

Caring

Headlines

July 3, 2014

The inaugural

Barbara A. Dunderdale

Lecture on the future of Nursing

See story on
page 4

Gwen Sherwood, RN, professor
and dean of Academic Affairs at the
University of North Carolina, Chapel
Hill, School of Nursing



Optimizing inpatient flow

looking at ways to reduce length of stay

Led by myself, Michael Jaff, DO, medical director of Care Re-Design, and Brit Nicholson, MD, senior vice president and chief medical officer, a hospital-wide initiative has been launched to try to optimize patient flow so we can continue to care for the patients who need our services most.

Throughout the hospital, many efforts are underway to make care safer, more efficient, more affordable, and more satisfying for patients and families. One area of focus that has emerged as we go about this work is a growing level of frustration among patients and referring physicians unable to access care at MGH due to our perpetually high occupancy rate. More and more, we're having to turn patients away because there's simply no room at the inn. That's bad for business and bad for patients. Led by myself, Michael Jaff, DO, director of Care Re-Design, and Brit Nicholson, MD, senior vice president and chief medical officer, a hospital-wide initiative has been launched to try to optimize patient flow so we can continue to care for the patients who need our services most.

We'll be looking at many factors that affect how patients progress through care at MGH, but certainly high on our list of issues to address will be length of stay, and specifically days spent in the hospital that could potentially be avoided. Reducing potentially avoidable days would go a long way toward decompressing patient census and opening up beds for new patients, transfers, and referrals.

As we look at length of stay by service or department, we see that certain patient populations are



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

more (or less) prone to exceed their expected length of stay. We calculate expected LOS using a risk-adjusted, population-based methodology based on a national database. The methodology uses diagnoses and demographic data to determine the expected LOS for each patient based on similar factors within the population.

Not surprisingly, medical, surgical, neurological, and neurosurgical patients tend to accrue the most number of potentially avoidable days, so that will be a good place for us to focus our efforts. We want patients to spend as much time as they need in the hospital—no more, no less. We also don't want to reduce length of stay at the expense of patient outcomes or quality of care, so we'll be monitoring re-admission rates to make sure the progress we're making is real.

continued on next page

Virtually every system in the hospital impacts length of stay—lab tests, patient transport, imaging, prescriptions, room-cleaning, everything. We are a more efficient hospital today than we have ever been, but we need to continue that work. We need your ideas and input as we try to responsibly achieve the perfect length of stay for each and every patient who comes through our doors.

Guardianship (most prevalent in the Neurology Service) is another factor that affects length of stay. Guardianship is a legal mechanism by which a guardian is appointed by the court to make decisions on behalf of patients who are deemed legally incapacitated. Though guardianship represents a small percentage of our patient population, it is a costly and time-consuming process that significantly affects length of stay. One solution we’re considering is having an advance-practice nurse dedicated exclusively to the paperwork and administrative tasks associated with guardianship, which would have a positive impact both on patient care and length of stay.

Discharge practices are another area we’ll be looking at. Currently, most patients are discharged after 2:00pm. Ideally, we’d like to discharge patients before 10:00am to make beds available for patients being admitted later in the day and to avoid that demanding overlap of patients coming and going at the same time. We’re working with physicians to try to arrange for prescriptions and discharge documentation to be completed the night before anticipated discharges. So there are a lot of opportunities to impact length of stay there.

In order to make any meaningful change, we have to be able to measure and track our progress. Toward that end, we’re developing a dashboard to reflect data collected throughout the hospital and help us visualize our results. Our goal is to reduce hospital-wide length of stay by 0.5 days and reduce potentially avoidable days by 25-50%. The length-of-stay dashboard will tell us how we’re doing in terms of achieving those goals and also track our pre-10:00am discharge success and 30-day re-admission rate.

Our efforts to reduce length of stay and free up beds so we can accommodate more patients will be an ongoing part of our work as we move forward. Virtually every system in the hospital impacts length of stay—lab tests, patient transport, imaging, prescriptions, room-cleaning, everything. We are a more efficient hospital today than we have ever been, but we need to continue that work. We need your ideas and input as we try to responsibly achieve the perfect length of stay for each and every patient who comes through our doors. And we want every patient who needs our help to be able to get through those doors and into a bed.

For more information about our efforts to optimize patient flow, or to make a suggestion, contact Erin Conklin, senior consultant, MGH Center for Quality & Safety, at 617-726-7806, or send e-mail to MGHLOS@partners.org.

