain, but she was much more adept at employing strategies to control it. She realized that if she addressed her pain early and modified her body mechanics, she could prevent high levels of pain for an extended period of time. Anna ended her physical therapy treatment with a good plan for long-term pain-management and an exercise program that promoted maintenance of her strength and function.

During my continuing education as a physical therapist, I've learned that the best outcomes are achieved when we work together with patients and families as a team. Using resources available in the community and throughout MGH, I'm able to promote health and wellness for patients like Anna during their episodes of care and for their long-term well-being.

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

It's significant that Alissa showed equal concern for Anna's physical and emotional well-being. Both had a bearing on her recovery. Alissa was candid with Anna about the long-term effects of arthritis, but at the same time, educated and empowered her to take control of her pain-management through exercise, socialization, and medication. Alissa used a multi-faceted approach to meet Anna's physical, emotional, and psycho-social needs and help facilitate her re-entry into the community.

Thank-you, Alissa.

# Stop the Clot<sup>®</sup>

*Creating new avenues to inform patients and families about blood-clot prevention*

—by Lynn B. Oertel, RN, and Diane DeTour, RN

“**B**e your own advocate.”  
“Ask questions.”  
“Know your risk factors.”  
These were some of the messages conveyed to the nearly 80 attendees of the annual Stop The Clot Forum<sup>®</sup>, held Saturday, October 19, 2013, in O’Keeffe Auditorium.

Stop The Clot Forum<sup>®</sup> is an educational event sponsored by the MGH Anticoagulation Management Service (AMS) and the National Blood Clot Alliance (NBCA).

Nationally recognized experts spoke about blood clots, clotting disorders, and how to treat and prevent them. They stressed the importance of being knowledgeable, advocating for yourself, and asking questions. Jack Ansell, MD, past chair of the NBCA Medical and Scientific Advisory Board, referenced a study that showed the importance of using appropriate terminology when talking with patients about blood clots and risk factors. Clear and simple language is vital in raising public awareness about the scope of blood-clotting diseases. Michael Jaff, DO, medical director for the MGH Institute for Heart, Vascular, and Stroke Care, spoke about standard treatment and prevention of blood clots. Andra James, MD, professor of Obstetrics and Gynecology at the University of Virginia, focused on blood clots and women. And Catherine Cabral, RPh, assistant professor of Pharmacy Practice at the Albany Medical Center, reviewed safety tips related to blood thinners.

Michael Jaff, DO, medical director for the MGH Institute for Heart, Vascular, and Stroke Care, speaks about blood-clot treatment and prevention.

While experts shared helpful information, the real show-stoppers were AMS patients who shared stories about the impact blood clots have had on their lives. During the panel discussion, patient, Mark Voelkel observed, “I had a pain in my back, but I didn’t think anything of it.” Later, he was diagnosed with a pulmonary embolism (a blood clot in his lung).

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## Anti-Coagulation Management (continued)

Conferences such as the Stop The Clot Forum® help disseminate important information to patients and families. The hope is that attendees will use this information to engage in conversations and ask more meaningful questions of their healthcare providers.

Rachel Moynihan underscored the value of speaking up and not assuming that symptoms will go away. Said Moynihan, “Ask questions, and be sure to get all symptoms checked out.”

Pattie MacDowell shared that, “At first I was embarrassed to let anyone know I’d had a stroke.” She went on to list a number of tips that helped during her rehabilitation and recovery.

Referring to the AMS clinic, Madolyn Wilson commented, “It’s so helpful to have someone to answer my questions on the other end of the phone.”

The expertise of AMS nurses and the relationships they develop with their patients was evident in every scenario. Stories demonstrated the crucial role anticoagulation clinicians play in bringing about positive outcomes among this patient population.

Building on the success of last year’s forum, this year’s Stop The Clot Forum® was video-taped so the information could be posted on the NBCA’s website and other on-line venues. A grant from the Centers for Disease Control provided funding for the program. Utilizing on-line websites and social media helps educate pa-

tients, families, and the general public and is an effective way to share important information with a broader audience.

Patients and families from all over New England made the trip to Boston for the Stop The Clot Forum®. Many attendees were patients of the MGH Anticoagulation Management Service who looked forward to meeting the nurses who help manage their care long-distance. AMS nurses staffed the event and were instrumental in promoting it.

Lynn Oertel, RN, clinical nurse specialist, and Diane DeTour, RN, staff nurse, coordinated the event in collaboration with the NBCA, and Oertel also served as moderator.

