

Caring

Headlines

September 18, 2014



Fall-Prevention

What strategies are you using to keep patients safe?

Share your ideas

Bathroom NEED? Think SPEED!!!
Locate nearby staff for help, then
"text it out".



See related stories
on pages 7-11

Striking a balance between safety and privacy, White 11 staff nurse, Jena Manthorne, RN, is at the ready should her patient need assistance while in the bathroom.

National Patient Safety Goals

focusing on patient identification and effective communication among caregivers

Within the requirements of each National Patient Safety Goal, The Joint Commission includes examples of best practices to help hospitals meet the intended spirit and standard of excellence for each goal.

A

s many of you know, The Joint Commission's National Patient Safety Goals were created in 2002 to help organizations identify patient-safety issues and prioritize their improvement efforts to ensure optimal care to patients across the country. Because of the nature and scope of its work, The Joint Commission is in a position to see frequently occurring safety issues and bring them to the attention of hospitals seeking accreditation so that solutions can be implemented in a timely and consistent manner.

National Patient Safety Goals apply to all settings in which patients receive care. They are developed based on voluntary reports of patient harm received from Joint Commission-accredited organizations. All National Patient Safety Goals are in keeping with the mission and vision of MGH and every other hospital that strives to keep patients safe. Within the requirements of each goal, The Joint Commission includes examples of best practices to help hospitals meet the intended spirit and standard of excellence prescribed for each goal. At MGH, our quality-improvement initiatives are based on the Institute of Medicine's Six Aims of Improvement put forth in the 2001 call to action, *Crossing the Quality Chasm*. As an organization, we strive to provide care that is safe, effective, patient-centered, timely, efficient, and equitable. For the purposes of this column, I'd like to focus on National Patient Safety Goals #1 and #2.



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

National Patient Safety Goal #1

Ensuring the accuracy of patient identification is a fundamental requirement for providing safe patient care. This was one of the first goals identified by the Joint Commission as it is the basis for every other National Patient Safety Goal and the Six Aims of the Institute of Medicine. Safe, high-quality care depends on the patient being accurately identified every time he or she enters the healthcare system. Wrong-patient errors continue to be reported across the country. Ongoing, accurate verification of the patient's identity, using two consistent identifiers, is the surest way to guard against mis-identification throughout the continuum of care (treatments, specimen-collection, medication-administration, transfusions, procedures, surgeries, and all other services).

At MGH, we use the patient's name and medical-record number to identify inpatients at all junctures of care, including medication-administration. In the ambulatory-care setting, if a patient has not

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As healthcare providers, we appreciate the importance of proactively working to keep patients safe. We're fortunate to have The Joint Commission's National Patient Safety Goals to help us do just that. For more information about the National Patient Safety Goals, go to the Regulatory Readiness tab of the Excellence Every Day portal page.

yet been issued a medical-record number or it has not yet been retrieved, the patient's name and date of birth may be used as the two identifiers.

When ensuring the correct patient receives the correct blood or blood product for transfusion, at MGH, we use and document a two-person verification process, which is conducted in the presence of the patient. Earlier this year, after an in-depth, inter-disciplinary planning process, we launched a new documentation tool for blood transfusion. The change was based on best practice; it enhances patient safety, and it's more efficient for patients and caregivers. Since implementation, we've seen dramatic improvement in blood-transfusion documentation and staff satisfaction using the new tool.

National Patient Safety Goal #2

Another priority identified by The Joint Commission is effective communication among all members of the care team. When originally introduced, this goal contained many elements of performance (EPs). But as hospitals, including MGH, identified best practices to decrease potential risk to patients, the EPs became standards (verbal orders, telephone orders, acceptable abbreviations, and hand-overs). What remains in this goal is the need for continued improvement in reporting

critical results of tests and diagnostic procedures in a timely manner to the clinician who will take action.

At MGH, we've defined a list of critical tests, critical results and values, and an acceptable length of time for the reporting of critical results to the responsible licensed caregiver. Records are being kept to ensure ongoing timeliness of the process.

We recently re-visited the process for communicating critical results from the lab to the inpatient caregiver. I want to stress that all staff involved in the process of reporting and receiving critical results are responsible for ensuring that the correct result is communicated and understood. A 'read-back' of the patient's name, medical record number, and critical-result value are considered best practice and required by National Patient Safety Goal #2 and MGH policy.

As healthcare providers, we appreciate the importance of proactively working to keep patients safe. We're fortunate to have The

Joint Commission's National Patient Safety Goals to help us do just that.

For more information about the National Patient Safety Goals, go to the Regulatory Readiness tab of the Excellence Every Day portal page at: http://www.mghpcs.org/eed_portal/index.asp.