In this Issue

The Inaugural Barbara A. Dunderdale Lecture on the Future of Nursing	1	Albert H. Brown Visiting Scholar.....	10
Jeanette Ives Erickson.....	2	Orren Carrere Fox Award.....	11
• Optimizing Inpatient Flow		Fielding the Issues	12-13
The Inaugural Barbara A. Dunderdale Lecture on the Future of Nursing	4	• National Patient Safety Goal #1	
Critical Care Nurse Residency Program	6-7	• Partners eCare Revenue Cycle Implementation	
Clinical Narrative	8-9	Announcements.....	14
• Reverend John Kearns		Professional Achievements.....	15
		HCAHPS.....	16

The inaugural Barbara A. Dunderdale Lecture on the Future of Nursing

If you were anywhere near O’Keeffe Auditorium at 1:30pm on June 5, 2014, you were feelin’ the love as the MGH community came together to celebrate the inaugural Barbara A. Dunderdale, RN, Lecture on the Future of Nursing. Some may know Dunderdale as an alumna of the MGH School of Nursing; others may remember her as a staff nurse, nursing director, mentor, or patient advocate; still others may know of her work with the Development Office where she’s raised millions of dollars to help advance the mission of MGH. What Dunderdale brought to all those roles was her passion for nursing, her passion for patient care, and her passion for MGH.

Barbara A. Dunderdale Day and Annual Lecture on the Future of Nursing was established as a way of thanking Dunderdale for her years of service and countless contributions over the decades. In her opening remarks, senior vice president for Patient Care, Jeanette Ives Erickson, RN, noted, “It’s so wonderful to come together to celebrate an extraordinary nursing career and honor the many patients Barbara has served. It doesn’t get any better than this.”

Ken Slater, who along with his wife and family was instrumental in creating this annual event, lent his voice to those singing Dunderdale’s praises. Said Slater, “We will always remember the name, Barbara Dunderdale. She doesn’t just inspire confidence, she *instills* it. Her sense of humor, energy, genuine concern, and caring nature make her an incredible wife, mother, grandmother, and most especially, nurse.”

Dunderdale took the podium to a roaring ovation. Clearly moved by the momentousness of the occasion, she said, “I believe nursing, the most trusted of professions, is the backbone of compassionate, highly skilled care. And I think the best is yet to come for nursing. It was truly my privilege to work with the finest nurses in the noblest profession. I learned from you that the patient is always first and foremost; that the little things count; that you can’t do it alone. I learned to lead with your mind and your heart; to have the courage to challenge the status quo; to take care of one another; and to let hope prevail.

“I’m grateful to the Slater family and their continued benevolence to the MGH community.” She went on to thank the many other individuals who helped establish the Dunderdale lectureship and the leadership of Patient Care Services and the department of Nursing, saying, “You’ve honored me and my colleagues in the Development Office whose work, like my fellow nurses, advances our mission every day.” In closing, she said, “I give thanks for this moment in time that I will cherish forever.”

continued on next page



Recognition/Celebration (continued)

Keynote speaker, Gwen Sherwood, RN, professor and associate dean of Academic Affairs at the University of North Carolina, Chapel Hill, School of Nursing, presented, “Integrating Quality and Safety Competencies to Improve Care Outcomes.” Sherwood set the stage for her talk with questions like, “How do we ensure that research and evidence get translated back to the bedside?” and “How do we inform, educate, and share what we learn so that communities of care are always on the leading edge of knowledge and understanding?”

Sherwood’s entire presentation was set against the backdrop of a case study involving the tragic death of 15-year-old, Lewis Blackman, who lost his life at a large teaching hospital following elective surgery because caregivers missed signs that he was slowly bleeding to death.

In the 15 years since the IOM Report, *To Err Is Human: Building a Safer Health System*, health care has made great progress in re-designing systems to be more transparent; in trying to prevent errors before they occur; and in learning from both good and bad experiences to improve the care and safety of patients and families. Said Sherwood, “High-reliability organizations are always thinking about where the next error is likely to occur.”

Sherwood spoke about the need to focus on:

- transforming education to transform practice
- transforming systems through a culture of patient safety
- transformational leadership

She identified core competencies, necessary to make quality and safety an integral part of nurses’ work:

- Patient-centered care
- Teamwork and collaboration
- Evidence-based practice
- Quality-improvement
- Safety
- Informatics

Tying her remarks back to the Lewis Blackman case, she stressed the need to always, always, always ask, “What else could it be?” and “Does this make sense?”

In closing she reminded staff that safety belongs to everyone; every micro-system must be aligned to support safety; and we can learn from every success and every failure. Sherwood thanked Dunderdale for helping us define the future of nursing, for being the kind of nurse that challenges and inspires us to always do better, and for leading the way to change the paradigm.



Critical Care Nurse Residency Program

—by Gail Alexander, RN, professional development specialist

Donahue reiterated that the role of the preceptor is key to the successful transition of nurse residents to confident, professional nurses. Said Donahue, “Make no mistake, the influence of the preceptor lasts well beyond the six-month orientation period.”

On June 16, 2014, senior vice president for Patient Care, Jeanette Ives Erickson, RN, welcomed friends, families, and colleagues to a celebration of the most recent graduating class of the Critical Care Nurse Residency Program. Ives Erickson congratulated nurse residents for meeting the rigorous demands of the program and applauded the support of their families and friends. She acknowledged the invaluable guidance of critical-care unit leadership and preceptors, without whom the program would not be possible. And she thanked the Knight Nursing Center for its contributions in ensuring the success of the program.