Conferences such as the Stop The Clot Forum® help disseminate important information to patients and families. The hope is that attendees will use this information to engage in conversations and ask more meaningful questions of their healthcare providers.

The NBCA is a patient-led, voluntary, health advocacy organization. For more information about blood clots, treatment, or prevention, call 617-726-2768, or visit the NBCA website at: [www.stopthe-clot.org](http://www.stopthe-clot.org). Video of the Stop The Clot Forum® will available soon.



(Photos provided by staff)

Patient panelists (l-r): Madolyn Wilson, Rachel Moynihan, Mark Voelkel, and Pattie MacDowell. Nurse moderator, Diane DeTour, RN, is on the right.

# Spirituality and medicine

## *Highlights of Spiritual Care Week*

By staff chaplains, Rabbi Ben Lanckton and Kate Gerne

**T**ogether, spirituality and medicine create a healing environment. Christina Puchalski, MD, in her Spiritual Care Week presentation, October 23, 2013, conveyed this message beautifully. Puchalski, a leader in the field of spirituality and medicine and founder of GWISH (George Washington Institute for Spirituality and Health), spoke to an audience of chaplains, nurses, doctors, and other healthcare providers. Her presentation was one of many events offered by the MGH Chaplaincy for Spiritual Care Week, October 21–25th. The theme of this year's celebration, the Golden Rule: "Do Unto Others as You Would Have Them Do unto You," took many forms, from Hershey's kisses at an educational booth in the Main Lobby, to live piano music for the MGH community, to the annual Blessing of the Hands for hundreds of patients, families, and staff members.

A new feature this year was the Religious Tradition Worship Series, where Muslim, Baha'i, Christian, Jewish, and Buddhist groups all had time and space in the MGH Chapel to observe authentic worship experiences of their respective traditions.

The Chaplaincy joined in celebrating Disability Awareness Month, welcoming

Rick Guidotti, award-winning fashion photographer and founder of Positive Exposure, a program that seeks to change societal attitudes toward individuals with genetic difference. His powerful presentation included photographs of people from around the world, celebrating the beauty of human diversity—another testament to the power of the Golden Rule.

Spiritual Care Week is an opportunity to highlight the work that chaplains do, expose the MGH community to an array of spiritual practices, and encourage others to nurture their own spirituality. It's our hope that the week brought awareness to the importance of healing environments and of looking after one another.

For more information about the MGH Chaplaincy or to suggest ideas for next year's Spiritual Care Week celebration, call 617-726-2220.



At left: speaker, Christina Puchalski, MD, founder of GWISH (George Washington Institute for Spirituality and Health).  
At right: members of the MGH Chaplaincy take a break from staffing educational booth in the Main Corridor during Spiritual Care Week.

# Blake 6 explores barriers to using ceiling-lifts

## *resolution brings increased utilization*

—by Terry Snyder, senior ergonomics consultant

Recently, Tony DiGiovine, RN, nursing director for the Blake 6 Transplant Unit, reached out to the Partners Occupational Health Ergonomics Program for assistance in determining why staff were reluctant to use overhead ceiling lifts to transfer patients, and whether there was anything they could do to increase utilization. To gain an understanding of the issues, a confidential, on-line survey was administered. The survey revealed 65% of respondents reported some level of musculoskeletal discomfort, which they attributed to manual patient-handling. So why not use the lifts? Reasons cited for not using ceiling lifts included issues such as inconvenience, time constraints, inexperience using the device, and fear that patients wouldn't like it.

Staff indicated they'd be willing to try the lifts if these obstacles could be overcome. So DiGiovine and his staff implemented several strategies in preparation for a six-month trial period. They stocked more lift slings on the unit; slings were proactively placed under patients who couldn't move by themselves; staff under-

went re-training on ceiling-lift utilization; experienced lift users acted as coaches to newer users; and unit leadership encouraged the use of ceiling lifts whenever appropriate.

A post-trial-period survey revealed a marked decrease in the number of staff reporting discomfort; marked improvement in perceived convenience and time issues; and staff reported significant benefits for themselves and their patients. Some comments included: "I'm not as worn out after working with a total-care patient"; "There's less back strain, and it's easier to transport immobile patients"; and "Patients feel more secure when they're moved by lifts."

Says DiGiovine, "Having nurses and patient care associates champion this effort at the unit level was invaluable. They really helped motivate their peers."

