

Caring

Headlines

October 16, 2014

The SAFER Fair



*Collaborative
governance
committees
working to
keep patients
safe*

*See story on
page 4*

Kathryn Eagan, RN (right), restraint solutions champion and staff nurse in the Respiratory Acute Care Unit, demonstrates proper way to secure hand restraint at recent PCS SAFER Fair.

See something, say something

reducing waste and redundancy in the workplace

As we prepare for what promises to be an equally challenging year, we're looking at new ways to work together to serve our patients and families...

And as always, our success depends on the commitment and creativity of the entire MGH community.

There's never a bad time for a good idea. As I write this column, Patient Care Services is engaged in our annual strategic planning process for 2015, MGH leadership is already thinking about the budget for 2016, and we're coming off one of the most challenging years in recent history—a year that ended with some difficult financial decisions and some painful reductions. As we prepare for what promises to be an equally challenging year, we're looking at new ways to work together to serve our patients and families. We're looking for ways to eliminate redundancy and waste. We're looking for ways to optimize the resources we have while still running at peak safety and efficiency. And as always, our success depends on the commitment and creativity of the entire MGH community.

As we explore opportunities to increase our productivity, we have areas of high priority, such as reducing length of stay, preventing hospital re-admissions, and bolstering the work we're doing on Innovation Units. But eliminating waste and redundancy in *any* way is a priority. I'm asking every individual, every unit, and every department in Patient Care Services to look at their local operations and ask: How can we improve? Where can we eliminate waste? Are we utilizing our time and resources in the best possible way for our patients and families?



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

Front-line staff are always the best source of ideas when it comes to increasing efficiency and identifying opportunities to reduce waste. I'd like to co-opt Homeland Security's slogan of, "See something, say something," for our own efforts to eliminate waste and redundancy in the workplace. Many of you are doing this already.

For instance, a nurse in the PACU noticed that some of their documents were printing to the pharmacy printer, which uses a special (much more expensive) kind of paper. She brought the issue to light so it could be resolved. She said something so this wasteful, albeit accidental, practice could be discontinued. Are there similar opportunities in your work area?

It wasn't that long ago that someone noticed wound-care products were being over-stocked on their unit. That simple observation led to the creation of a task force to determine which wound-care products should be considered par-level, reducing

continued on next page

These are the kinds of ideas we're looking for—ideas that originate from our commitment to provide exceptional care and service. Yes, we want to cut expenses, but only in ways that preserve or improve the quality of care. We need your help. The best systems are those that reflect the wisdom and insight of the people who use them every day.

waste, saving money, and making clean utility rooms neater and more orderly for inventory storage.

In the physical therapy setting, some pediatric patients are required to wear special casts that prevent them from fitting into standard car seats. This was a trying and time-consuming obstacle for clinicians and families to deal with on a case-by-cases basis. One creative therapist found a solution in the form of a special strapping system. She worked with the multi-disciplinary team and the MGH General Store to make the straps available to families. This is a great example of reducing wasted time while improving patient- and staff-satisfaction.

To increase efficiency and responsiveness, the department of Speech-Language Pathology created a new staff coordinator role, which rotates to a different staff member every three months. The staff coordinator manages daily consults, identifies priority patients, and assigns them according to clinician and team availability. Serving in this new role has not only helped develop leadership skills but also gives staff a sense of the 'big picture.' Another solution that both reduces wasted time and improves patient- and staff-satisfaction with no added cost to the hospital.

Over the years, our Staff Nurse Advisory Committee has been the source of many ideas to improve systems and enhance patient care. Staff Nurse Ad-

visory members raised an idea to make patient transport between ICUs and medical and cardiac units safer and more efficient. As a result, best practices were identified and adopted that led to enhanced communication among those units.

At the request of the Staff Nurse Advisory Committee, National Patient Safety Goals are now a standing item on their agenda, which has helped us identify inconsistencies in practice, knowledge deficits, and workflow issues.

These are the kinds of ideas we're looking for—ideas that originate from our commitment to provide exceptional care and service. Yes, we want to cut expenses, but only in ways that preserve or improve the quality of care. We need your help. The best systems are those that reflect the wisdom and insight of the people who use them every day.

Wasn't it anthropologist, Margaret Mead, who said, "Never believe that a few caring people can't change the world. For indeed, that's all who ever have." Well, we have more caring people per capita at MGH than anywhere else in the world!

Please send your ideas directly to me or give them to your managers or supervisors. I look forward to hearing your suggestions. Thank-you for your service, your resiliency, and your expertise as we navigate this challenging economic landscape.