Nursing director, Vivian Donahue, RN, spoke about the influence the Critical Care Nurse Residency Program has had in the Cardiac and Cardiac Surgical ICUs. She identified the characteristics necessary to become a successful critical-care nurse as, resiliency, compassion, intelligence, and the ability to work under pressure as a member of a team. Donahue reiterated that the role of the preceptor is key to the successful transition of nurse residents to confident, professional nurses. Said Donahue, “Make no mistake, the influence of the preceptor lasts well beyond the six-month orientation period.”

Cardiac Surgical ICU critical-care nurse resident, Vanessa Poirier, RN, read a clinical narrative describing her care of a critically ill woman over three successive days. Poirier and her preceptor, Alyssa Vecchione, RN, answered questions about the narrative related to the three aspects of relationship-based care: relationship with self; relationship with

colleagues; and relationship with patients and families.

Poirier described how knowing her own strengths and limitations was important in terms of her ability to provide safe, high-quality care. As she said in her narrative, “I was nervous at first because as a new grad, you have moments when you ask yourself whether you can really handle this right now.” At the height of a very busy day, when her patient was becoming even more acutely ill, Poirier asked for a break to, “take a moment for myself.” According to the relationship-based-care model, self-knowledge and self-reflection are key elements in the ability to develop the resiliency necessary to foster a healthy relationship with self.

The teamwork aspect of relationship-based care focuses on shared purpose and principles. A pivotal relationship in the Critical Care Residency Program is the one between the resident and his/her preceptor. In her narrative, Poirier said, “I never felt alone.” Vecchione stressed the need for a team approach when caring for complex, critically ill patients, a lesson Poirier learned well. She recalled her thoughts when she asked for help once when preparing to participate in a life-saving procedure: “I kept hearing my preceptors voice in my head.” Vecchione described how she and Poirier developed trust over time and how that trust helped Poirier assume more and more responsibility throughout her residency.

As new nurses concentrate on integrating the new knowledge and skills required to work in an acute-care setting, they sometimes lose sight of the ‘human’ aspect of patient- and family-centered care. Vecchione described how she initially did all the

Education/Support (continued)

communicating with patients and families until Poirier had time to develop her own communication skills. Gradually, Vecchione drew Poirier into their interactions with patients and families.

Poirier shared that when she first started caring for patients post-operatively, she'd set an alarm to remind her to bring the family in to visit their loved one. She soon learned the importance of relationship-building: "I remember the first moment I was recognized for the care I gave as a nurse. More importantly, the moment I realized the impact I have, not only on the patients I care for, but their families, as well. For the past two months I'd been caught up in a world of tasks and check-boxes. I'd lost sight of why I love this job and the impact I have on patients. Mr. F and his family reminded me of that."

Gaurdia Bannister, RN, executive director for The Institute for Patient Care, and Gino Chisari, RN, director of The Norman Knight Nursing Center for Clinical and Professional Development,

presented certificates of completion to:

- Jennifer Berntsen, RN, Surgical ICU
- Mary Foley, RN, Medical ICU
- Jasmine Gonzalez, RN, Cardiac Surgical ICU
- Jennifer Heiden, RN, Surgical ICU
- Kara Murphy, RN, Neuroscience ICU
- Casey Paschal, RN, Blake 12 ICU
- Vanessa Poirier, RN, Cardiac Surgical SICU
- Neil Pratt, RN, Medical ICU
- Tania Santini, RN, Blake 12 ICU
- Megan Sullivan, RN, Medical ICU
- Kacie Nugent, RN, Neuroscience ICU
- Amanda Woitowicz, RN, Cardiac ICU

Since the inception of the Critical Care Nurse Residency Program in 2001, 200 nurses have completed the curriculum and begun careers at MGH. For more information about the Critical Care Nurse Residency Program, call Gino Chisari at 617-643-6530.

Photos clockwise from top left: (l-r): Gail Alexander, RN, CCRN Residency Program coordinator; preceptor; Alyssa Vecchione, RN; and nurse resident, Vanessa Poirier, RN. Group shot of critical-care nurse residents (l-r; front to back) are: Megan Sullivan, RN; Jennifer Heiden, RN; Jennifer Berntsen, RN; Kacie Nugent, RN; Amanda Woitowicz, RN; Casey Paschal, RN; Jasmine Gonzalez, RN; Mary Foley, RN; Neil Pratt, RN; Kara Murphy, RN; and Vanessa Poirier, RN. Nurse resident, Tania Santini, RN, is not pictured. Candid shot of nurse residents in the audience.



(Photos by Brian Wilson)

Chaplain guides family member on journey of spiritual discovery

Though very sick with a poor prognosis, Marie maintained hope through her faith in God. Even though I felt her belief in complete healing was unrealistic, I respected her choice to focus on hope and tailored my practice to support her.

“I’m sad because I’m powerless.” I first met Marie at the time of her cancer diagnosis when she requested a French-speaking chaplain. I found Marie to be a strong and determined woman who, through hard work and business expertise, had raised three sons and managed to send them to graduate school in the United States.

Though very sick with a poor prognosis, Marie maintained hope through her faith in God. She relied heavily on her prayer and the prayer of others.