Other keys to success included:

- staff being able to give opinions confidentially
- survey findings being shared with staff
- concerns being acknowledged and addressed
- leadership's expectations regarding ceiling-lift use being clearly communicated

Nursing assistants and registered nurses rank in the top five occupations considered at greatest risk for musculoskeletal disorders, and manual handling of patients is widely recognized as the primary cause of musculoskeletal injuries among healthcare providers.

This safe patient-handling intervention was presented at a Combined Leadership meeting in September. For a copy of the presentation or to implement a similar intervention on your unit, contact Terry Snyder at: [TBSnyder@Partners.org](mailto:TBSnyder@Partners.org).



Patient, Stacy Cohen, in sling and harness, volunteers to demonstrate ceiling lifts along with Blake 6 staff members (l-r): Betty Henderson, PCA; Cynthia Velazquez, RN; Deb Whitaker, RN; Sara Duane, RN; and Deb Murphy, RN.

# Bi-lingual colleagues are not medical interpreters

*we should not impose on them to perform outside their scope of practice*

Professional medical interpreters have been trained in medical terminology, national professional standards of practice, and code of ethics. They've been trained to respect patient confidentiality, honor their own neutral role, and maintain the integrity of the patient-provider relationship.

*Question:* What is the policy on the use of medical interpreters for patients who are Limited English Proficient (LEP) or Deaf and Hard of Hearing (DHH)?

*Jeanette:* MGH policy states that only trained medical interpreters should facilitate communication between patients and caregivers. Professional medical interpreters have been trained in medical terminology, national professional standards of practice, and code of ethics. They've been trained to respect patient confidentiality, honor their own neutral role, and maintain the integrity of the patient-provider relationship.

*Question:* Is it acceptable to ask a colleague who speaks the same language as the patient to interpret for me?

*Jeanette:* The policy says that only trained medical interpreters should facilitate communication between patients and caregivers. Asking colleagues to provide interpretation is asking them to perform duties not within their scope of practice. Depending on the role and fluency of the colleague, she may feel uncomfortable saying No, which places her in a difficult situation. Also, asking a colleague to interpret for you prevents them from attending to their own important work.

*Question:* What if a medical interpreter isn't readily available and what I need to communicate is quick and simple?

*Jeanette:* At MGH, a medical interpreter is always readily available—if not in person, then by phone or video. We should always communicate with LEP and DHH patients in the most accurate and effective way possible. Sometimes what we think is going to be a quick and simple exchange could result in a more in-depth conversation as the patient becomes more involved and begins to ask questions. Bi-lingual colleagues can support non-medical conversations, such as relaying comfort needs (a desire for food or drink, or a need to use the bathroom) or directions (how to get to the Pharmacy, for instance).

*Question:* Colleagues on my unit who are bi-lingual don't mind being asked to interpret.

*Jeanette:* We've heard from many bi-lingual staff in various roles that they're uncomfortable when asked to interpret for clinicians. They recognize the enormous responsibility and don't feel comfortable performing those duties. Often, they feel pressured to do so. We need to adhere to our policy that all employees perform roles within their scope of practice. To truly deliver care that's patient- and family-centered, we must meet our patient's language needs by partnering with medical interpreters.

For more information or to request a medical interpreter, call 617-726-6966.

# Announcements

## Global Health certificates at the IHP

The MGH Institute of Health Professions School of Nursing is offering two certificates in Global Health Nursing.

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 nurses.

Both programs offer flexible schedules for working professionals.

Programs begin in January.

For more information, go to: <http://www.mghihp.edu/academics/nursing/degree-options/global-health/default.aspx>, or call 617-726-6649.

## Munn Doctoral Fellowship in Nursing Research

### Call for Applications

The Yvonne L. Munn Center for Nursing Research is expanding the current Munn Post-Doctoral Fellowship to support pre-doctoral nurses completing dissertations. The Munn Doctoral Fellowship now accepts applications from both pre-doctoral dissertation candidates and post-doctoral nurses actively advancing a program of research. The fellowship provides a buy-out of time and resources to advance the scholar's research agenda.

The fellowship provides added time and resources for pre-doctoral candidates to accelerate completion of their dissertations and post-doctoral applicants to advance their research programs.

Concept papers are due January 19, 2014; final applications are due February 7, 2014. For more information, contact Diane Carroll, RN, at 617-724-4934 or Amanda Coakley, RN, at 617-726-5334, or visit the Munn Center website at: <http://www.mghpcs.org/munncenter/>.

