

# Caring

Headlines

December 18, 2014

## The Mackoff visit, fostering a just culture, and enhancing patient safety

How stories become strategies

The Wisdom of Experience

See Jeanette Ives Erickson's column on page 2, and story on page 4



Norman Knight visiting scholar, Barbara Mackoff, RN (left), and executive director of The Institute for Patient Care, Gaurdia Banister, RN, at the October 27, 2014, presentation, "The Wisdom of Experience."

# Fostering a just culture is fundamental to ensuring patient and staff safety

I hope many of you had an opportunity to attend one of Barbara Mackoff's three presentations of, "The Wisdom of Experience," when she was here in October as this year's Norman Knight visiting scholar. They were powerful, engrossing sessions that centered around safety narratives written and read by five MGH staff nurses (see article on page 4). Each nurse shared a personal experience with an adverse event that threatened the safety of one of her patients. I hope you can appreciate the courage it took for these five nurses to come forward and share these stories with their peers and colleagues in such a public way. We owe them a debt of gratitude for their willingness to talk openly about these events that, in the past, may have elicited a desire to blame, but which are really opportunities to re-evaluate systems, implement improvements, and ultimately prevent them from happening again.

Barbara Mackoff's visit was a wonderful reminder of the importance of fostering a just culture where every employee is encouraged to report mistakes. Mistakes are often precursors to more serious adverse events. Mistakes can be indicators of previously undetected system failures that if left unchecked could result in greater risk for patients and/or staff. It's imperative that every member of an organiza-



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

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Any discussion of just culture must make mention of Lucian Leape, MD, and his role in bringing just culture into the national discussion on patient safety. As a member of the Quality of Health Care in America Committee at the Institute of Medicine and adjunct professor of the Harvard School of Public Health, Leape is credited with saying that the single biggest impediment to error-prevention in the medical industry is, "that we punish people for making mistakes." He's known for his ground-breaking 1994 JAMA article, "Error in Medicine," that called for the application of systems theory in preventing medical errors.

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A just culture pre-supposes that no clinician would willfully or intentionally harm a patient... In a just culture, the organization and individuals are continually learning from their mistakes, so they can continually improve systems, so they can continually enhance the safety of the environment for patients and staff.

Based largely on Leape’s contributions, the principles of a just culture have come to be widely accepted as:

- ensuring frontline personnel feel comfortable disclosing errors—including their own—while maintaining professional accountability
- not holding individual practitioners accountable for system failures over which they have no control
- recognizing many individual or ‘active’ errors represent predictable interactions between human operators and the systems in which they work
- revising health care’s culture that once held individuals accountable for all errors or mishaps that befell patients in their care
- not tolerating conscious disregard for clear risks to patients or gross misconduct (e.g., falsifying records or practicing while intoxicated)

A just culture pre-supposes that no clinician would willfully or intentionally harm a patient. So individual practitioners should not be held accountable for systems failures over which they have no control. In a just culture, the organization and individuals are continually learning from their mistakes, so they can continually improve systems, so they can continually enhance the safety of the environment for patients and staff.

We are fortunate to have a robust safety reporting system. Every safety report submitted to the MGH Center for Quality & Safety is evidence. Every event or near-miss that’s reported is an opportunity to prevent an accident in the future. We rely on employees to speak up when they identify shortcomings in a particular practice, policy, pathway, or device. And we do so with the hope that they feel safe and supported sharing this vital information. We work hard to foster an environment where errors and near-misses are openly identified so they can be analyzed and corrected.

I want to thank our brave colleagues, Laura Ritch, RN; Mary-Elizabeth Powers, RN; Lisette Packer, RN; Anne-Marie Thompson, RN; and Amanda Small, RN, for sharing their safety narratives with our visiting scholar and with the entire MGH community. It was a valuable and inspiring learning opportunity.

As long as there are human beings, there are going to be mistakes. If our approach to mistakes were simply to punish the perpetrators, problems would never get solved. And as long as we’re committed to delivering the highest quality care to patients and families, perpetuating a culture of safety and fostering a just culture will always go hand-in-hand.

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# Mackoff presents “The Wisdom of Experience”

—by Mary Ellin Smith, RN, professional development manager

“Don’t come back from hell empty-handed.” That was the message delivered by Norman Knight visiting scholar, Barbara Mackoff, RN, October 27, 2014, in her presentation, “The Wisdom of Experience.” Mackoff, a Fulbright specialist and AONE faculty member, spoke about the importance of safety narratives and how they can help foster exemplary practice and improve patient safety.

Mackoff began each of her three sessions by sharing an excerpt from a safety narrative written by senior vice president for Patient Care, Jeanette Ives Erickson, RN, when she was a new nurse. The incident reflected an environment of shame and blame and set the stage for a discussion of just culture, creating a blame-free environment, and the reading of several safety narratives by MGH staff.

White 7 surgical nurse, Laura Ritch, RN, told of administering a blood product to a patient only to discover that the product was supposed to have been administered prior to the procedure. The order had been written in such a way that it was only visible using the zoom function in POE.



ED observation unit nurse, Anne Marie Thompson, RN, fields questions after reading her safety narrative

Pediatric nurse, Mary-Elizabeth ‘Daisy’ Powers, RN, recounted a night when an overwhelming need for pediatric psychiatric care raised issues concerning staff’s ability to meet their needs. Powers alerted her nursing director, who mobilized the resources of numerous departments to ensure a safe environment for patients and staff.

Oncology nurse, Lisette Packer, RN, recalled how a patient’s IV pump rate wasn’t changed to offset a change in the patient’s medication. Despite the fact that several nurses followed appropriate scanning procedure, the scanning system itself did not make the necessary adjustment.

