

Caring

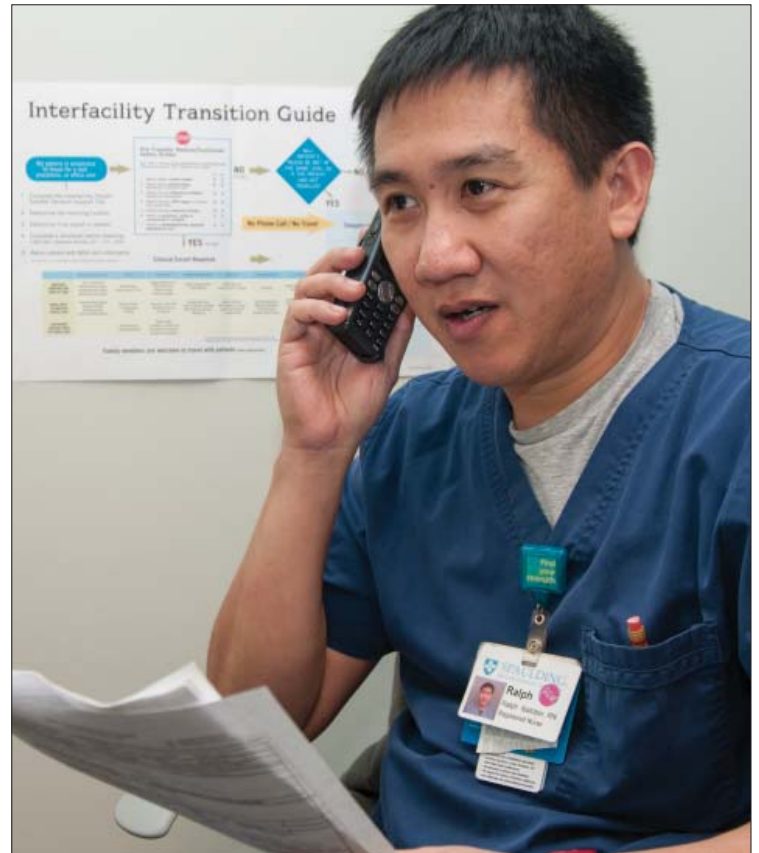
Headlines

January 23, 2014

The Safe Patient Hand-Over Summit

*Enhancing communication, improving patient care:
a collaborative approach to hand-overs with outlying hospitals*

(See story on page 4)



Above left: MGH staff technologist and officer of the day, Jennifer Riley, RTR, fields call from referring hospital.
At right, Spaulding Rehabilitation Hospital charge nurse Ralph Ibalabor, RN, speaks directly with clinician at MGH about impending transfer.

Staff perceptions of the professional practice environment

A good-news story in a year of unprecedented change

The survey, which has been revised over the years to remain relevant as our environment evolves, is one of the most important tools we have to evaluate staff satisfaction, identify opportunities to improve the practice environment, and craft strategies to implement those improvements.

Many PCS clinicians have worked at MGH long enough to remember the first time the Staff Perceptions of the Professional Practice Environment Survey was conducted in 1999. The survey, which has been revised over the years to remain relevant as our environment evolves, is one of the most important tools we have to evaluate staff satisfaction, identify opportunities to improve the practice environment, and craft strategies to implement those improvements.

The Staff Perceptions Survey is designed to measure specific characteristics considered to be essential components of professional practice and crucial to attracting and retaining exceptional clinical staff (the cornerstone of any Magnet hospital). Those characteristics are:

- Autonomy/Leadership
- Clinician/MD Relations
- Control over Practice
- Communication regarding Patients
- Teamwork
- Handling Disagreement and Conflict
- Internal Work Motivation
- Cultural Sensitivity

And one additional question was included to assess staff's overall satisfaction with their professional practice environment.