Even though I felt her belief in complete healing was unrealistic and that some of the treatments she chose to pursue were excessive, I respected her choice to focus on hope and tailored my practice to support her. I found I was powerless to say or do anything that would change the course of her disease or the way in which she’d learned to cope with the challenges of life. In her powerlessness, I became more deeply aware of my own powerlessness and accepted her invitation to be a prayerful presence with her.

I found prayers in French that spoke directly to the spiritual struggles she was facing, such as suffering, loss of hope, and God’s love for her. I printed them out on cards accompanied by comforting images so she could use them as a source of spiritual strength and as witness to the prayer of others.

On the day she would die, I entered Marie’s room and slowly drew back the curtain. She lay still, un-



Reverend John Kearns
staff chaplain

der a white woven blanket that covered her up to her chin. Her moist skin shone as if her whole face had been anointed, her black and silver hair laid in neat rows of braids from her forehead to just behind her ears. On the couch, stretched out with the shades drawn, her daughter-in-law, Celine, slept curled up in a ball. Upon seeing them both asleep, I quietly sat and prayed.

It wasn’t long before Celine opened her eyes and sat up. I went over and sat next to her and we talked quietly. She told me she was sad because they were losing Marie. She was sad because Marie had suffered so much, for so long, and now was dying slowly. Celine told me that though her husband was Catholic, like Marie, she wasn’t. She was evangelical.

For Celine, however, her faith inspired her to be like Jesus. “When Jesus was with the sad; he was sad.

continued on next page

“What is your word for me from God?” Celine asked. “Powerlessness” I said. I felt as though I had disappointed her. “You told me earlier that Jesus was your teacher. When he was with the suffering, he suffered; with the sad, he was sad. When Jesus was with the powerless, he also was powerless.”

When Jesus was with the suffering, he suffered with them. When Jesus was with the joyful; he was joyful.” She wondered why God hadn’t answered her prayers like He had in the past. She began to sob, “I’m sad because I’m powerless. I can’t do anything to change this.”

“I can’t either,” I admitted.

Marie’s eyes opened, then closed, then opened again. They were darker, cloudier than before.

“Bonjour Marie.” I said.

“Bonjour Maman,” said Celine.

We went to her bedside and sat so we were as close to Marie as possible. I opened a French prayer book from which I had read on previous visits. She always requested prayer. I read Psalms 121 and 139 then wondered aloud if I should continue.

“Yes,” said Celine. “She loves prayer. She loves to be read to.”

We continued. Celine shared an experience from when she was younger. She had gone to seek counsel from a Catholic priest who didn’t have time to talk to her but gave her, “a word from God.” That word changed her life. She lamented that God was “turning his back” on her now. Why hadn’t He helped her? We explored why she thought God would turn away from someone who was calling out for help. She held out her arms with her palms facing upward modeling God’s posture of availability.

“What is your word for me from God?” Celine asked.

“Powerlessness” I said. I felt as though I had disappointed her. “You told me earlier that Jesus was your teacher. When he was with the suffering, he suffered; with the sad, he was sad. When Jesus was with the powerless, he also was powerless.”

Aware of the centrality of Jesus and his life to Celine’s faith, I shared images of his powerlessness in his own suffering, in his mother’s pain and suffering, in her presence with the Beloved disciple at the cross. What appeared to be the moment of greatest powerlessness for Jesus was the moment of God’s greatest power. I cited St. Paul’s description of the cross as, “a stumbling block” to non-believers, but not for we who believe. In this way, I joined with Celine in her experience of faith. We were believers together confronted by our own powerlessness before death.

I had to excuse myself to go to a meeting, but I told Celine I’d check in before leaving for the day.

Later, I received a page that Marie had died and the family would like me to visit. I felt a combination of sadness and relief. Marie lay still in bed. Celine stood next to her, crying, her husband, Marie’s son, nearby talking on a phone.

Celine came to me and sobbed on my shoulder. “I was powerless,” She said. “I’m so sad. My heart hurts.” She asked me to bless Marie. I got a cup of water and blessed it. I washed Marie’s face and head as I prayed: “Through the waters of baptism, Marie died with Christ and rose with him to new life. May she now share with Him, eternal glory.”

My blessing empowered Celine and her husband to do the same. Celine told Marie how much she loved her and that they would baptize their daughter Marie. Celine’s husband, took the water and with a simple cross on her forehead, thanked his mother, told her he loved her, and began to pray. I joined him in the Our Father and Hail Mary.

In a little while, Celine said, “I was powerless. I couldn’t save her.”

“You prayed with her all day,” I said. “The only thing she wanted was prayer. That’s all she ever wanted, and you did that. You were with her when she died. She wasn’t alone.”

Celine said, “Just before she died, she opened her eyes and looked at me. She took a deep breath and died.”

“It sounds like you were with her in her powerlessness,” I said.

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

For patients and families with a tradition of faith, illness can raise questions about the meaning of suffering. Reverend Kearns beautifully guided Celine on a journey of discovery within her own faith. He recognized that she needed to make sense of God’s will so that she and her family could find solace as they grieved the loss of their beloved Marie. With prayer, compassion, understanding, and presence, Reverend Kearns helped Celine see that sometimes having the power to change things isn’t the most important power to possess.