ED observation unit nurse, Anne-Marie Thompson, RN, spoke about an error she made many years ago before numerous safety precautions

had been put in place. She administered a short- rather than long-acting dose of medication. She described her horror at discovering the error, how difficult it was to tell the patient and his wife, and the support she received from her nursing director. Today, if an error occurs on the unit, Thompson’s nursing director often asks her to speak with the clinician as a means of de-briefing and getting some much-needed perspective.

Neuroscience nurse, Amanda Small, RN, described a patient fall and the guilt she felt at her perceived failure to protect her patient. A careful review of the incident revealed several systems failures contributed to the series of events surrounding the fall.

The common denominator among all the narratives was that each incident was the result of a system failure not individual error, and the reporting of each incident led to improved systems and a safer care environment. Mackoff’s mantra not to return from hell empty-handed was not lost on the scores of attendees at each session.

For more information about the Mackoff visit, call Mary Ellin Smith, RN, at 4-5801.



Director of PCS Office of Quality & Safety, Colleen Snyderman, RN (left), is among many who offer support and appreciation to those who volunteered to share their stories. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, looks on.

# Sharing innovative use of technology to promote patient safety

—by Lynn Oertel, RN, clinical nurse specialist

**O**n Friday, November 21, 2014, the MGH Anticoagulation Management Service (AMS) hosted the 8th annual North American DAWN AC User Group meeting. The meeting was attended by clinicians and information-technology experts who utilize DAWN AC, a software designed specifically for anticoagulation-management and follow-up. Throughout the day, clinicians from hospitals and healthcare systems across the country shared examples of how they use the software to improve care and enhance patient safety at their clinics.

AMS presenters at 8th annual North American DAWN AC User Group meeting (l-r): Diane DeTour, RN; Lynn Oertel, RN; and Irina Seliverstov, RN.



Attendees came from as far away as Alaska and Iceland.

MGH was well represented with two AMS staff nurses presenting examples of innovative approaches they use to ensure patient safety and high-quality care in their daily practice. Diane DeTour, RN, presented, “Promoting Patient Safety during Transition of Care: Known or Unknown,” which focused on electronic interfaces between DAWN AC and MGH to identify important transitions in care. The interfaces inform AMS staff when transitions occur within this vulnerable patient population, providing opportunities for nurses to intervene in a timely fashion.

Irina Seliverstov, RN, discussed the importance of patient compliance in her presentation, “The Use of Telephone Reminder Calls Improves Compliance with INR Testing.” Seliverstov shared data highlighting the success of efforts to promote adherence with INR blood-testing using automated phone calls to remind patients when they’re overdue. Patient response was extremely high, and the use of automated reminder calls resulted in significant savings over mailed reminder notices.

Lynn Oertel, RN, clinical nurse specialist, coordinated and moderated the program that provided opportunities to network and share best practices among inter-disciplinary professionals working in the same specialty. The program is one example of how AMS continues to be a center of excellence for anticoagulation-management.

For more information about anticoagulation management or this year’s North American DAWN AC User Group meeting, call Lynn Oertel at 617-726-6955.

# Preparing staff to deal with disruptive patient behavior

*enhancing the safety of patients,  
staff, and visitors*

*Question:* What, specifically, is considered disruptive behavior?

*Jeanette:* Disruptive behavior is anything that could be considered intimidating, threatening, dangerous, or pose a risk to patients, staff, or visitors. It includes verbal abuse (name-calling, profanity, racial/ethnic epithets), sexual harassment, inappropriate touching, unwanted approaches, physical assault, or any other behavior that interferes with staffs' ability to perform their duties.

*Question:* What should we do if we encounter disruptive patient behavior?

*Jeanette:* Safety is our number-one priority. Contact Police & Security (6-2121) immediately for assistance. Notify unit leadership (never worry alone). And consider the following if warranted: does anyone require medical assistance, re-assignment, or any other supportive interventions? Does the patient require emergent medical or psychiatric evaluation? Have other patients or visitors been affected? Conduct a team huddle to revise plan of care, and file a safety report.

*Question:* I understand there's a disruptive patient behavior work group?

*Jeanette:* Yes. The multi-disciplinary group meets monthly to review safety reports submitted in this category. We review reports to determine contributing factors, such as, delirium, confusion, withdrawal, brain injury, psychiatric illness. We look at other factors, such as, care activities being performed when the behavior escalated, the location or setting where the incident took place, and the condition of the environment at the time of the incident. This review guides subsequent interventions.

Interventions may include meeting with staff and leadership to develop an Acute Care Plan to better manage the behavior; activation of the Key Information Icon in LMR; initiating unit-based MOAB training (Management of Aggressive Behavior); or referral to other resources.

*Question:* What is the Key Information Icon?

*Jeanette:* The Key Information Icon for disruptive behavior was created to help keep patients safe and improve communication throughout the hospital by identifying patients who pose a high risk for disruptive behavior. The workgroup activates the icon in LMR based on their review of safety reports. Activating the icon conveys an assessment of the patient's risk factors, frequency and severity of episodes, risk of re-occurrence, and may result in a discussion with providers when appropriate. The icon appears in CAS near other patient flags. Clicking the icon reveals a care note to assist in the safe provision of care and provides reference to the Acute Care Plan in LMR.

*Question:* Who can we contact for more information ?

*Jeanette:* For assistance developing an Acute Care Plan or to schedule unit-based inservice training, contact Jen Repper-DeLisi, RN, at 6-3370.

For SMART team consultation, contact Jennifer Goba in Police & Security, at 6-2121.

For information about the Delirium program on White 8, call Colleen Gonzalez, RN, at 3-5478.

For information about the Inpatient Addiction Consult Team, call Sara Macchiano, RN, at 6-6384.

For information about the Key Information Icon, call Robin Lipkis-Orlando, RN, at 3-3911.