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

The survey was administered again in 2013, and I'm happy to report that, overall, scores reflected either a slight increase or no change in each of the characteristics listed above. Teamwork showed the greatest increase with a 0.9 gain over 2011 scores. And 86% of respondents reported being satisfied or very satisfied working at MGH.

Of the 4,334 clinicians eligible to participate in the survey (all professional staff throughout Patient Care Services, including nurses practicing in the ambulatory setting), 1,834 actually completed it, which represents a 42.3% response rate. When I think of the eventful year we had—rolling out Innovation Units, participating in care re-design, gearing up for Partners eCare, and welcoming new members to the PCS leadership team—I'm impressed that the response rate was as high as it was, and heartened that the results were so positive. It says a lot about the strength and resiliency of our workforce and about our commitment to Excellence Every Day.

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The results of the survey have been compiled and disseminated with unit- and department-specific summaries. My hope is that staff and leadership will review the results together, celebrate your positive outcomes, and engage in meaningful dialogue about how to address issues specific to your area.

More than just evaluating satisfaction, the Staff Perceptions Survey gives us important feedback that we can use to identify shortcomings, set new goals, and actively work to improve the practice environment. That process has already begun with thoughtful comments provided by staff in the survey. Comments like:

The relationship between nurses, physical therapists, and occupational therapists has improved over the years. We have an excellent work environment that supports teamwork and camaraderie.

Practice on my unit has improved substantially over the past year, a direct result of better staffing levels and leadership working hard to promote teamwork.

Working at MGH has given me the incentive to consider going back to school.

Positive feedback is always welcome and very gratifying, but often the best opportunities for improvement come from constructive observations about what we could be doing better. Comments like:

Professional practice on my unit is hindered by too many e-mails.

So many changes are happening all at once, I fear something will slip through the cracks.

Following the Marathon bombings, staff wanted to be involved, informed; I think leadership could have done a better job of sharing information.

This is great feedback, and I appreciate the honesty and candor of staff who took the time to share their thoughts. This allows us to address these important concerns and share the solutions with others who may have similar issues on their units. For instance, we're in the process of developing an e-mail 'tips slip' with suggestions on how to use and manage your e-mail account

to minimize unnecessary e-mails. Watch future issues of *Caring Headlines* for details. We launched our Innovation Unit initiative precisely to *keep* things from slipping through the cracks. We're monitoring that work very closely and re-designing systems in a timely fashion to ensure patient and staff safety. And yes, the Marathon bombings shed light on the need for a more comprehensive emergency communication system, which is why MGH has implemented the new Employee Alert System (see the November 7, 2013, *Caring Headlines* for details). I encourage everyone to register for this service at www.notifind.net/NF_SUBSCRIBE, or call David Reisman for more information (4-4163).

The results of the survey have been compiled and disseminated with unit- and department-specific summaries. My hope is that staff and leadership will review the results together, celebrate your positive outcomes, and engage in meaningful dialogue about how to address issues specific to your area. As in the past, I'll be sharing the results of the survey in a number of forums. I look forward to hearing your ideas and the fruits of your own discussions as we continue to craft solutions.

I'd like to thank Dorothy Jones, RN; Mary Duffy, RN; and staff of The Yvonne Munn Center for Nursing Research for their work in preparing, administering, and compiling the results of the survey; and Gaurdia Banister, RN, and Marianne Ditomassi, RN, for critically reviewing the executive summary.

Responses to the Staff Perceptions of the Professional Practice Environment Survey provide powerful data if we use the information the way it was intended. The power lies not in what we *learn* from the data, but in what we *do* with that knowledge.

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The Safe Patient Hand-Over Summit

—by Shawn Bonk; Karen Miguel, RN; and John Murphy, RN

Attendees of the first Safe Patient Hand-Over Summit, held at Spaulding Rehabilitation Hospital in Charlestown.