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The annual SAFER Fair

showcasing the work of collaborative governance committees

—submitted by collaborative governance representative

At the third annual SAFER fair, committee champions staffed booths, showcasing their work over the past year, sharing information, and answering questions for the hundreds of staff members and visitors who passed through the Bulfinch tent.

On Wednesday, September 17, 2014, the MGH community had an opportunity to see what collaborative governance committees are doing to make the hospital environment safe for patients, families, and staff at the third annual SAFER fair. Committee champions staffed booths, showcasing their work over the past year, sharing information, and answering questions for the hundreds of staff members and visitors who passed through the Bulfinch tent.

Visitors to the Diversity Committee table learned about different cultures and traditions and had a chance to indicate their own homeland on a world map, which was filled with pins by the end of the day.



The Ethics in Clinical Practice Committee provided information on the Massachusetts Medical Orders on Life Sustaining Treatment Policy, Moral Courage (with their button, “Got Courage?”) and through a fun and thoughtful game, reviewed the ethical principles that guide clinical practice.

The Fall Prevention Committee responded to many questions about how to make home and work environments safer. With many employees caring for frail family members, their advice was highly sought after.

The Informatics Committee shared the work they’ve done around changing the treatment record so treatments are appropriately recorded and redundancy is avoided. A glucometer was used to demonstrate enhanced documentation features available through eBridge.

The Pain Management Committee offered information on how to appropriately assess and manage pain. With a simple ‘clothes pin’ test, they helped visitors see ways to assess, treat, and manage their own pain.

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Patient Safety (continued)

The Patient Education Committee provided information on understanding treatment plans and advice for patients on how to communicate with their caregivers. Clinicians had an opportunity to review patient-education materials written in plain language.

The Policies, Products & Procedures Committee familiarized visitors with the new narcotic wasting procedure by having them practice various methods of properly disposing of and documenting narcotic wasting. They shared their table with the Compliance department who demonstrated the new policy-manager system, called Ellucid.

The Research & Evidence-Based Practice Committee spotlighted the impact of research and the importance of staying abreast of changes in healthcare practices and care-delivery.

The Restraint Solutions in Clinical Practice Committee showcased new products designed to keep patients safe without having to be restrained. Using a mannequin, clinicians had an opportunity to practice scenarios in which patients might need to be placed in restraints.

The Skin Care Committee, in addition to demonstrating ways to prevent skin

breakdown, unveiled their new ceiling-lift video, which underscored the importance of ceiling lifts in reducing pressure ulcers for patients and guarding against back injuries for staff.

Collaborative Governance is the communication and decision-making structure of Patient Care Services. For more information, or if you'd like to explore becoming a champion, contact Mary Ellin Smith, RN, professional development manager, at 4-5801.



Collaborative Governance Celebration

—submitted by collaborative governance representative

The September 17, 2014, collaborative governance celebration at the Paul S. Russell, MD, Museum was part thoughtful reflection, part recognition of past accomplishments, and part passing of the torch to future leaders of collaborative governance committees. Welcoming committee champions and members of PCS leadership, senior vice president for Patient Care, Jeanette Ives Erickson, RN, spoke about the origins of collaborative governance.

Created in 1997, collaborative governance is a decision-making model that places the authority, responsibility, and accountability for patient care with clinicians closest to the bedside. It quickly became a key component of our professional practice model and an integral mechanism

for inter-disciplinary communication. From eight committees in 1997, collaborative governance has grown to include 12 committees with champions from all disciplines within Patient Care Services. Ives Erickson thanked champions for their work and dedication and thanked unit and departmental leadership for making it possible for clinicians to attend meetings.



Gaurdia Banister, RN, executive director of The Institute for Patient Care, introduced Grace Aylesbury, RN, staff nurse and co-chair of the Diversity Committee. Aylesbury shared some insightful reflections on her tenure as co-chair (see text on opposite page).

Banister thanked retiring committee leaders for their contributions, including: Maureen Beaulieu, RN, out-going co-chair of the Policies, Products & Procedures Committee (in-coming co-chair, Kristen Kingsley, RN); Diane Carroll, RN, out-going advisor to the Research & Evidence-Based Practice Committee (incoming advisor, Ginger Capasso, RN); and Berney Graham, LICSW, out-going co-chair of the Ethics in Clinical Practice Committee (in-coming co-chair, Bryan Cyr, RN).

For more information about collaborative governance, contact Mary Ellin Smith, RN, at 4-5801.