# What level of post-acute care is right for your patient?

All members of the healthcare team, including patients and families, need to have a working understanding of the levels of post-acute care to ensure patients' needs are fully met after discharge

**H**ow do caregivers know what level of post-acute care best meets their patients' needs? Home care? Skilled nursing facility? Long-term acute-care facility? To help answer that question, a multi-disciplinary team has created a series of educational materials clearly delineating the various levels of post-acute care according to Medicare guidelines. Staff will have access to these materials via grand rounds, posters (see page 8), staff meetings, HealthStream, and the length-of-stay site on the Excellence Every Day portal page: <http://intranet.massgeneral.org/LOS>.

All members of the healthcare team, including patients and families, need to have a working understanding of the levels of post-acute care to ensure patients' needs are fully met after discharge. Post-acute care choices should be based on:

- individual patient needs
- plans for ongoing treatment
- input from the team, family, and patient
- availability of care options
- insurance considerations

A discharge plan that places the patient in the most appropriate care setting can vastly affect clinical outcomes and minimize the possibility of re-admission. Following is a summary of the various post-acute care options:

*Outpatient/ambulatory care:* Patients are not homebound, but require ongoing care after discharge. They must have access to transportation, and the number and types of visits are based on the patient's progress.

*Example:* Mass General/North Shore Center for Outpatient Care

*Home care:* Patients are able to return home but require ongoing care. Medically complex patients average 10–15 visits per episode of care.

*Example:* Partners Healthcare at Home

*Skilled nursing facility (SNF):* Patients require nursing and medical care and can tolerate one to three hours of therapy per day to establish or maintain stability. Average stay is 10–20 days. SNFs may vary in the services they offer and the complexity of patients they accept.

*Examples:* Spaulding North End and Spaulding West Roxbury

*Inpatient rehabilitation facility (IRF):* Patients need hospital-level care with a high degree of rehabilitation therapy and moderate medical and nursing care. Average stay is 12–16 days.

*Example:* Spaulding Rehabilitation Hospital Boston

*Long-term acute care (LTAC):* Patients need hospital-level care with a high degree of medical and nursing care and moderate rehabilitation therapy to establish and maintain stability. Average stay is more than 25 days.

*Examples:* Spaulding Cambridge and Spaulding North Shore

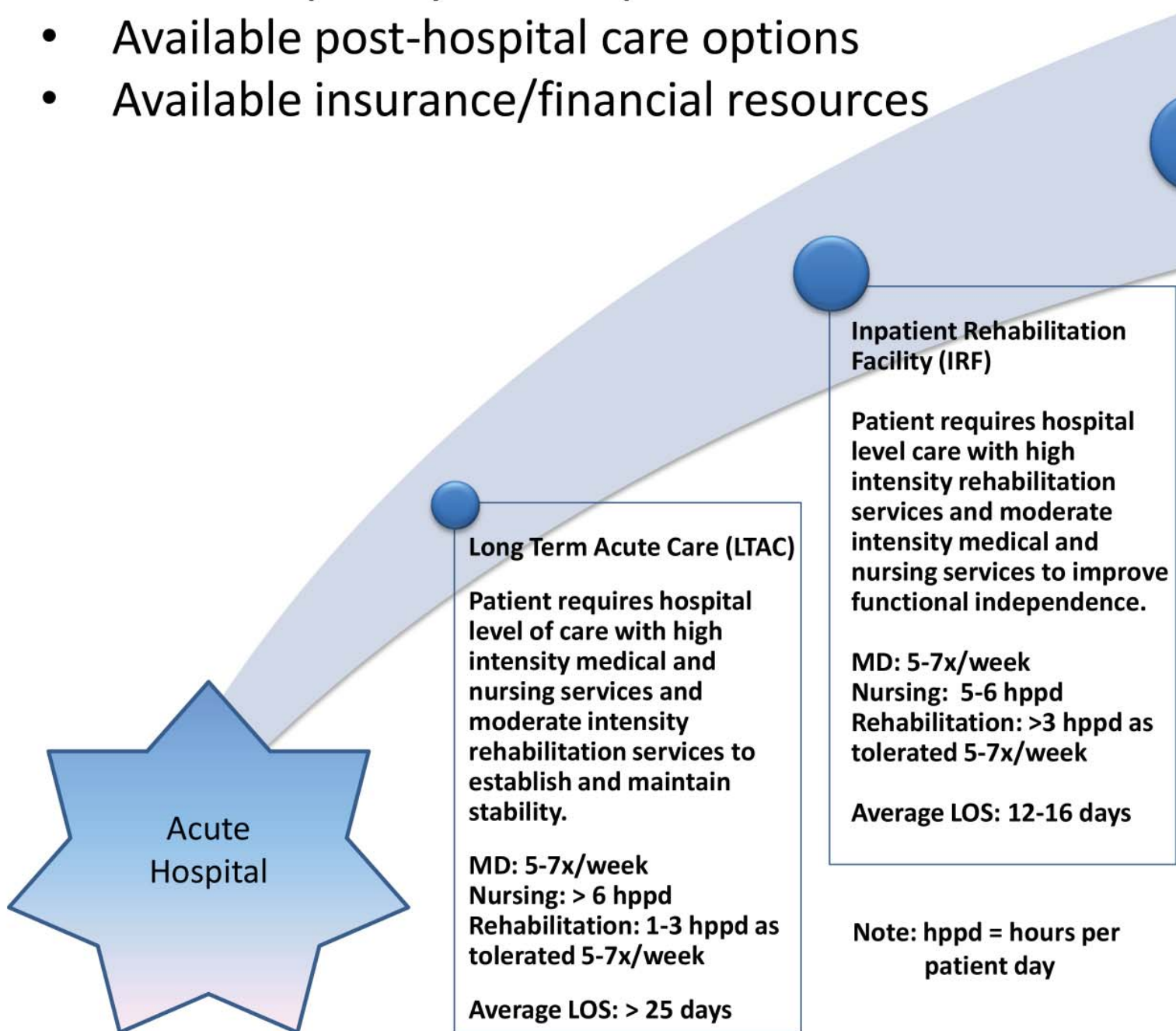
The (removable) poster on the next page provides a visual representation of the various levels of post-acute care. The goal is to ensure patients safely return to maximum functionality and independence. Educational materials include types of care that can be expected for each level, common barriers to post-acute-care placement, and tips to facilitate appropriate placement.