On December 12, 2013, clinical leaders from 25 rehabilitation, skilled nursing, and long-term care facilities came together at the Charlestown campus of Spaulding Rehabilitation Hospital to participate in the first Safe Patient Hand-Over Summit. The goal

of the summit was to share a collaborative approach for transferring patients from outside facilities to the acute-care setting for same-day visits, tests, and procedures. The new hand-over process, devised by staff from MGH and the Spaulding Hospital Network (SHN), is intended to ensure a safe, consistent, informed transition from one facility to the other.

Karen Miguel, RN, imaging patient safety officer, facilitated the event, underscoring the need for an

improved hand-over process. Using interactive audience-response devices, Miguel polled participants to assess the efficiency and thoroughness of current hand-over practices. Attendees confirmed that the hand-over process between facilities leaves room for improvement. More than 65% of staff from outside facilities reported that nurse-to-nurse or clinician-to-clinician hand-overs are not the norm for their patient transfers. When you consider that as many as 350 patients are transferred from outside facilities to acute-care hospitals each week, the need for a safe, standardized hand-over process is evident.

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(Photos by Paul Batista)

Safety (continued)

There was unanimous buy-in that implementing a standardized process for transitioning patients between facilities is in the best interest of patients, patient-safety, and our ability to deliver seamless, high-quality care.

Nancy Schmidt, senior vice president for Referral Relations and Network Development, Partners Continuing Care, described the efforts Partners Continuing Care is making to enhance safe transitions. Terrence O'Malley, MD, medical director for Non Acute Spaulding Hospital Network, outlined statewide initiatives for improving patient hand-overs, including an information network that healthcare providers will soon be able to access to securely send patient information.

Robert Kacmarek, RRT, director, MGH Respiratory Care Services, highlighted elements of the program developed by MGH and SHN to support safely transitioning patients to other facilities and back again on the same day. He talked about www.safepatienttransfers.org, a website that explains the process for safely transitioning patients to acute-care facilities.

The day concluded with an interactive panel discussion facilitated by John Murphy, RN, staff specialist, MGH Center for Quality & Safety. Panelists, David Shahian, MD, vice president, MGH Center for Quality & Safety; Lee Ann Tata, RN, MGH nursing director; Genevieve Conlin, RN, director of Nursing,

Spaulding Rehabilitation Hospital, Boston; Joanne Fucile, RN, vice president of Hospital Operations and director of Nursing, Spaulding Rehabilitation Hospital, Cambridge; Sean Kukauskas, NREMT-P, director of Ambulance Services, Spaulding Rehabilitation Hospital; and Rachael McKenzie, RN, nursing director, MGH Case Management, fielded questions about their roles and what staff can do to help make this program a success.

Staff at outlying facilities were encouraged to contact members of the Safe Patient Transport Team at either MGH or SHN for more information about the program. Members of the Safe Patient Transport Team are available to visit facilities to share more information about this innovative approach to transferring patients safely between facilities.

There was unanimous buy-in from attendees that implementing a standardized process for transitioning patients between facilities is in the best interest of patients, patient-safety, and our ability to deliver seamless, high-quality care. For more information about the first Safe Patient Hand-Over Summit, call John Murphy, RN, at 617-726-7997.



(L-r): presenters, Terrence O'Malley, MD, medical director for Non Acute Spaulding Hospital Network; Nancy Schmidt, senior vice president for Referral Relations and Network Development, Partners Continuing Care; and Bob Kacmarek, RRT, director, MGH Respiratory Care Services.

Vigilant, non-judgmental care helps earn trust of complex medical patient

My name is Amy Lizotte, and I am a staff nurse on the Bigelow 11 Medical Unit. I recently took care of 'Patrick,' a 32-year-old man with a history of substance abuse. In the hand-over communication from the transferring nurse, I learned that Patrick was being admitted with right-sided flank and scrotal pain, dysuria (painful urination), and nausea. I was told that he had been using the bathroom frequently and was requiring pain medication. Before a patient even arrives on the unit, I begin to think about their potential needs. I collaborated with the resource nurse to have his bed placed close to the bathroom thinking this would help preserve his independence and also maintain a safe environment while he was on pain medication.