Above center: senior vice president for Patient Care, Jeanette Ives Erickson, RN, addresses the gathering. Lower left, executive director of The Institute for Patient Care, Gaurdia Banister with Maureen Beaulieu, RN (left), and Berney Graham, LICSW. Lower right (l-r): director of Speech-Language Pathology, Carmen Vega-Barachowitz, CCC-SLP; Ives Erickson; associate chief nurse, Debra Burke, RN; and executive director for PCS Operations, Marianne Ditomassi, RN, applaud the proceedings.

(Photos by Paul Batista)

Cultural ‘themes’ help inform patient care

The following are excerpts from remarks by Grace Aylesbury, RN, co-chair of the Diversity Committee, at the recent celebration of collaborative governance at the Paul S. Russell, MD, Museum, September 17, 2014.

As a Filipino nurse and co-chair of the Diversity Committee, I’ve had the privilege of learning a tremendous amount about what makes us all different. Our differences are what make humanity interesting, and together with our similarities unite us as humankind. I’ve learned not only about other cultures vastly different from my own, but I also re-familiarized myself with my own culture.

Every month at our meetings, members share information about their background, family, customs, and culture. Listening to these presentations, I’ve noticed three common themes.

The first theme is *person*. In Vietnamese culture, a person touching another person’s head is a sign of disrespect. This is important for me to know because as a nurse, I use touch as part of my assessment tool. In the Chinese culture, establishing eye contact is a sign of disrespect. If I didn’t know that, I might misinterpret lack of eye contact as avoidance.

The second theme is *time*. Different cultures view time in different ways. In some Asian cultures, time is like a rubber band—it can be stretched. A person can show up an hour late for an appointment because culturally, they view time more as a guideline than a strict schedule to be adhered to.

Another example of time and culture has to do with sacred observances. In the Muslim culture, Ramadan is a month devoted to praying and fasting. In the Haitian culture, when a person is sick, it is considered a time of resting and healing. Getting out of bed when you’re sick will make your condition worse. Again, this is good for me to know because as a nurse, I often encourage patients to get out of bed so they don’t become de-conditioned.

The third theme is *care*. We have a tendency to take western medicine for granted because that’s what we’re used to. But patients from other cultures don’t necessarily subscribe to our way of thinking. Some cultures prefer female nurses. Some cultures view pain differently. In the Philippines, being stoic is valued while outward expression of pain is not.

Having the opportunity to listen and learn from my fellow champions on the Diversity Committee has been a great benefit to my practice. Keeping these themes in mind while caring for patients helps me better navigate their needs, particularly for patients from different backgrounds than my own. Drawing on what I’ve learned, I’m able to supplement my clinical skills with an understanding of patients’ customs, beliefs, and practices. Honoring and respecting patients’ culture is just one way of achieving harmonious interactions, earning their trust, and speeding their recovery.

Grace Aylesbury, RN, co-chair of the Diversity Committee, delivers remarks at collaborative governance celebration.



Oncology nurse learns important lesson:

Medical professionals have hopes and fears just like everyone else

'Mary' was a sweet, 80-year-old woman with the nicest smile and the greatest sense of humor. I loved her from the moment I met her. She was admitted for new weakness, fever, and failure to thrive. Her scans showed disease progression, and doctors agreed she had only weeks, possibly a month, to live.

My name is Jesse MacKinnon. As a staff nurse on the Lunder 9 Oncology Unit, I often have to communicate life-changing news to patients and families.

I have to discuss chemotherapy, radiation, and surgical procedures that can forever alter their way of life and completely change their notion of what 'normal' means. Each patient and family member is unique, which means nurses must approach these difficult topics in a different manner, tone, and attitude every time we sit down to have these conversations. These discussions are not easy and are by no means routine. With experience, these conversations have gotten easier to navigate, and the fear of broaching these topics has dissipated somewhat. However, a recent patient experience caused me to discover that fear all over again—the exact same fear I felt during my first nurse-patient, end-of-life discussion.

'Mary' was a sweet, 80-year-old woman with the nicest smile and the greatest sense of humor. I loved her from the moment I met her. Mary also happened to be the wife of a doctor, a man who'd been a surgeon for more than half a century. Mary was admitted for new weakness, fever, and failure to thrive. Her scans showed disease progression,



Jesse MacKinnon, RN,
staff nurse, Lunder 9 Oncology Unit

and doctors agreed she had only weeks, possibly a month, to live. As I sat in rounds, fear began to rise inside me as I contemplated the conversation I knew I would have to have with Mary and her husband.