For more information, call Laurene Dynan, RN, clinical educator, CCMU, at 617-724-9879.



## Placement decision is based on:

- Assessment of patient's individual clinical needs
- Plans for ongoing treatment pre- and post-discharge
- Patient/family/responsible person choices and input
- Interdisciplinary team input
- Available post-hospital care options
- Available insurance/financial resources





# Levels of Care

Maximum  
Level of  
Function &  
Independence

## Outpatient Care

Patient is not homebound but requires ongoing care.

Transportation must be available or accessible.

Number and types of appointments are based on patient's progression. May include:

MD, RN, PT, OT, SLP, Vestibular Rehab, Pulmonary Rehab, Cardiac Rehab, Day Care, Social Work, and others.

## Home Care/VNA

Patient is clinically and functionally able to return home but requires ongoing care.

RN, PT, OT, SLP, MSW intermittent home visits. Number and frequency of visits depend on patient needs.

Average of 10-15 visits per episode of care for medically complex patients.

## Skilled Nursing Facility (SNF)

Patient requires moderate medical care, lower intensity rehabilitation and nursing care to establish/maintain stability.

MD/NP: 1-3x/week  
Nursing: 3-4 hppd  
Rehabilitation: <1-3 hppd

Average LOS: 10-20 days

## Hospice Care: Home/Residential or General Inpatient (GIP)

Recommend starting with home/residential plan of care then transfer to a facility if needed. Federal law requires a doctor's statement of a life expectancy of < 6 months.

Home or Residential: Can be provided in any setting; if an institutional setting will have an added room & board charge; patient does not need to be DNR.

GIP: Can be provided in any facility setting (SNF/LTAC/Hospice House/Acute Hospital); Medicare requires the facility to have a registered nurse providing direct care on all three shifts and to have overnight accommodations for family members; no room and board charge; patient must be DNR.

# Trusting relationship helps advance care of medically complex patient

**M**y name is Stefanie Michael, and every time I walk through the doors of MGH, I'm struck with a complex set of feelings. I'm amazed at the massive physical structure. I'm in awe of the research and medical miracles that occur here every day. And I feel a healthy sense of fear at what may lie ahead during my shift, knowing that each patient interaction impacts a life for better or worse.

House medicine patients (many of who do not have a primary care physician, or may be homeless or disenfranchised) often present with complex medical problems compounded by social and psychological needs. I practice as a staff nurse on Bigelow 11, an all nursing general medicine unit, and I help care for these patients. Mrs. R was a 58-year-old woman with Laennec's cirrhosis who was admitted with anemia and a GI bleed. Her liver failure had been previously managed as an outpatient with hematocrit checks and recent endoscopy, colonoscopy, and video capsule study.

I joined Mrs. R's primary team a few weeks into her almost two-month stay on Bigelow 11. Her mental status had just started to clear after many days of acute confusion. I recognized Mrs. R's jaundiced skin, yellowish eyes, and distended abdomen as advanced liver failure. Because of the fluid build-up in her abdomen, frequent large-volume paracenteses (fluid removal) were performed at the bedside. The procedures were usually accompanied by drops in blood pressure and hematocrit levels requiring the administration of albumin, fluid, and several other interventions. Mrs. R reported feeling better post-procedure, but the discomfort would return in a day or two. Balancing her comfort with the risk of infection and resultant fluid shifts posed a major challenge. Her expanding abdomen made eating and taking meds uncomfortable. For her nausea and waning appetite, I administered Zofran before breakfast and provided preferred foods. We spaced the tablets throughout the morning to avoid abdominal fullness. When gas pain



Stefanie Michael, RN, staff nurse  
Bigelow 11 Medical Unit

became a problem, I requested she be given Simethicone, which seemed to provide a measure of relief.

Due to her liver failure, Mrs. R was at high risk for confusion from elevated ammonia levels. She was given Lactulose to help control the ammonia, but it caused frequent diarrhea. Mrs. R required two or three doses of Lactulose a day, but weakness and limited mobility made elimination difficult. After much discussion about the benefits of mobilizing her, my colleague and I decided the best plan would be to help Mrs. R transfer to a bedside commode for toileting as needed throughout the day. It took longer than using a bedpan, but it was a huge factor in Mrs. R's recovery process. And eventually, she graduated to using a walker and a raised toilet seat in the bathroom.

Previously a heavy drinker, Mrs. R had been sober for six months, and she wanted to be listed as a candidate for liver transplant. I couldn't help wondering what had driven Mrs. R to the path her life had taken, but I respected her wishes and treated her with the respect that all human beings deserve.

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Mrs. R was a 58-year-old woman with Laennec's cirrhosis who was admitted with anemia and a GI bleed... I joined Mrs. R's primary team a few weeks into her almost two-month stay on Bigelow 11. Her mental status had just started to clear after many days of acute confusion. I recognized Mrs. R's jaundiced skin, yellowish eyes, and distended abdomen as advanced liver failure.

Mrs. R displayed a unique affect: flat but intermittently anxious. She spoke very little. Though I usually get to know patients and families through small talk and inquiries about their lives, Mrs. R preferred quiet and limited interaction. I respected that and only asked questions necessary for her care.