Thank-you, John.

Medical Nursing's Albert H. Brown Visiting Scholar Program

—by Lee Ann Tata, RN, nursing director

Carol Hall Ellenbecker, RN, professor, College of Nursing and Health Sciences at UMass, Boston, presents, "The Patient Protection and Affordable Care Act: What we can Expect for Patients and Practice."

On April 17, 2014, Medical Nursing welcomed Carol Hall Ellenbecker, RN, professor, College of Nursing and Health Sciences at UMass, Boston, as the third Albert H. Brown visiting scholar. In her opening remarks, associate chief nurse, Theresa Gallivan, RN, thanked Dorothy Terrell, a member of the MGH Board of Trustees, for her ongoing support of the program that bears the name of her late husband.



(Photo by Michelle Rose)

The day began with a presentation by Camie Berardi, from the Massachusetts Health Connector, who provided an overview of the Affordable Care Act (ACA) and what the program means to the residents of Massachusetts, including where we are in the implementation process. An in-depth discussion followed on how nurses can help patients navigate the system and ensure resources are utilized.

Ellenbecker's presentation, "The Patient Protection and Affordable Care Act: What we can Expect for Patients and Practice," focused on changes related to the ACA and what it will mean for patients, nurses, and other healthcare professionals going forward. Ellenbecker reviewed specific provisions of the act and how they'll affect care.

A panel discussion with Naomi Martel, RN, attending nurse; Grace Good, RN, Team 5 leader; Deidre Sweeney, RN, clinical manager, Complex Care Service; Leah Roumanis, RN, Bullfinch Medical Group; and Marcy Bergeron, RN, director of Primary Care Services and Clinical Operations, focused on best practices related to access, quality, and outcomes at MGH. Panelists shared case studies of some of the more complex and challenging patient-care scenarios. Discussion revolved around coordination of care, safe discharge, preventing re-admissions, and coordinating care after discharge.

The Planning Committee for this year's Albert H. Brown Visiting Scholar Program included: Lee Ann Tata, RN, nursing director; Jacqui Collins, RN, clinical nurse specialist; Jennifer Mills, RN, nursing director; Kate Barba, RN, clinical nurse specialist; and Caitlin Clear, administrative assistant. For more information about the Albert H. Brown Visiting Scholar Program, call Lee Ann Tata, RN, 4-5320.

Orren Carrere Fox Award

Guest of honor a no-show, and we couldn't be happier!

—by Mary Ellin Smith, RN, professional development manager

(L-r): Robert Kacmarek, RRT, director, Respiratory Care Services; award recipient, Kathleen Figurido, RRT; and Peggy Settle, RN, nursing director.

“Orren is unable to attend because he’s helping to build a school in Peru.” What better reason to celebrate! Former NICU patient, Orren Carrere Fox, now 17 years old, was unable to attend the 2014 presentation of the Orren Carrere Fox Award for NICU Caregivers, which bears his name, because

he was in South America on a humanitarian mission—talk about a parent’s dream come true. The Orren Carrere Fox Award was created by Orren’s parents, Libby DeLana and Henry Fox, to recognize the compassionate, holistic, family-centered care they received when Orren was a patient in the NICU as a premie 17 years ago.

This year’s recipient, respiratory therapist, Kathleen Figurido, RRT, has worked in Pediatrics since coming to MGH 18 years ago. In welcoming family, friends, and colleagues, NICU nursing director, Peggy Settle, RN, described Figurido as a committed and compassionate nurse, someone who always has a smile on her face.

Bob Kacmarek, RRT, director of Respiratory Care Services, called-Figurido a strong advocate for her patients and families and a worthy recipient of the Orren Carrere Fox Award.

Accepting the award, Figurido said it was an honor and a privilege to work in the NICU where there is such commitment to collaborative care and supporting families through difficult life experiences. She thanked the Fox family for their ongoing support and ended by saying, “I am blessed to work here.”

For more information about the Orren Carrere Fox Award, call Mary Ellin Smith, RN, professional development manager, at 4-5801.



(Photo by Paul Batista)

2014 National Patient Safety Goals

Goal #1: patient-identification

National Patient Safety Goals were established in 2002 to help accredited organizations address specific areas of concern regarding patient safety. New goals are identified periodically based on a review of safety reports, and specific requirements are developed to help prevent those incidents from happening again.

Question: I heard that the Joint Commission identified some new National Patient Safety Goals for 2014.

Jeanette: Yes. National Patient Safety Goals (NPSGs) were established in 2002 to help accredited organizations address specific areas of concern regarding patient safety. New goals are identified periodically based on a review of safety reports, and specific requirements are developed to help prevent those incidents from happening again. Once National Patient Safety Goals become standards, the numbers are retired. That accounts for the odd numbering pattern of the goals.

Question: What are the new NPSGs?