As other staff heard about the news, they began wishing me luck; one by one, they all mentioned the situation. I realized they understood my trepidation at having to have this conversation with a fellow clinician. I began to wonder why we get so fearful when it comes to telling other clinicians bad news.

Mary's doctor delivered the news of her prognosis, and after he left I took on what I think is the most important role of the oncology nurse—acting as a sounding board for the life-changing news they've just heard. The first question they asked was the same question almost

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every patient asks a nurse after hearing this news: “What do you think?”

I’ve been asked this question a hundred times, and I’ve answered it honestly each time. But this time, I found myself searching for words. I knew what I thought. I agreed with the doctors’ assessment, not just because the scans showed progressive disease, but simply from caring for Mary. She was losing weight every day; she was exhausted and slept most of the time; she no longer wanted to eat. I knew from experience that a month was optimistic. Days to weeks was more likely.

Still, I searched for the right words. I asked myself, was I fearful because her husband, the surgeon, already knew the truth? Was I fearful that my clinical judgment wouldn’t be accepted simply because it was bad news? Were they looking for me to have a different opinion to give them a sense of hope?

Mary’s husband asked me a question that made me realize something very important. He said, “Have you seen many cases like this?”

Though the question was intended in a medical context, I could tell he was looking to me for clarity of the situation in the best way he knew how. It was the same question any husband would ask, whether he was a doctor, or a lawyer, or a landscaper. He was simply asking for reassurance that listening to this medical advice was the right thing to do.

At that point, I let my guard down. I was no longer nervous. I began treating the situation like any nurse-family interaction, as opposed to a clinician-to-clinician discussion. It happened naturally. I just started talking, answering their questions to the best of my ability.

Mary’s husband said, “It seems the scans show no hope of this disease getting any better.”

I answered the way I do for all my patients who receive this kind of crushing bad news. I told him that hope comes in many forms. While it may be true there’s no hope the disease will go into remission, we can look for a different kind of hope.

Hope that Mary finds peace and comfort in her final days. Hope that we, as her family and caregiv-

ers, listen to her needs and wishes and help her achieve them. Hope that we have the ability to make her comfortable to the best of our ability.

I believe Mary’s husband found solace in our conversation as he soon turned his attention as a doctor to comfort care, helping the palliative care team, and contributing to conversations about how best to medicate Mary. I cared for Mary for another week before she passed away on home hospice. Our relationship was one of the strongest I’ve had with a patient and family as an oncology nurse.

Taking care of patients with ties to the medical field happens often, especially in a hospital like MGH. Although it can be daunting to care for them, medical professionals are people, too. And although their jobs give them knowledge, their fears and emotions about sickness and death are the same as everyone else’s. They may ask questions that sound medical in nature, but that’s their training. Mary’s husband was a surgeon, and that’s how he needed to wrap his mind around the situation. Just as an engineer might require detailed information, or an athlete may focus on the physical aspects of an illness, Mary’s husband needed to discuss end-of-life goals through a medical prism. As their nurse, I needed to mold my thoughts and explanations to meet their needs. Mary and her husband were no different from any other patient and family member I’ve cared for. Whether I’m caring for a doctor, fellow nurse, or some other medical professional, I’ve learned to stay true to myself and my care because that’s what’s best for my patient.

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

In his book, *Being Mortal: Medicine and What Matters in the End*, Atul Gawande, MD, talks about end-of-life patients having hope for, “the best possible day.” Jesse intuitively offered Mary and her husband honesty, compassion, and the opportunity to talk about their questions and fears. His initial trepidation at having an end-of-life conversation with a fellow medical professional was quickly overshadowed by his nursing instincts and his desire to give Mary that best possible day.

Thank-you, Jesse.

Just as an engineer might require detailed information, or an athlete may focus on the physical aspects of an illness, Mary’s husband needed to discuss end-of-life goals through a medical prism. As their nurse, I needed to mold my thoughts and explanations to meet their needs. Mary and her husband were no different from any other patient and family member I’ve cared for.

Organ donation in the Cardiac ICU

—by Susan Stengrevics, RN, clinical nurse specialist

Due to a national shortage, there is a long wait for organ transplants. In the Ellison 9 Cardiac ICU, staff often support patients for months before a donor can be found. At the same time, patients are admitted to the Cardiac ICU who've suffered serious cardiac events. Sadly, some of these patients turn out to be potential organ donors.