When Patrick arrived, he was sleepy and lethargic. I had to shout his name and jostle him to get him to open his eyes. Even then, he fell asleep during our conversation, and he was unable to sit up. I knew this represented an acute change from what the transferring nurse had described. My first thought was that he might be over-medicated, but I wanted to rule out other possibilities. I checked his vital signs. He was lethargic but rousable and oriented. I checked his oxygen saturation, which was normal. The chances of a stroke were low because his strength was equal in all extremities, he was able to follow commands, and his speech was clear. Hypoglycemia could cause lethargy, but his glucose level was normal, and he had no history of diabetes. I discussed my assess-

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Amy Lizotte, RN, staff nurse, Bigelow 11 Medical Unit

ment with the doctor who agreed that Patrick was over-medicated.

I saw that Patrick had received IV Dilaudid for pain and Ativan for nausea. Drowsiness is a common side-effect of both medications, so pain medication was high on my list of possible causes for Patrick's change in mental status. Individually these medications can lead to hypoxia (oxygen deprivation), and that effect can be increased when the medications are combined. I did a full medication review and double-checked the dose and time the medications had been administered. Based on his appearance and the known side-effects of the medications, I knew the combination and amount of medication he'd received was too much for him. Our goal for Patrick needed to be controlling his pain while minimizing sedation and avoiding hypoxia. I discussed with the intern changing his medications to lower doses that would still control his pain but not make him so lethargic. And I suggested continuous oxygen-saturation monitoring to watch his respiratory status.

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Sometimes, patients who seem to have a straight-forward diagnosis become more complex when we look holistically at their needs... I feel I set a foundation for Patrick's hospital stay that kept the perspective on him as a whole person rather than as a 'routine admission.'

Seeing that Patrick was unable to sit up without support, I knew he was at high risk for falling, so I initiated LEAF fall precautions (continually re-orient him to his surroundings, keep the call bell within reach, make sure the room is clutter-free, and maintain a safe environment). For added safety, I activated the bed alarm. I made Patrick aware of this and explained why I felt it was necessary. I didn't want to embarrass him or lose his trust over a bed alarm. I set up an hourly toileting schedule until his mental status improved.

As Patrick became more awake, he was able to communicate his pain level. I knew I had to ask him about his substance abuse because patients with a history of substance abuse can have a higher tolerance to pain medication, and that can affect correct dosing. It was an important question, but it could be risky; I didn't want to lose the trust we'd established.

I tried to make the conversation non-judgmental, emphasizing my need to know to ensure he received the proper pain medication. Patrick reported that he used marijuana on a daily basis and cocaine two or three times a week. I think because of the trust we'd established, Patrick felt comfortable talking about his history and didn't feel he had to deny or hide anything.

When the intern returned to assess him, Patrick clenched his side and moaned in pain. He rated his pain as 10/10. The intern and I discussed appropriate medications and dosing, and I requested an order for a consult with Pain Management since they're experts in pain and substance abuse. Because of the possibility of enabling his addiction, we discussed alternate therapies such as heat and relaxation. Patrick wasn't receptive to these approaches so rather than force them, I tried distraction. I engaged him in a conversation about his work and hobbies to get to know him as a person. He became more relaxed and didn't have as much pain during this interaction.

It was later determined that Patrick may have a kidney stone. I knew that meant he'd need to be hydrated with intravenous (IV) fluids so I made the necessary arrangements to prepare. I also suggested that the doctor have his urine strained to collect the kidney stone.

While continuing to focus on his acute medical issues and while Patrick was taking pain medication, I wanted to avoid the common side-effect of constipation, so I discussed initiating a bowel regimen as a preventive measure. I educated Patrick about the process and knew this would need to be continually assessed while he was on pain medications.