Early on, I recognized that Mrs. R had a hard time making decisions. So once I learned her preferences, I'd say, "Would you like some cranberry juice with your medication?" This still gave her a choice, but minimized the options making it less stressful for her. This approach also worked well for planning her personal care, medication-administration, and other interventions.

Mrs. R's husband was also anxious. He would pace the floor and come get me when his wife had a need. After gently reminding him about the call bell, I increased my surveillance rounds to help allay his anxiety and need to come searching. He would show up mid-morning with a list of questions and goals for the day. I found it helpful to pick one or two things on the list and let him know when I planned to address them. I'd often sit with Mr. and Mrs. R to see if there were any concerns I should raise at morning rounds. It was helpful to match my list with theirs so Mr. R could be assured his concerns would be addressed.

Once it was safe, Mrs. R was allowed to leave the unit in a wheelchair accompanied by her family. Both Mr. and Mrs. R were grateful for this change of scenery. Mr. R's presence sometimes increased Mrs. R's anxiety, but visits from her brother had the opposite effect. He frequently flew in from out of state and would stay overnight in Mrs. R's room. During one of my resource shifts, we were asked to temporarily relocate Mrs. R to another room to accommodate an emergency admission. When I approached Mr. and Mrs. R about the move, Mrs. R nearly panicked at the prospect of leaving her familiar room. After some creative collaboration with Admitting and some alternate room changes, I happily told Mrs. R that she wouldn't have to leave her familiar surroundings. The relief in the room was palpable.

About seven weeks into her stay, Mrs. R developed C-diff and, potentially, spontaneous bacterial peritonitis. Her BUN and creatinine levels rose and her systolic blood pressure dipped into the 70s with poor urine output. The senior physician and nursing supervisor were paged and briefed. In an impromptu meeting with the medical team, I shared my concern about Mrs. R's need for 1:1 nursing care and her failure to

respond to our many interventions. Within a few hours, her condition warranted transfer to the ICU.

Mr. and Mrs. R were concerned about this change in Mrs. R's condition. In his matter-of-fact way, Mr. R obtained some green bags and started packing their personal items. With tears in her eyes, Mrs. R asked how long she'd have to stay in the ICU. I heard the anxiety in her voice as she contemplated this move to an unfamiliar place.

Pausing for a moment, I sat on her bed and took her hand. "Mrs. R," I said, "this transfer is for your benefit. The ICU is better equipped to handle the care you need right now. We want you to come back as soon as you're medically stable." Then to lighten the mood, I added, "You might like the attention in the ICU so much that you won't want to come back."

Mrs. R mustered a courtesy smile. A while later, while I was checking her blood pressure, she said, "You're so calming, Stefanie." A woman of few words, that simple comment spoke volumes to me.

Mrs. R was taken to the ICU on Blake 12. A colleague and I visited her there after her liver transplant. She had a tracheostomy due to post-operative complications. It was her first time up in a chair, and her eyes had that familiar look of uncertainty. We stayed just a few minutes hoping that seeing us would cheer her up and reassure her. Despite some additional complications, Mrs. R eventually transferred to Blake 6 (Transplant). I bumped into Mr. R there the day Mrs. R was scheduled to transfer to rehab. I peeked my head into her room, and she smiled excitedly. She thanked me for coming. Her skin looked healthy with no hint of jaundice, and her eyes were bright with anticipation. Though she didn't say much, I knew she and Mr. R were grateful for this second chance at life. It was a privilege to play a small part in her amazing recovery.

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

Stefanie walks us through her process of coming to know Mrs. R. It is this knowledge of her patient that allows Stefanie to provide exquisite, patient-focused care. She knows when Mrs. R and her husband are anxious and how to allay their anxiety. She knows what Mrs. R is capable of and her limitations, and she fashions her care to optimize Mrs. R's recovery. What a wonderful example of relationship-based care, achieved through listening and knowing her patient.

Thank-you, Stefanie.

# New feature available in Kronos

*employees can now access information about  
hours worked, overtime, and earned time*

Effective  
December 15,  
2014, employees  
are now able to  
view information  
about the total  
number of hours  
they've worked,  
overtime, and  
earned-time using  
Kronos terminals  
throughout the  
hospital.

*Question:* I heard there's a new feature in Kronos. Can you tell me more about it?

*Jeanette:* Effective December 15, 2014, employees are now able to view information about the total number of hours they've worked using Kronos terminals throughout the hospital.

*Question:* Can I view any other information?

*Jeanette:* Employees can view their overtime and earned-time status for the previous pay period, the current day, or the current pay period.

*Question:* Can anyone use this feature?

*Jeanette:* MGH employees who use Kronos terminals to swipe in and out can use this new feature. Employees who regularly use Kronos Self Service (KSS) can use it, as well. Information can only be viewed at Kronos terminals; this feature is not yet available on desktop or laptop computers.

*Question:* Are there instructions? How will I know how to access the information?

*Jeanette:* Instruction cards have been posted beside Kronos terminals. Employees can read the instructions or use the pictures or diagrams as a guide.

*Question:* Will other employees be able to see information about the hours I've worked?

*Jeanette:* No. Your colleagues do not have access to any information about your hours. You'll need your MGH identification badge to access the information, and the screen times out after ten seconds. Your information disappears so it can't be viewed by others.

*Question:* What prompted the addition of this new feature?

*Jeanette:* Employees are often curious about the number of hours they've worked. In the past, they've had to seek out their managers or timekeepers to obtain that information. This new function allows employees to easily access that information themselves.

*Question:* Is this new feature available all the time and from every Kronos terminal?

*Jeanette:* Yes. This information is available to employees all the time. Every Kronos terminal has this new feature. Be mindful of colleagues who might be trying to swipe in or out while you're viewing your information. Try to access your information at a time when others are not waiting to use the terminal.

*Question:* Who can I contact if I have questions?