Identifying and approaching potential donors is a highly sensitive and delicate process. In the past nine months, through expert care and collaboration, staff of the Cardiac ICU have identified six medi-

cally suitable candidates. Consent was secured from all six, and all went on to become donors. That's a 100% conversion rate, which is almost unheard of.

The road to organ donation requires an exquisite level of coordination among nurses, physicians, social workers, chaplains, and many others, not to mention the New England Organ Bank (NEOB) team. The untimely death of a loved one coupled with the prospect of organ donation can be a lot for families to process. For many, the idea of organ donation is a comfort. Discussions must be handled with great diplomacy.

Kevin Keily, MGH in-house coordinator for the NEOB, informed us recently that MGH has received a US Health & Human Services Medal of Honor for excellence in organ donation. The Cardiac ICU was specifically recognized for its culture of care and support for donor patients and families.

The NEOB follows up with families of donors after transplant. One family member recently learned that his wife's liver had saved a man's life; her corneas

had been given to another recipient, and her kidneys went to support research. The husband expressed great appreciation for the care his wife received, saying, "Everyone was fantastic. We know they did everything they could for her. It was unbelievable how warm and caring everyone was." He added that organ donation was a source of comfort as the family grieved the loss of their loved one.

It is through the commitment of the entire team that these outcomes are achieved. Organ donation requires a unique and extraordinary kind of interaction with patients and families. When done right, it can give the donor family a sense of meaning and purpose during a devastating time, while providing a joyous second chance for another fortunate family.



A small representation of the donor team in the Cardiac ICU (l-r): Susan Stengrevics, RN; Monica Doucette, RN; Marguerite Hamel-Nardozi, LICSW; Erica Edwards, RN; Kevin Kiely, NEOB; Nino Mihатов, MD (back); Diana Donahue, chaplain; Abishai Lawson, RN; and Tricia Coffey, RN.

CPE Residency returns to MGH

—by Reverend John Polk, director, MGH Chaplaincy

The Clinical Pastoral Education (CPE) Residency returns to MGH this fall for the first time since the 1980s. This specialized training, accredited by the Association of Clinical Pastoral Education, brings advanced-level chaplains-in-training to our hospital to work full-time for one year. Each resident is assigned to several patient-care units and works as a member of the inter-disciplinary team.

The CPE Residency enables MGH to be a training ground for professional chaplains. Prior to resuming the residency program, CPE education was available to students primarily at a beginner's level. Other healthcare professionals are welcome to participate; the current class includes social worker, Justine Sullivan, LICSW, who's learning the art and science of spiritual care alongside chaplains. Gordon Hilsman, who recently joined the Chaplaincy team, is serving as interim supervisor of the residency program. For more information go to the MGH Chaplaincy website at: <http://www.mghpcs.org/chaplaincy/>.



Back row (l-r):
Gordon Hilsman;
Michael Bousquet;
Reverend Augustine
Chika; and Reverend
John Polk.
Front row: Tonia
Petty; Amanda March;
Samsiah Abdul Majid;
and Justine Sullivan,
LICSW.

(Photo provided by staff)

Sharing best practices ensures safe, high-quality care

Question: How does something become a 'best practice'?

Jeanette: A best practice is a method or approach that consistently shows results superior to those achieved by other means. In health care, best practices are built on research and evidence and are often shared in the form of clinical practice guidelines.

Question: Who is responsible for implementing best practices?

Jeanette: Every member of the healthcare team is responsible. Every member of the team has a responsibility and accountability to ensure safe, high-quality care.

Question: Can you give me some examples of best practices?

Jeanette: Some of our more prominent best practices have been captured in PCS *Did you know?* posters generated by the Research & Evidence-Based Practice Committee, such as the poster on preventing pressure ulcers (which stresses re-positioning; ceiling lifts; adequate nutrition and hydration; and patient-specific exercises).

Another *Did you know?* poster focusing on oral care will be distributed later this year. The nurse at the bedside is responsible for assessing patients' oral health. Frequent, comprehensive oral care helps decrease bacteria in the mouth and reduce the prevalence of pneumonia. One episode of hospital-acquired pneumonia can increase length of stay by an average of nine days. So you can see why sharing best practices is so important.

Question: Are there best practices that impact all patients?

Jeanette: Absolutely. One of the most important best practices is effective communication among caregivers. The most common cause of healthcare-related sentinel events is poor

communication among providers. Having a standard, evidenced-based format for hand-overs between providers is a crucial best practice. At MGH we've adopted I-PASS, which stands for: Illness severity; Patient assessment; Action list; Situational awareness and contingency planning; and Synthesis by the receiver. (See the September 4th and September 19th issues of *Caring Headlines* for more information).