## Service Excellence Awards

Nominations are now being accepted for a new MGH award program that recognizes achievement in improving the patient experience. The program recognizes employees based on excellent (or significantly improved) survey results as well as nominations submitted by colleagues.

You can nominate teams that have successfully improved the patient experience or leaders who continually inspire outstanding service. Recipients will be recognized at a ceremony led by MGH leadership in February, 2014. Take a moment to submit a nomination recognizing the work and dedication of successful teams and leaders at MGH.

Nominations are due by 3:00pm, Friday, December 20, 2013.

For more information, contact Cindy Sprogis at 617-643-5982.

## Simmons College healthcare MBAs

### Scholarships available for MGH employees

Simmons College School of Management is accepting applications for its part-time, January and September, Healthcare MBA program. MGH employees are eligible to apply for a Future Healthcare Leaders Scholarship (up to \$30,000 over three years). Scholarships are given to applicants who demonstrate academic achievement and success in the healthcare industry.

Deadline for January admission is December 1, 2013.

For more information, call Carolyn Kirkman of MGH Training and Workforce Development at 617-724-3368, or visit their website at: [http://is.partners.org/hr/New\\_Web/mgh/mgh\\_training\\_Simmons.html](http://is.partners.org/hr/New_Web/mgh/mgh_training_Simmons.html).

## MGH Institute offers PhD in Rehabilitation Sciences

The PhD in Rehabilitation Sciences at the MGH Institute of Health Professions is designed for clinically certified healthcare professionals wishing to acquire advanced knowledge and skills to conduct clinical research with an emphasis on assessing clinical outcomes in rehabilitation.

Full funding is available for as many as six qualified candidates. For more information, e-mail [mlnicholas@mghihp.edu](mailto:mlnicholas@mghihp.edu) or go to: [www.mghihp.edu/phd](http://www.mghihp.edu/phd).

## Become an ergonomics champion

The PHS Occupational Health "Train the Trainer in Office Ergonomics" course is designed for individuals or departments interested in creating a more ergonomically correct work space. This interactive class uses a combination of lectures, case studies, demonstrations, and work-station evaluations to guide ergonomic improvements. Attendees will learn to position keyboards, monitors, devices, and chairs to promote proper posture and positioning.

Tuesday, December 17, 2013  
8:45am–12:15pm

MGH Training and Workforce Development  
Charles River Plaza  
Suite 200,

For more information, call 978-808-7688, or go to: <http://is.partners.org/hr/training/pds/phs/enrollment.html>

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# Collaborative Governance Celebration

On Wednesday, October 23, 2013, collaborative governance celebrated 16 years of empowering staff and supporting clinicians in their efforts to deliver the best possible care to patients and families. In her remarks, senior vice president for Patient Care, Jeanette Ives Erickson, RN, conveyed her pride in the committees' many accomplishments and challenged them to continue to seek opportunities to influence the care delivered at the 'best hospital in the world.'

Featured speaker, Julie McCarthy, RN, co-chair of the Patient Education Committee, recalled how she felt upon becoming a member of collaborative governance. "I was amazed at how involved I could be as a staff nurse. I was participating in decision-making that changed care at the institutional level as well as at the

bedside... I'm truly blessed to be part of collaborative governance and the empowerment, autonomy, and respect it engenders."

The annual collaborative governance celebration is also an opportunity to recognize and thank outgoing committee leaders for their service and accomplishments. This year, that included:

- Sharon Brackett, RN, coach, Ethics in Clinical Practice
- Deborah D'Avolio, RN, advisor, Fall Prevention
- Joanne Empoliti, RN, advisor, Policy, Procedure & Products
- Bridget Lyons, RN, co-chair, Fall Prevention
- Sally Millar, RN, advisor, Informatics
- Kathryn Whalen, RN, co-chair, Research & Evidence-Based Practice

For more information about collaborative governance, call Mary Ellin Smith, RN, professional development manager, at 4-5801.



Marie Elena Gioiella, LICSW (left), with Joanne Empoliti, RN, outgoing advisor of Policy, Procedure & Products Committee



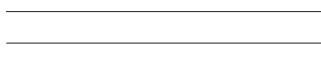
Theresa Gallivan, RN (left), and Gaurdia Banister, RN (right), with outgoing coach of the Ethics in Clinical Practice Committee, Sharon Brackett, RN.



Julie McCarthy, RN, keynote speaker and co-chair of Patient Education Committee

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