*Jeanette:* Employees with questions should contact their HR business partner, or call 6-5140.

# Professional Achievements

## Teves certified

Allison Teves, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in August, 2014.

## Salvucci certified

Marcia Salvucci, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in June, 2014.

## Harrison certified

Tara Harrison, RN, staff nurse, Burns Unit, became certified as a critical care nurse by the American Association of Critical Care Nurses, in October, 2014.

## Matacunas certified

Brooke Matacunas, Main Operating Room, became certified as a surgical technologist by the National Board of Surgical Technology and Surgical Assisting, in August, 2014.

## LaSala appointed

Cynthia LaSala, RN, clinical nurse specialist, General Medicine, was appointed chair of the Conference Planning Committee for the American Nurses Association in October, 2014.

## Don certified

Susan Don, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in August, 2014.

## Hession certified

Ann Hession, RN, staff nurse, Labor & Delivery, became certified as a registered nurse by the American Nurses Credentialing Center, in October, 2014.

## Nortelus certified

Nadege Alexandre Nortelus, Main Operating Room, became certified as a surgical technologist by the National Board of Surgical Technology and Surgical Assisting, in August, 2014.

## Banister honored

Gaurdia Banister, RN, executive director of the The Institute for Patient Care, was named Distinguished Alumna for the University of Wyoming, October 25, 2014.

## Beaumont certified

Damaris Beaumont, Main Operating Room, became certified as a surgical technologist by the National Board of Surgical Technology and Surgical Assisting, in August, 2014.

## Leone certified

Annette Leone, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in August, 2014.

## O'Sullivan certified

Susan O'Sullivan, RN, staff nurse, Labor & Delivery, became certified as a registered nurse by the American Nurses Credentialing Center, in October, 2014.

## Bolton certified

Kim Bolton, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in August, 2014.

## Maclsaac certified

Jeanne Maclsaac, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in August, 2014.

## O'Toole certified

Katelyn O'Toole, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in August, 2014.

## Hutchison certified

Melina Hutchison, RN, staff nurse, Cardiac Surgical Intensive Care Unit, became certified as a critical care nurse by the American Association of Critical Care Nurses, in September, 2014.

## Goulding certified

Judith Goulding, Main Operating Room, became certified as a surgical technologist by the National Board of Surgical Technology and Surgical Assisting, in April, 2014.

## Harmon Mahony presents

Carol Harmon Mahony, OTR/L, occupational therapist, presented, "Fracture Management" and "Wrist Injuries," at the Graduate Occupational Therapy Program at Tufts University, September 29 and October 6, 2014, respectively.

## Orencole presents

Mary Orencole, RN, adult nurse practitioner, Cardiology, presented, "Heart Failure in Patients with Cancer—the Role of CRT," at the Program for All-Inclusive Care for the Elderly (PACE), in Philadelphia, October 18, 2014.

## Arnstein licensed

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, became licensed to practice as a clinical nurse specialist, a new licensure category in Massachusetts, by the Massachusetts Board of Registration in Nursing, in October, 2014.

## Ford Paula certified

Ashley Ford Paula, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in August, 2014.

## Roche presents

Constance Roche, RN, nurse practitioner, Surgical Oncology, presented, "Clinical Breast Exam Workshop," at the 17th annual Premier Women's Healthcare Conference of the National Association of Nurse Practitioners in Women's Health, in Savannah, Georgia, October 18, 2014.

## Pomerleau presents

Mimi Pomerleau, RN, nurse practitioner, Obstetrics, served as moderator for the panel discussion, "Perinatal Staffing Guidelines," at the Massachusetts section of the Association of Women's Health Obstetric and Neonatal Nurses' conference, Riding the Tide: Contemporary Issues in Perinatal Nursing, in Falmouth, October 24, 2014.

## Folger appointed

Abby Folger, PT, physical therapist, was appointed assembly representative for the southern Metro District of the Assembly of Representatives of the American Physical Therapy Association of Massachusetts, through December, 2015.

## Capasso licensed

Virginia Capasso, RN, clinical nurse specialist, MGH Wound Care Program, became licensed to practice as a clinical nurse specialist, a new licensure category in Massachusetts, by the Massachusetts Board of Registration in Nursing, in October, 2014.

*continued on next page*

## Professional Achievements (continued)

### Blake 14 team honored

The Blake 14 night-shift team received the MGH Excellence in Action Award from hospital president, Peter Slavin, MD, December 17, 2014.

### Spracklin certified

Dale Spracklin, RN, staff nurse, Main Operating Room, became certified as an operating room nurse by CCI Competency and Credentialing, in August, 2014.

### Azevedo certified

Robin Azevedo, RN, staff nurse, Labor & Delivery, became certified as a registered nurse by the American Nurses Credentialing Center, in October, 2014.

### McConville a panelist

Alice McConville, RN, attending nurse, was a panelist in the, "Creating a Safe Practice Environment," discussion at Keeping Patients and Nursing Staff Safe: Challenges and Possibilities, Conference of the American Nurses Association, in Natick, October 17, 2014.

### Rosa presents poster

Katherine Rosa, RN, Connell nursing research scholar, The Yvonne L. Munn Center for Nursing Research, presented her poster, "Health, Caring, Consciousness, Mutual Process, Patterning, Presence, and Meaning Unfolding in a Praxis Relationship," at the Society of Rogerian Scholars conference in Knoxville, Tennessee, October 7, 2014.

### Inter-disciplinary team publishes

B. Taylor Thompson, MD, and Lillian Ananian, RN, authored the article, "Family Presence on ICU Work Rounds," in the September, 2014, *ICU Management*.

### Convery presents

Mary Susan Convery, LICSW, social worker, presented, "Psychological First Aid," to YouthConnect clinical staff at the Boys and Girls Club, in Roxbury, October 23, 2014.