Effective communication is a best practice we want to utilize in every clinical situation—when there's a change in a patient's status, upon admission, during transfers, and providing daily care throughout the entire hospitalization. Timely communication with physical therapists, occupational therapists, social workers, speech-language pathologist, and all members of the team is a key best practice to ensure optimal care. Effective communication fosters collaborative practice and facilitates the patient's progression throughout the continuum of care.

Question: What about communicating with patients and families where there might be a language barrier?

Jeanette: A critical best practice when communicating with patients and families with limited English proficiency is to partner with a professional medical interpreter. Medical interpreters are available in person for most frequently requested languages; by telephone for approximately 200 languages; and by video link for Spanish or Portuguese interpretation. It's especially important to use medical interpreters during the discharge process. Remember that Care Notes has many documents available in other languages. You shouldn't ask bilingual colleagues to interpret for you; it's outside their scope of practice.

Identifying and sharing best practices are at the heart of high-quality care. For more information about best practices, I suggest you contact a member of the Research & Evidence-Based Practice Committee; you can find their contact information under the Collaborative Governance tab on the Excellence Every Day portal page (<http://www.mghpcs.org/IPC/Programs/Committees/Research.asp>).

Professional Achievements

DeThomaso certified

Danielle DeThomaso, RN, staff nurse, Neurology, became certified as a neuroscience nurse by the American Board of Neuroscience Nursing, in September, 2014.

Capasso appointed

Virginia Capasso, RN, clinical nurse specialist, was appointed a member of the Scientific Committee of the American College of Certified Wound Specialists, in September, 2014.

Nurses present

Jane Flanagan, RN, nurse scientist; Amanda Coakley, RN, staff specialist; and Christine Donahue Annese, RN, staff specialist, presented, "Writing for Publication in the International Journal of Nursing Knowledge," at the International Conference on Nursing Knowledge, in Porto, Portugal, September 11–13, 2014.

Arnstein presents

Paul Arnstein, RN, pain clinical nurse specialist, presented the Jean Guveyan Lecture, "Navigating through the Turbulence," at the 24th national conference of the American Society for Pain Management Nursing, in San Diego, September 18, 2014.

Arnstein also presented, "Risk Evaluations and Mitigation Strategies for Extended Release and Long-Acting Opioids: Achieving Safe Use While Improving Patient Care," at the same conference.

Robinson appointed

Ellen Robinson, RN, clinical nurse specialist, was appointed faculty associate at the Harvard Medical School Center for Bioethics in September, 2014.

Larkin honored

Mary Larkin, RN, clinical research manager, MGH Diabetes Research Center, received the 2014 Distinguished Clinical Research Nurse Award from the International Association of Clinical Research Nurses, September 14, 2014.

Social workers present

Social workers, Anne LaFleur, LICSW, and Lynn Helfand, LICSW, presented, "ECMO as a Bridge to Lung Transplant: Implications for Social Workers," at the 20th annual international conference of the Society for Transplant Social Workers in Boston, September 3, 2014.

Miller and Rowley present

Kathleen Miller, RN, director of The Wellness Center, and Joanne Rowley, RN, holistic nurse educator, presented, "Working With Populations Facing Many Challenges," at The New Science of Resiliency and its Clinical Applications conference for the MGH Benson-Henry Institute for Mind Body Medicine at Harvard Medical School, September 19, 2014. Rowley and Miller presented, "Mindfulness," at the same conference.

Van Leuvan certified

Allison Van Leuvan, RN, staff nurse, Yawkey Infusion Unit, became certified as an oncology nurse by the Oncology Certification Nurses Network, on August 26, 2014.

Rosa presents poster

Katherine Rosa, RN, Connell nursing research scholar, presented her poster, "Health, Caring, Consciousness, Mutual Process, Patterning, Presence, and Meaning Unfolding in a Praxis Relationship," at the meeting of the Society of Rogerian Scholars in Knoxville, Tennessee, October 7, 2014.

Nurses publish

Gaurdia Banister, RN; Helene Bowen Brady, RN; and Marion Winfrey, RN, authored the article, "Using Career Nurse Mentors to Support Minority Nursing Students and Facilitate their Transition to Practice," in the July/August, 2014, *Journal of Professional Nursing*.