Jeanette: The 2014 NPSGs are:

- Identify patients correctly (NPSG.01.01.01)
- Improve staff communication (NPSG.02.03.01)
- Use medicines safely (NPSG.03.04.01)
- Use alarms safely (NPSG.06.01.01)
- Prevent infections (NPSG.07.01.01)
- Identify patient safety risks (NPSG.15.01.01)
- Universal protocol (UP.01.01.01)

Question: Why is patient-identification goal #1?

Jeanette: ‘Wrong-patient’ errors can occur during virtually any stage of diagnosis or treatment, including medication-administration, collection of blood

and other samples, or during any other provision of care and treatment. Identifying patients correctly allows us to: accurately identify the patient as the intended recipient of the service or treatment; and match the appropriate service or treatment to that patient. MGH requires the use of at least two patient identifiers, either: name and medical record number, or name and date of birth.

Question: When should these patient identifiers be used?

Jeanette: Two patient identifiers should be used, for example, when administering medications and blood products, when drawing blood or obtaining other specimens, or when transporting a patient to a test or procedure. When collecting blood and specimens, all tubes and containers must be labeled at the time of collection in the presence of the patient.

Question: Who can administer blood products at MGH?

Jeanette: MGH policy states that blood transfusions can only be administered by approved clinicians, such as registered nurses, nurse practitioners, nurse midwives, physicians, physician assistants, certified registered nurse anesthetists, respiratory therapists, and perfusionists.

For more information, contact the PCS Office of Quality & Safety at 3-0140.

Partners eCare

Clinical systems downtime for cut-over to new revenue cycle

Question: I know we're getting close to implementation of Partners eCare. How will life be different after implementation?

Jeanette: On July 12, 2014, the revenue-cycle component of Partners eCare is going live. This includes registration, billing, scheduling, the master patient list, admit/discharge/transfer (ADT), and bed-management. The new system will replace PATCOM, CBEDs, IDX, and a few other 'home-grown' systems. In order for this change to take place, certain systems will experience a controlled downtime during the cut-over.

Question: When and how will we be affected?

Jeanette: Most major clinical systems will be unavailable from 11:00pm, July 11th, through 6:30am, July 12th. During that time:

- CAS will be available to view inpatient notes and results. Notes and results for newly admitted patients will not be available
- POE (order entry) will be available to view inpatient orders placed before 11:00pm, July 11th. New orders for inpatients and newly admitted patients will be hand-written on paper and not viewable in POE
- eMAR will not be available. Paper MARs from fail-safe computers should be printed out and used for charting medication-administration
- The lab will be down from 12:30–3:00am and only process stat requests during that time. Because POE will not be accepting orders, paper requisitions will be used for labs from 11:00pm–6:30am. Results will be called in from 12:30–3:00am; otherwise, inpatient results will be viewable in CAS. Call the lab for results on newly admitted patients
- Pharmacy will be down from 12:30–3:00am. Because POE will not be accepting orders, medication orders will be faxed to the Pharmacy for both inpatients and newly admitted patients

- Radiology and diet orders will be sent to those departments because POE will not be accepting orders
- EDIS will not be viewable outside the ED
- Metavision (the OR system) will function as a stand-alone system only
- eBridge and OB EMR will be unable to take notes; you'll need to use paper notes for these systems. LMR will be able to take notes

Question: What happens when the new system goes live?

Jeanette: Once the cut-over is complete, orders placed during the downtime will be entered into POE by the responsible clinicians. Nurses will be responsible for reconciling the MAR with administrations and orders placed during the downtime.

Question: Will support be available throughout the transition?

Jeanette: Downtime manuals are being developed and updated and will be distributed starting the week of June 30th. Fail-safe computers are being updated with screen shots to assist physicians with order-writing. Forms and downtime procedures will be available on fail-safe computers.

Partners eCare experts and super users will be on hand to ensure a smooth transition to the new system.

Please take some time to familiarize yourself with your fail-safe computer, the downtime manual, and the downtime and recovery procedures.

For more information, call Annabaker Garber, RN, director of PCS Informatics at 617-724-3561.

Announcements

Free one-day bereavement program for children

Saturday, July 19, 2014
8:30am–4:00pm
at the MGH Institute
for Health Professions in the
Charlestown Navy Yard

For information, call
617-724-4525

Biomedical Engineering updated website

Questions about one of the
35,000 medical devices at MGH?
Visit the Biomed website.

Biomedical Engineering has updated its website to be more user-friendly and useful for clinicians. In direct response to feedback from staff, Biomed has significantly augmented the content of its website to include more device types and information, such as operator's manuals, training videos, and links to manufacturer's websites and policies. Areas such as Technology News, Safety Tips, FAQs, alarm management, and infusion pumps are regularly updated.

Check out the updated site, available through Clinical References → "Biomedical Engineering Websites at BWH and MGH," then click on MGH.

For more information, or to offer comments or suggestions, contact Eileen Hall at 617-724-3216.

Free Webinar

MGH Institute of Health Professions presents:

"Crowd Funding for the Classroom"

Wednesday, July 9, 2014
12:00–1:00pm

MGH Institute of Health Professions alumnus, Thomas Shull, CCC-SLP, speech-language pathologist for Boston Public Schools, will provide an overview of crowd-funding resources and strategies on how to get funded.