### Konner and Gunderson present

Social workers, Karen Konner, LICSW, and Natasha Gunderson, LICSW, presented, "Disaster Mental Health," for the Social Work in Healthcare Class at the School of Social Work at Boston College, October 16, 2014.

### Chang presents

Lin-Ti Chang, RN, staff specialist, presented, "Evaluation of Mass Casualty Incident Education to Guide Disaster Responder Preparedness," and "Lessons Medical Disaster Response Learned from the Haiti Earthquake," at the 2014 Shanghai International Summit for Nursing, in Shanghai, China, October 15–17, 2014.

### Pomerleau presents

Mimi Pomerleau, RN, nurse practitioner, Obstetrics, presented, "Moving Best Practice to the Bedside—It's Up to All of Us!" at the Rhode Island Regional Perinatal Conference in Providence, Rhode Island, October 6, 2014.

### Que presents

Anne Que, RN, nurse anesthetist, Anesthesia, Critical Care and Pain Medicine, presented, "Medically-Challenging Case, Opioid Sparing Anesthetic for Patients at Risk for Opioid Abuse," at the annual meeting of the American Society of Anesthesiologists, in New Orleans, October 11–15, 2014.

### Callahan presents

Janet Callahan, PT, physical therapist, presented, "Expanding Neurologic Expertise: Advanced Practice in Vestibular Physical Therapy," and "The Eyes Have it: Diagnostic Utility of the Oculomotor Examination," at the American Physical Therapy Association of Massachusetts conference, November 1–2, 2014.

### Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, presented, "Innovations Across the Continuum of Pain Care," and "Patients with Chronic Pain and Substance Abuse: a Needs-Based Approach," at the Licensing and Regulatory Affairs Conference on Pain in Novi, Michigan, November 12, 2014.

### Goldsmith and Roe present

Tessa Goldsmith, CCC-SLP, speech-language pathologist, and Justin Roe presented, "Human Papilloma Virus in Head & Neck Cancer—Changing Demographics and Challenges in Dysphagia Management," at the 2014 annual convention of the American Speech-Language-Hearing Association, in Orlando, Florida, November 20, 2014.

### Whitney presents

Associate chief nurse, Kevin Whitney, RN, presented, "Patient-Centered Care," at the Patient-Centered Care: a Strategic Imperative panel series, at the American College of Healthcare Executives of Massachusetts, November 12, 2014.

### O'Brien presents

Mary O'Brien, RN, professional development specialist, presented, "The Winds of Grace are Always Blowing.. One Nurse's Journey as a First Responder," at the Nurses as First Responders: What Does the Evidence Tell Us? Nursing Research Conference at Newport Hospital in Newport, Rhode Island, November 6, 2014.

### Speech-language pathologists present

Rebecca Inzana, CCC-SLP; Mary Riotte, CCC-SLP; and Meredith O'Dea, CCC-SLP, presented, "Utilizing Advanced Simulation and Electronic Health Records in Inter-Professional Education," at the 2014 annual convention of the American Speech-Language-Hearing Association, in Orlando, Florida, November 20, 2014.

### Inter-disciplinary team presents

Rebecca Inzana, CCC-SLP; Caitlin Fitzgerald, PT; Mary Everson, OTR/L; Meredith O'Dea, CCC-SLP; and Trisha Zeytoonjian, RN, presented, "A Collaborative Inter-Professional Clinical Education Model to Improve Compassionate Team-Based Care," at the Conference for Advancing Compassionate Care Through Inter-Professional Education for Collaborative Practice at the Schwartz Center Arnold P. Gold Foundation and Macy Foundation, in Atlanta, in October, 2014.

## Professional Achievements (continued)

### Sullivan presents

Stacey Sullivan, CCC-SLP, speech-language pathologist, presented, "Medication Considerations: a Working Knowledge of Pharmacology for the Medical SLP," at the 2014 annual convention of the American Speech-Language-Hearing Association, in Orlando, Florida, November 22, 2014.

### Inter-disciplinary team publishes

Hani Abujudeh, MD; Shima Aran, MD; Laleh Daftari Besheli, MD; Karen Miguel, RN; Elkan Halpern, and James Thrall, MD, authored the article, "Outpatient Falls Prevention Program Outcome: an Increase, a Plateau, and a Decrease in Incident Reports," in *AJR (American Journal of Roentgenology)* in September 2014.

### Tremblay presents poster

Speech-language pathologist, Sarah Tremblay, CCC-SLP, presented her poster, "Sharing Practices Across Cultures: Model of Collaboration in Ecuador for Children with Feeding and Swallowing Disorders," at the 2014 annual convention of the American Speech-Language-Hearing Association, in Orlando, Florida, November 20, 2014.

### Speech-language pathologists present

Speech-language pathologists, Carmen Vega-Barachowitz, CCC-SLP; Dee Adams Nikjeh, CCC-SLP; Robert Fifer, CCC-A; and Marie Ireland, presented, "Ask the Experts About Audiology and SLP Billing, Coding, and Documentation," at the 2014 annual convention of the American Speech-Language-Hearing Association, in Orlando, Florida, November 20, 2014.

### Scott publishes

Chaplain, Katrina Scott, authored the chapter, "On Thinking About an Advance Care Directive," in *Everyday Humanism*, released in October, 2014.

### SLPs present poster

Speech-language pathologists, Maggie Balz, CCC-SLP, and Delphine Herrmann, CCC-SLP, presented their poster, "Facebook Jeopardy, Texting and Ordering Coffee: Applying Evidence-Based Practice to Outpatient Aphasia Groups," at the 2014 annual convention of the American Speech-Language-Hearing Association, in Orlando, Florida, November 20, 2014.