Inter-disciplinary team publishes

Jocelyn Jacquart; Kathleen Miller, RN; Andrea Radossi; Vivian Haime; Eric Macklin; Diana Gilburd, LICSW; Mimi Nelson Oliver, LICSW; Darshan Mehta, MD; Albert Yeung, MD; Gregory Fricchione, MD; Herbert Benson, MD; and John Denninger, MD, authored the article, "The Effectiveness of a Community-Based Mind-Body Group Intervention for Symptoms of Depression and Anxiety," in the summer, 2014, *Advances in Mind-Body Medicine*.

Hutchinson certified

Melinda Hutchinson, RN, staff nurse, Transplant, became certified as a critical care nurse by the American Association of Critical Care Nurses, in September, 2014.

Penzias publishes

Alexandra Penzias, RN, clinical nurse specialist, Radiology, authored the article, "Management and Leadership: the Magnet Recognition Program and the Radiology Setting: Part One," in the September, 2014, *Journal of Radiology Nursing*.

Inter-disciplinary team publishes

Ellen Robinson, RN; Susan Lee, RN; Angelika Zollfrank; Martha Juchak, RN; Debra Frost, RN; and Pamela Grace, RN, authored the article, "Enhancing Moral Agency: Clinical Ethics Residency for Nurses," in a recent Hastings Center Report.

Nurses present poster

Joanne Hughes Empoliti, RN, nursing director; Amanda Coakley, RN, staff specialist; Christine Annese, RN, staff specialist; Hannah Moran, RN, staff nurse; and Trisha Zeytoonjian, RN, clinical nurse specialist, presented their poster, "Assessing Clinical Learning Needs of Nurses by New Unit Leadership," at the International Conference on Nursing Knowledge," in Porto, Portugal, September 11–13, 2014.

Announcements

Senior HealthWISE events

All events are free for seniors 60 and older

“Hip and Knee Arthritis: Options for Staying Healthy”
Thursday, October 16th
11:00am–12:00pm
Haber Conference Room

Speaker: Jonathon Spanyer, MD, fellow, department of Orthopedic Surgery, will talk about symptoms, diagnosis, and treatment options for hip and knee arthritis.

“Rejuvenate Your Brain”
Thursday, November 6th
11:00am–12:00pm
Haber Conference Room

Speaker: Marie Pasinski, MD, neurologist, will provide tips to rejuvenate your brain at any age. Learn how to boost your memory and brain power. Investing in your brain is the most important investment you can make!

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

ACLS Classes

Certification:

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

Day one:
November 6, 2014
8:00am–3:00pm

Day two:
November 7th
8:00am–1:00pm

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.

pdf.

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.

New Pneumonia Patient-Education Material

To see the new patient-education document on pneumonia, go to: <http://handbook.partners.org/content/pdf/MGHPtEdDischPneumonia.pdf>. Or go to Partners Applications, Clinical References, Partners Handbook, and follow the prompts to Patient Education Documents, Respiratory. The document contains information on:

- Prevention
- What to expect
- When you're doing well
- When and whom to call when you're not doing well
- Follow-up appointment details
- Definition of pneumonia

Beginning in mid-October, Provider Order Entry (POE) will support the use of the new pneumonia patient-education document for adult patients 18 years old or older. POE will prompt clinicians similar to the way they're prompted for heart-failure patients, and there will be a link to open the document directly.

For more information, contact: Michelle Anastasi, RN, at 617-724-1582; Monica Staples, RN, at 617-643-5059; or Deb Connolly, RN, at 617-724-9499.

Disability Champion Award

Join the MGH Employee Disability Resource Group (EDRG) for the second annual presentation of the Disability Champion Award at this year's:

Breakfast of Champions
October 21, 2014
8:00am
East Garden Dining Room

For more information, call project manager, Linda Akuamoah Boateng, at 617-643-2886

When domestic violence overlaps with disability

Resources for Healthcare and Service Providers

October 27, 2014
12:00pm–1:00pm
Haber Auditorium

Program will explore the unique challenges healthcare professionals encounter caring for patients with disabilities who are living with abuse. Panelists from MGH and state agencies will explain how to coordinate services and resources to meet the needs of this patient population.

Open to the public.
Nursing contact hours available.
Social Work CEUs pending.

RSVP encouraged, not required. To RSVP, e-mail MGHAccessibility@partners.org.

Co-sponsored by the Massachusetts General Council on Disabilities Awareness and the Mass General Domestic Violence Working Group in recognition of both National Domestic Violence and Disabilities Employment Awareness Month

MGH celebrates National Health Literacy Month

—by Mallory A. Hillard; Mary Stacy, RN; and Julie McCarthy, RN,
for the Patient Education Committee

October is National Health Literacy Month. Since its inception in 1999, National Health Literacy Month has been widely observed as a time to promote patient-education resources to foster effective education and communication between patients and clinicians.