Sponsored by the MGH Institute Office of Alumni Relations.

For more information or to register, call 617-726-0968.

New Fibroid Program at MGH

Radiology and Obstetrics & Gynecology are introducing the new Fibroid Program to provide access to a multi-disciplinary team of specialists who collaborate to offer a full range of treatments for women with uterine fibroids.

A nurse coordinator helps navigate care throughout the course of treatment, including scheduling and connecting patients to available resources.

Treatments and services include:

- Diagnostic imaging
- Minimally invasive surgery
- Image-guided procedures

Consultations are available on Tuesdays from 8:00am–12:00pm in the the Yawkey 4 OB-GYN suite.

For more information go to:
massgeneral.org/fibroids.

For appointments, call 857-238-4733 or submit an on-line appointment request.

ACLS Classes

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

Day one:
July 10, 2014
8:00am–3:00pm

Day two:
July 11th
8:00am–1:00pm

Re-certification (one-day class):
August 13th
5:30–10:30pm

For information,
call 617-726-3905.

Class locations will be announced upon registration.

To register, go to:
http://www.massgeneral.org/emergencymedicine/assets/Library/ACLS_registration_form.pdf.

Atrial Fibrillation

Patient Education Classes

Patients and family members are invited to join the Cardiac Arrhythmia Service to learn more about atrial fibrillation and current therapies used to treat 'A fib.'

Upcoming classes:

"Stroke-Prevention and Blood Thinners 101"
July 28th
November 24th

"AF Treatment:
When, Why and How"
August 25th
December 22nd

"Ablation A-Z"
September 22nd

Classes are free and held monthly in the Haber Conference Room from 5:00–6:00pm.

For more information or to register for a class go to the Atrial Fibrillation Program website:
www.massgeneral.org/atrialfibrillation

Senior HealthWISE

All events are free for seniors 60 and older

"Planning Healthy Meals and Snacks"

Thursday, July 10, 2014
11:00am–12:00pm

Haber Conference Room
Speakers: Anna Nakayama and Andrea Krivelow, dietetic interns

Speakers will provide recipe ideas and discuss tips so planning is both easy and enjoyable.

For more information,
call 4-6756.

The Brian A. McGovern, MD, Award

Nominations now being accepted

The MGPO is now accepting nominations for the 2014 McGovern Award for Clinical Excellence. Nominate a physician who is a superb clinical role model, may be considered an 'unsung hero,' and is focused on patient care. Physicians in every clinical department are eligible to be nominated.

All attending and trainee physicians, clinicians, volunteers, students, and patients are welcome to submit a nomination.

Nominations are due by Saturday, July 19, 2014. To submit a nomination, go to <https://mgpo.massgeneral.org/mcgovern/>, or send an e-mail to Shaina Druy at sdruy@partners.org.

For more information,
call 617-726-3680.

Professional Achievements

Penzias appointed

Alexandra Penzias, RN, clinical nurse specialist, Imaging, was appointed a columnist for the *Journal of Radiology*, in May, 2014.

Rizzo appointed

Lori Rizzo, RN, staff specialist, Perioperative Services, was appointed a member of the Board of Directors of the Massachusetts chapter of the Association of Perioperative Registered Nurses, May 13, 2014.

Staples appointed

Monica Staples, RN, clinical nurse specialist, General Medicine, was appointed a board member of the Practice Advisory Panel for the Massachusetts Board of Registration in Nursing, in May, 2014.

Robinson honored

Ellen Robinson, RN, nurse ethicist, received the Dean Rita P. Kelleher Award from the Connell School of Nursing at Boston College, May 31, 2014.

Adams and Fryer present

Jeffrey Adams, RN, and Ashley-Kay Fryer, presented, "Nurse Leader Influence and Success: a Relationship Between Innovation and Practice Environments," at the annual meeting of the American Organization of Nurse Executives, in Orlando, Florida, March 14, 2014.

Padelford presents poster

Jessica Padelford, RN, practice manager, Transplant Clinic, presented her poster, "How Much Longer Do I Need to Wait? Quality Improvement Project to Decrease Length of Post-Transplant Clinic Visits," at the 22nd annual Transplant Management Forum of the United Network for Organ Sharing Transplant Management, in Baltimore, April 28–30, 2014.

Lunder 10 staff nurses earn inaugural certification

Lunder 10 staff nurses, Teri-Ann Aylward, RN, Amy Cheung, RN, and Susan O'Donnell, RN, passed the inaugural Blood and Marrow Transplant certification exam, in February, 2014.

Convery presents

Mary Susan Convery, LICSW, social worker, presented, "Story-Telling as a Therapeutic Tool; Assisting Cancer Patients Coping with Advanced Disease," at the Journal of Grief Conference at Bridgewater State University School of Social Work in Bridgewater, May 12, 2014.

Irwin presents poster

Linda Irwin, RN, director of Compliance, presented her poster, "Living Donor Follow-up: a Multi-Disciplinary Approach to Improve Compliance with Post-Donation Care," at the 22nd annual Transplant Management Forum of the United Network for Organ Sharing Transplant Management, in Baltimore, April 28–30, 2014.