Patrick reported that he was a half-pack-per-day smoker on top of his marijuana use. I informed him of the hospi-

tal's policy on smoking and asked if he had any cigarettes he'd like secured. For some patients, it's difficult to stop smoking while in the hospital. Patrick said he'd be willing to wear a nicotine patch so I collaborated with the doctor to order the patch as a standing order, and I placed an order with the Smoking Cessation Program to talk with Patrick.

Throughout my interactions with Patrick I assessed his home support. I knew he'd need a good support system to quit smoking and using recreational drugs. He insisted his drug use was not negatively impacting his life. I knew he wasn't ready to quit but offered to contact the hospital's addiction service or a social worker if he changed his mind. He was happy to talk with me and hear about options, but he refused the consult, and I respected his wishes. I documented the talk in my nursing notes.

Patrick was worried about missing work. With his permission, I called his boss and informed her that Patrick would not be in and gave her a brief explanation (protecting his confidentiality). I could tell he was relieved to have this taken care of, and I was glad he trusted me enough to make the call.

Sometimes, patients who seem to have a straight-forward diagnosis become more complex when we look holistically at their needs. Patients with substance abuse can be especially challenging because we may not be able to fix their addiction problem, but we have to address their history to ensure a safe and effective treatment plan. I feel I set a foundation for Patrick's hospital stay that kept the perspective on him as a whole person rather than a 'routine admission.' I know I helped facilitate a positive environment for him and established a feeling of trust, which may have been what he needed to realize the seriousness of his addiction and its potential effect on his health.

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

Amy describes the intricate planning and critical thinking that go into caring for a seemingly 'routine' medical patient. Identifying the cause of Patrick's status change; managing his pain while taking into account his history of substance abuse; and perhaps most important, establishing trust, enabled the team to keep Patrick safe and maintain his confidence in their ability to care for him. This narrative beautifully captures the vigilance, intuition, and attention to nuance necessary to care for a complex medical patient.

Thank-you, Amy.

A 13-year-old boy, a generous gift, and a lesson about what it means to become a man

—by Jamie Rossi, CCLS, child life specialist

Elliot O'Malley is a 13-year-old boy who has come to MGH for numerous outpatient procedures over the years, all of which required general anesthesia. This was a frightening prospect for Elliot, so as time went on, his care team devised a number of coping mechanisms to help allay his anxiety. One intervention that really helped was the iPad. A grateful family had donated one to our unit, and Elliot enjoyed using it while waiting in the holding area. He'd even bring it into the procedure room to help him through the anesthesia-induction process. The iPad helped Elliot take his mind off of his immediate surroundings and distracted him while his parents spoke with doctors and took care of necessary paperwork.

Recently, Elliot returned to MGH, but not for an outpatient procedure. He came to donate two iPads to the Pediatric Endoscopy Unit in honor of child life specialist, Jamie Rossi, CCLS, and GI physician, Aubrey Katz, MD.

Elliot had received some money for his Bar Mitzvah and decided to use the money to buy iPads so that other children who come in for procedures would be able to enjoy them the way he had. The entire team was impressed by his kind and generous gesture.

According to Jewish tradition, a Bar Mitzvah is when a young boy becomes a man. Judging by Elliot's actions, he has indeed grown into a fine young man. I'm proud to have been his child life specialist for the past few years.

For more information about Pediatric Endoscopy, or this generous donation, call 617-643-9276.

Below left: Elliot O'Malley is pictured with his parents (back row, second and fourth from left) child life specialist, Jamie Rossi, CCLS (front row, headband); and staff of the Pediatric Endoscopy Unit
At right Elliot poses with Aubrey Katz, MD



(Photos by Walter Reeves)

The synergy between care re-design and Innovation Units

What we're learning is that as we improve access, reduce direct patient-care costs, and improve patient flow, we're discovering synergy between our care re-design efforts and the work taking place on Innovation Units.