### Inter-disciplinary team publishes

Jarone Lee, MD; Lucy Willis, MD; David Newman, MD; Alberto Hazan, MD; Aileen Kurobe; Lorraine Giordano, MD; Haytham Kaafarani, MD; Caitlin Laidlaw, LICSW; and Kaushal Shah, MD, authored the article, "Are Sexual Assault Victims Presenting to the Emergency Department in a Timely Manner?" in the November 6, 2014, issue of *Social Work*.

### Speech-language pathologists present

Speech-language pathologists, Carmen Vega-Barachowitz, CCC-SLP; Dee Adams Nikjeh, CCC-SLP; Denise Dougherty, CCC-SLP; Timothy Weise, CCC-SLP; and Katie Holterman, CCC-SLP, presented, "The Amazing Race: Staying Ahead of Coding and Reimbursement Changes," at the 2014 annual convention of the American Speech-Language-Hearing Association, in Orlando, Florida, November 20, 2014.

### Berrett-Abebe and Convery publish

Social workers, Julie Berrett-Abebe, LICSW, and Mary Susan Convery, LICSW, authored the chapter, "The Power of Presence: Finding Hope in an Oncology Group Setting," in *Hope Matters: The Power of Social Work*, released in September, 2014.

### Inter-disciplinary team publishes

Elizabeth Speakman, LICSW; Ruth Paris; Marie Elena Gioiella, LICSW, and Jeanne Hathaway, MD, authored the article, "I Didn't Fight for My Life to be Treated Like This!: the Relationship Between the Experience of Cancer and Intimate Partner Abuse," in *Health Social Work*, December 1, 2014.

### Clinical Recognition Program

Clinicians Recognized  
August 1–December 1, 2014

#### Advanced Clinicians:

- Lore Innamorati, RN, General Medicine
- Carolyn McDonald, RN, Neuroscience
- Jesse MacKinnon, RN, Oncology
- Megan Keating, RN, Respiratory Acute Care Unit
- Maria Vareschi, RN, Emergency Department

#### Clinical Scholars:

- Carolyn LaVita, RRT, Respiratory Therapy
- Michael Tady, RN, Medical ICU

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#### Next Publication

January 22, 2015

# Announcements

## Voices of MGH

The new book, *Voices of the Massachusetts General Hospital 1950–2000: Wit, Wisdom and Untold Tales*, is a compilation of humorous and serious quotes, sayings, words of advice, and anecdotes from more than 100 MGH nurses and physicians over the years.

The 170-page, hardcover book, complete with historical photographs and references is now available in the MGH Gift Shop, on Amazon, at Barnes & Noble, and as an e-book.

For more information, call Colleen Marshall at 617-726-0275.

## Second annual Service Excellence Awards

Nominations are now being accepted for MGH Service Excellence Awards.

Awards recognize achievement in improving survey results, and outstanding performance by teams and leaders to provide or inspire outstanding service.

All departments, practices, and units are eligible.

Nominations must be received by Friday, December 19, 2014. Award ceremony will be held in April.

For more information, contact Beth Scott at 617-726-0343.

## Senior HealthWISE events

All events are free for seniors 60 and older

"Understanding Alzheimer's"  
Thursday, December 18th  
11:00am–12:00pm  
Haber Conference Room

Speaker: Fadi Ramadan, MD,  
Geriatric Medicine

For information on any of the above events, call 4-6756.

## Save the Dates

### Local NENIC educational events

February 10, 2015  
5:30–7:30pm

"New Nursing Informatics Scope and Standards of Practice" presented by, Paulette Fraser RN, ANA Scope and Standards Revision Workgroup member; Nursing Informatics Specialist, Dartmouth Hitchcock

April 30, 2015  
8:00am–4:00pm

"Trends in Clinical Informatics: a Nursing Perspective"

To register or submit an abstract about practice innovation or informatics research, go to: <http://www.nenic.org>.

For more information, contact Mary Kennedy, RN, at [program@nenic.org](mailto:program@nenic.org); or Joanna Jung, RN, at 617-549-2812.

## Celebration of life planned for Patti McNamara

The MGH community mourns the loss of colleague, Patricia McNamara, RN, who passed away suddenly, December 4, 2014. A graduate of Saint Elizabeth's School of Nursing and Northeastern University, McNamara worked as a registered nurse for 31 years at MGH, most recently in the GI Endoscopy unit. McNamara had a passion for life and nursing; she will be greatly missed.

A celebration of life is planned for after the first of the year. For information, call Marion Freehan, RN, at 6-8955.

## PhD in Rehabilitation Sciences at IHP

The PhD in Rehabilitation Sciences at the MGH IHP is designed for clinically certified/licensed healthcare professionals in Physical Therapy, Occupational Therapy, Speech-Language Pathology, Rehabilitation Nursing, and Physical Medicine and Rehabilitation who want to acquire advanced knowledge to conduct clinical research with an emphasis on assessing clinical outcomes in rehabilitation.

Funding to cover most of the program cost is available for up to six qualified candidates.

For more information, call 617-726-0685.

## Yvonne L. Munn Post-Doctoral Fellowship in Nursing Research

now accepting applications

The Munn Doctoral Fellowship is now seeking applications from both pre-doctoral nurse candidates (PhD(c)) and post-doctoral, PhD-prepared nurses actively advancing a program of research and related scholarship. Fellowship supports hours of practice time to give fellows the opportunity to achieve a research outcome. At the end of the fellowship, the pre-doctoral fellow is required to have a completed research study that meets the requirements of his/her doctoral studies, a manuscript for publication, and present the study to the MGH nursing community. The post-doctoral fellow will submit a grant application for internal/external funding.

Concept paper is due January 9, 2015;  
final application is due February 6, 2015.

For more information, call Mandi Coakley, RN, at 617-726-5334, or Peggy Settle, RN, at 617-726-9340.



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