Orencole presents

Mary Orencole, RN, nurse practitioner, Cardiology, presented, "Unique and Challenging Cases from the Device Clinic, EP Lab, and Arrhythmia Clinic Utilizing Heart-Failure Diagnostics," at the annual meeting of the Heart Rhythm Society, in San Francisco, May 9, 2014.

Inter-disciplinary team presents poster

Gail Gall, RN; Alexander Green, MD; and Karey Kenst, presented their poster, "Innovative Interprofessional Curriculum Addressing Quality and Safety for Patients with Limited English Proficiency," at the annual meeting of the National Academies of Practice, in Alexandria, Virginia, April 5, 2014.

Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, Pain Relief, presented, "Patients with Chronic Pain and Substance Abuse Need State-of-the-Art Nursing," during Nurse Week at McLean Hospital, May 9, 2014.

Whitney gives graduation address

Kevin Whitney, RN, associate chief nurse, presented, "Four Essential Practices for Achieving Excellence," at the Nursing graduation ceremony of the MGH Institute of Health Professions, May 8, 2014.

Nurses publish

Anne Gavigan, RN, staff nurse; Carolyn Cain, RN, staff nurse; and Diane Carroll, RN, nurse researcher, authored the article, "The Effects of a Preparatory Informational Session Prior to a Cardiovascular Procedure on Patient Outcomes," in *Clinical Nursing Research*.

Adams publishes

Jeffrey Adams, RN, director, The Center for Innovations in Care Delivery, authored the article, "Influencing the Development of Leaders: an Interview with Dr. Donna Havens," in the *Journal of Nursing Administration*, April 2014.

Inter-disciplinary team publishes

Ilana Ruff, MD; Syed Ali, MD; Joshua Goldstein, MD; Michael Lev, MD; William Copen, MD; Joyce McIntyre, RN; Natalia Rost, MD, and Lee Schwamm, MD, authored the article, "Improving Door-to-Needle Times: a Single Center Validation of the Target Stroke Hypothesis," in *Stroke*.

Adams appointed

Jeffrey Adams, RN, director, The Center for Innovations in Care Delivery, was appointed a member of the American Organization of Nurse Executives Research Committee, in April, 2014.

Published by

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

Publisher

Jeanette Ives Erickson, RN
senior vice president
for Patient Care

Managing Editor

Susan Sabia

Editorial Advisory Board

Chaplaincy

Reverend John Polk

Disability Program Manager

Zary Amirhosseini

Editorial Support

Marianne Ditomassi, RN
Mary Ellin Smith, RN
Maureen Schneider, RN

Medical Interpreters

Anabela Nunes

Materials Management

Edward Raeke

Nutrition & Food Services

Donna Belcher, RD
Susan Doyle, RD

Office of Patient Advocacy

Robin Lipkis-Orlando, RN

Office of Quality & Safety

Colleen Snyderman, RN

Orthotics & Prosthetics

Mark Tlumacki

PCS Diversity

Deborah Washington, RN

Physical Therapy

Occupational Therapy
Michael Sullivan, PT

Police, Security & Outside Services

Joe Crowley

Public Affairs

Colleen Marshall

Respiratory Care

Ed Burns, RRT

Social Services

Ellen Forman, LICSW

Speech, Language & Swallowing Disorders and Reading Disabilities

Carmen Vega-Barachowitz, SLP

Training and Support Staff

Stephanie Cooper

The Institute for Patient Care

Gaurdia Banister, RN

Volunteer Services

Wayne Newell

Distribution

Ursula Hoehl, 617-726-9057

Submissions

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

Next Publication

July 17, 2014

Inpatient HCAHPS Results

2013–2014

Measure	2013	2014 Year to Date	2013-2014 Change
Nurse Communication Composite	81.9	82.9	+1.0
Doctor Communication Composite	82.5	82.2	-0.3
Room Clean	74.5	73.1	-1.4
Quiet at Night	50.2	49.3	-0.9
Cleanliness/Quiet Composite	62.4	61.2	-1.2
Staff Responsiveness Composite	64.7	63.6	-1.1
Pain Management Composite	72.3	73.5	+1.2
Communication About Meds Composite	65.5	67.0	+1.5
Discharge Information Composite	91.8	92.1	+0.3
Overall Rating	81.2	80.8	-0.4
Likelihood to Recommend	90.4	90.2	-0.2

Nurse Communication, Pain Management, and Communication about Medication continue to outperform our baseline from 2013. Staff Responsiveness is improving; it's at its highest point this year, but Staff Responsiveness and Quiet Times are still slightly below our 2013 baseline, so more work is needed in these areas.

Data complete through April, 2014
 All results reflect Top-Box (or 'Always' response) percentages
 Pull date: June 16, 2014



Returns only to:
 Bigelow 10 Nursing Office,
 MGH, 55 Fruit Street
 Boston, MA 02114-2696



First Class
 US Postage Paid
 Permit #57416
 Boston, MA