This year, the PCS Patient Education Committee is celebrating Health Literacy Month with a special presentation by Nancy S. Morris, RN, as part of the Blum Visiting Scholar Program. Morris is associate professor of Nursing at the University of Massachusetts, Worcester; she practices clinically as an adult nurse practitioner in diabetes and geriatric primary care at the University of Massachusetts Memorial Medical Center; and has an appointment here at MGH as a nurse scientist in the Yvonne L. Munn Center for Nursing Research. Morris's research focuses primarily on health literacy and its impact on both the behavior and health outcomes of adult patients, especially those living with chronic diseases.

All are welcome to attend Morris's presentation on October 23, 2014, from 1:30pm–2:30pm in O'Keefe Auditorium, where she will present her research on health literacy.

In addition to Morris's presentation, the Patient Education Committee will host its annual Health Literacy booth in the Main Corridor on Wednesday, October 29th. Staffed by Patient Education Committee champions, the booth will offer a variety of patient-education materials for patients and clinicians alike.

Materials will be available focusing on general health as well as helping patients understand specific conditions and what they can do to take a more active role in their health care. Resources for clinicians will include materials on how

to educate and effectively communicate with patients and families.

For more information about National Health Literacy Month, go to: <http://www.healthliteracymonth.org>. For information about patient-education materials available at MGH, e-mail the Blum Center at PFLC@partners.org.

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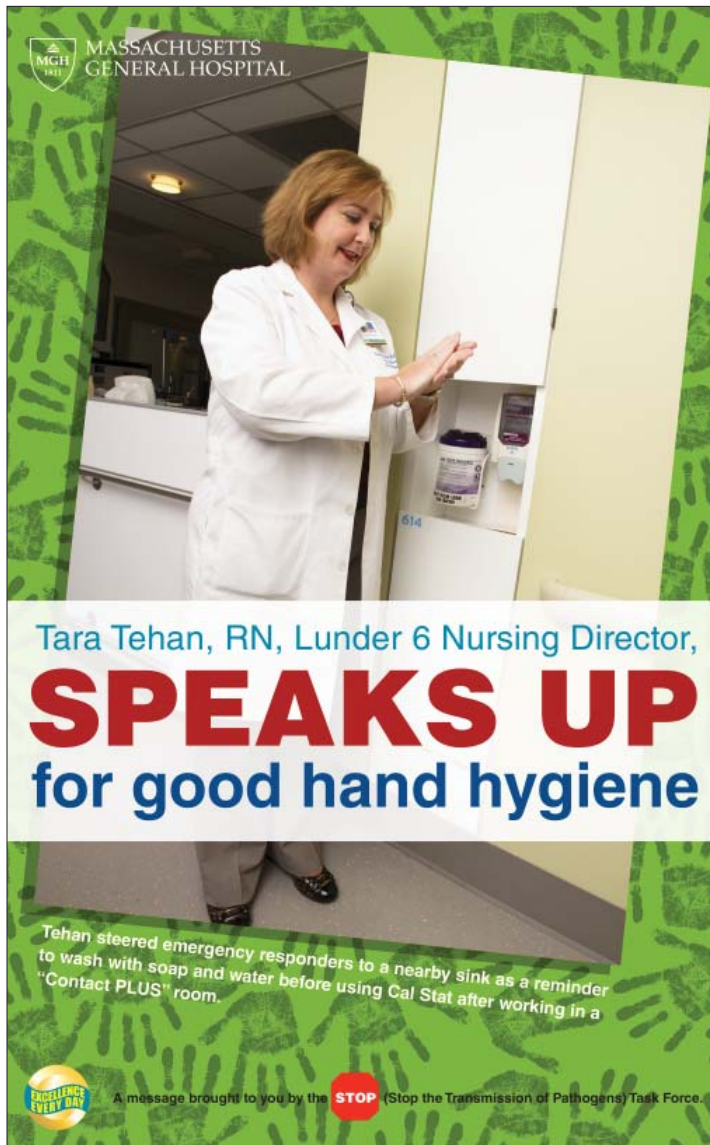
Milton Calderon, 617-724-1755

Submissions

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

Next Publication

November 6, 2014



Speak Up!

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.

Tara Tehan, RN, nursing director, Lunder 6 Neuro ICU, isn't shy when it comes to keeping patients safe. Expect a gentle reminder if you forget to practice good hand hygiene on her unit.

See something, say something.

Caring Headlines

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