Question: The December 19, 2013, issue of *Caring Headlines* provided extensive coverage of the work being conducted on Innovation Units and the associated outcomes. Can you share the related work being done by care re-design teams?

Jeanette: In 2010, Partners launched a comprehensive, strategic re-design process to position Partners HealthCare to succeed amid a challenging economic climate. The care re-design process is a multi-disciplinary undertaking that maps out current processes of care-delivery and recommends more efficient approaches, especially related to specific health conditions or procedures. The goal is to deliver more integrated, patient- and family-centered care by focusing on discrete conditions and episodes.

Question: What is the current focus of care re-design teams?

Jeanette: A number of care re-design efforts are under way looking at chronic obstructive pulmonary disease (COPD), neonatal care in the NICU, inpatient psychiatry, rheumatoid arthritis, and back pain. These teams were formed in April of 2012, and their work is still on-going. New teams were subsequently added to focus on breast cancer, heart failure, pain-management, kidney stones, and reducing the rate of re-admissions.

Question: There's a lot of discussion around re-admissions. What is the focus of that group?

Jeanette: With nearly all clinical departments working to reduce re-admissions, the new re-admission reduction team will build on those efforts to identify and test inpatient re-admission interventions. Three disease-specific task forces have been developed to reduce re-admissions among acute myocardial infarction, heart-failure, and pneumonia patients (these groups are a focus of the CMS re-admission reduction program).

Question: The principles and work associated with care re-design and the Innovation Units appear to be similar.

Jeanette: In my recent column describing work on Innovation Units, I mentioned how we, "learn by doing." What we're learning is that as we improve access, reduce direct patient-care costs, and improve patient flow, we're discovering synergy between our care re-design efforts and the work taking place on Innovation Units. The innovation work on White and Ellison 6 and the Arthroplasty Care Re-Design Team are a great example of how both help improve the patient experience. Going forward, it makes sense to think of these as one effort, working toward a common goal to improve the care we provide.

Announcements

MGH School of Nursing alumna passes away

The MGH community was saddened to learn of the passing of Alice Friedman, RN, an alumna of the MGH School of Nursing. Friedman passed away peacefully, January 14, 2014, at the age of 91.

Friedman was proud of her MGH roots; she was one of the first nurses to advocate for benefits and improved working conditions for nurses.

She will be missed.

The Doane Fund

Subsidized assisted living for retired nurses and others in nursing-related careers

Financial assistance is available through the Doane Fund to individuals who may be candidates for assisted living who meet the following criteria:

- retired nurses or other professionals who have served in nursing-related careers
- lived in greater Boston during part of their nursing career
- served in this caregiver or nursing-related role for ten years in Boston

For more information, contact Lance Chapman at 617-731-8500; extension 105 or lchapman@goddardhouse.org

Blum Center Events

National Health Observances: "Glaucoma"

Wednesday, January 29th
Learn more about glaucoma-prevention and treatment with Edward M. Barnett, MD.

Programs are free and open to MGH staff and patients. No registration required.

All sessions held in the Blum Patient & Family Learning Center from 12:00–1:00pm.

For more information, call 4-3823.

Senior HealthWISE events

All events are free for seniors 60 and older

"Understanding Normal Memory Changes and Dementia"

Thursday, January 23rd
11:00am–12:00pm
Haber Conference Room, MGH
Speaker: Fadi Ramadan, MD, Geriatric Medicine

Special Event:
"Tips for Successful Aging"

Monday, January 27th
11:00am–12:00pm
O'Keeffe Auditorium
Speaker: Ann Webster, director of the Mind Body for Successful Aging and the Mind Body Program for Cancer at the Benson-Henry Institute for Mind Body Medicine

"The Fruit of our Losses: Growing through Grief Work"

Thursday, February 6th
11:00am–12:00pm
Haber Conference Room
Speaker: Robert Weber, assistant clinical professor of Psychology, Harvard Medical School

For more information, call 4-6756.

One-stop intranet site for strategic priorities

Want to know more about the Partners-MGH patient care re-design, patient affordability, and budget review initiatives? Wondering about the time line?

To read the latest articles about this work, or if you have a cost-reduction idea or better way to deliver patient care, visit the new MGH/MGPO intranet site:

<http://priorities.massgeneral.org>.

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.

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/>.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services.

Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

New hours for Interpreter Services

To better serve patients and families, Medical Interpreter Services (main campus) is announcing new office hours. Effective immediately:

Spanish interpreters are available on-site Monday through Friday, 6:00am–8:00pm; (other languages may vary)
Spanish interpreters are available on-site Saturdays and Sundays, 8:00am–6:30pm

Access to remote telephonic interpreting in more than 200 languages is available around the clock wherever there is access to IPOP, VPOP or hospital telephone.

For more information, call 6-6966.

Professional Achievements

Tan certified

Lena Tan, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in November, 2013.

Nagle certified

Tanya Nagle, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in December, 2013.

Picillo certified

Mia Picillo, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in December, 2013.

Perch certified

Katherine Perch, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in November, 2013.

Olsen certified

Kathy Olsen, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in December, 2013.

Sarnia certified

Rosemary Sarnia, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in December, 2013.

Iacomini appointed

Marisa Iacomini, LICSW, social worker, was appointed a member of the Board of Directors of the Massachusetts Maternity and Foundling Hospital, in December, 2013.

Pengal certified

Christina Pengal, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in December, 2013.

Keating presents poster

Megan Keating, RN, staff nurse, presented her poster, "The Delicate Dance That is The Art of Nursing," at the 42nd biennial convention of Sigma Theta Tau International, in Indianapolis, Indiana, November 16–20, 2013.

Oldford certified

Elizabeth Oldford, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in December, 2013.

Inter-disciplinary team presents poster

Reverend Angelika Zollfrank; Michael Balboni; Adam Sullivan; and Tracy Balboni, MD, presented their poster, "Is Spiritual Care from Nurses and Physicians Appropriate at the End of Life? Predictors for Attitudes of Appropriateness Among Patients, Nurses, and Physicians," at the annual meeting of the American Society for Bioethics and Humanities, in Atlanta, Georgia, October 25 and 26, 2013.

Carroll publishes

Diane Carroll, RN, nurse researcher, authored the article, "The Effects of Intensive-Care-Unit Environments on Nurse Perception of Family Presence During Resuscitation and Invasive Procedures," in a recent issue of *Dimensions of Critical Care Nursing*.

Murphy certified

Suzanne Murphy, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in November, 2013.

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

Next Publication

February 6, 2014



MASSACHUSETTS GENERAL HOSPITAL

Johnathon Holmes, Nursing Student,
SPEAKS UP
for good hand hygiene

Jeanette Ives Erickson, RN, Senior Vice President for Patient Care Services and Chief Nurse, admires Holmes for his willingness to remind everyone to use Cal Stat before approaching patients – even when a reminder isn't needed.

EXCELLENCE EVERY DAY

A message brought to you by the **STOP** (Stop the Transmission of Pathogens) Task Force.

Speak Up!

See something, say something

Clean hands can help stop the spread of germs and reduce the risk of infection. Clean hands are especially important in the hospital setting. MGH is committed to achieving excellence in hand hygiene through vigilance and collaborative practice.

At MGH, healthcare workers are required to use Cal Stat, an alcohol-based hand sanitizer, before and after contact with patients or patients' environments. Patients, families, and visitors are encouraged to do the same, and sometimes a polite reminder is appreciated.

Help spread the message. Speak up for hand hygiene and promote Excellence Every Day.

At left: Johnathon Holmes, IHP nursing student, reminds visitors and colleagues to use Cal Stat before approaching patients. Jeanette Ives Erickson, RN, senior vice president for Patient Care, commends Holmes for his willingness to act as a patient safety advocate.

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