**2014 Joint Commission
National Patient Safety Goals**

Identify patients correctly

- Use two patient identifiers when providing care
- Perform and document a 2 person verification before blood administration

Improve staff communication

- Report critical results on a timely basis

Use medicines safely

- Label medications and solutions if not in original container
- Take special safety steps with anticoagulants
- Maintain and share accurate patient medication information

Use alarms safely

- Respond to every clinical alarm promptly
- Individualize parameters to decrease unnecessary alarms
- Remove monitoring when no longer needed

Prevent infections

- Use hand hygiene
- Provide care by using accepted guidelines
- Educate patients/families about prevention

Identify patient safety risks

- Identify patients most likely to commit suicide in all settings

Universal Protocol

- Conduct a pre-procedure check, mark the site, and perform the time-out (pause)

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Another year has ended, a new class of Hausman fellows enters the workforce

—by Ron Greene, Hausman program coordinator

If the Hausman Fellowship for Minority Nursing Students is any indication, the future of nursing is not only bright, it's driven, passionate, courageous, outspoken, selfless, and wise beyond its years. On August 22, 2014, the Hausman Fellowship for Minority Nursing Students recognized 16 formidable nursing students for completing a rigorous nursing and diversity curriculum. These senior students engaged in a unique learning experience at MGH to enhance their clinical skills and gain insight into how cultural identity can be an asset to patient care and team dynamics. Throughout the fellowship, students had opportunities to

Hausman fellow, Marissa Sylvia, welcomes program benefactor, Margaretta Hausman.



(Photo by Walter Reeves)

consciously reflect on their own individuality and the individuality of the patients and families they cared for. A major focus of the program is raising awareness of one's unique identity and understanding the influence it has on relationships with patients, families, and colleagues.

The Hausman Fellowship began in 2007 through the generosity of Margaretta Hausman, who, as an MGH patient, recognized a need for greater cultural awareness and diversity in the nursing workforce. The Hausman Program funds the Minority Nursing Fellowship; the Young Scholars Program for middle-school-aged children of entry-level MGH employees; the Minority Nurse Researcher Program that focuses on the development of minority nurse researchers; the Accent Reduction Program; the Multicultural Nurses Group (minority employees currently enrolled in nursing schools); and sponsorship of two annual nursing forums to raise awareness of the importance of a diverse workforce.

Fellows worked on units under the guidance of nurse preceptors. They worked all shifts, in community clinics, Informatics, and Case Management, and every Friday they attended de-briefings where they shared stories of their experiences throughout the week.

In a standing-room-only Haber Conference Room, Deborah Washington, RN, director of PCS Diversity, gave a brief overview of the Hausman Program, highlighting its impressive growth over the years and citing its prominence as a national model for diversity education and cultural competence.

Each student had an opportunity to share some snippets of their experiences and to thank Mrs. Hausman, who was in attendance.

Said Hausman fellow, Taylor Fischer, a senior at Boston College School of Nursing, "The beauty of

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The Hausman Fellowship for Minority Nursing Students

what it means to me

—by Hausman fellow, Melissa Correia

H: Health care has been a passion of mine since I served in the Peace Corps and experienced my first preventable death in a small village in Mali

A: Assumptions have a way of painting a false picture on a blank canvas. During my time in the Hausman Fellowship, I learned to leave all assumptions at the door. Assuming I had all the answers, assuming someone's health was a consequence of their ignorance, assuming things are always black or white—these are ideas I learned to let go of. Hausman taught me to listen and observe before anything else

U: Understanding. I gained a better understanding of the nursing profession and what it takes to 'make it' in the big leagues

S: Serving others, putting their needs before my own

M: Maturity. I matured as a result of working in a professional setting while forming and nurturing professional relationships and learning not to take things personally

A: Ask questions. Ask many questions. Ask to gain knowledge in a learning environment. Adapt to different environments, different patient populations, and different units. Allow yourself the opportunity to build confidence in many different aspects of nursing

N: Nursing is a universal profession, it speaks no language and sees no color, because inside, we all share the same human anatomy. Nursing gives no preference to one group over another. I am a minority, and I'm grateful for the opportunities the Hausman Fellowship provided

the Hausman Fellowship is that we were able to see so many different things, be exposed to things we've never seen before, and really see what it's like to be a nurse. Through this program, I have come to realize that nursing is the only profession I will ever be satisfied with. When I'm at the bedside, laughing with a patient or giving reassurance, that's when I feel at home. If I can touch one person and make their life bearable, I'll be happy."

Said Yvonne Shih, "I soon realized that a successful career is defined through your interaction with the surrounding work community. This internship gave me a look into the real world—a world in which genuine relationships go a long way. I realized that as humans, we depend on each other, each person contributes to our overall success. Everyone around us has a talent, value, and skill that we may not necessarily have, and that's great! I'm so encouraged by this program's emphasis on inter-dependence."



Fellow, Janelle Amoako, said, "I cannot describe how significant this experience has been for me. In this unique program, we have fellows who are Native American, Dominican, Nigerian, Puerto Rican, Taiwanese, Cape Verdean, Liberian, Jamaican, Vietnamese, Chinese, Mexican, Ghanaian, Peruvian, and Lebanese, and I learned something from every one of them. How amazing would it be to have this level of diversity as I begin my nursing career? There's no telling what we'd be able to do."

Said Ron Greene, RN, program coordinator, "I heard one fellow say that every time she

went to a new unit she'd extend her hand and introduce herself as a Hausman fellow. No one can refuse a smile and an extended hand, she said. It gave me great pleasure to know I had something to do with this group coming together, learning from one another, and teaching us all so much."

For more information about the Hausman Fellowship for Minority Nursing Students, call Deborah Washington at 617-724-7469.



(Clockwise from top left): Ron Greene, Hausman program coordinator; with faculty member; Janis Peters; Deb Washington, RN, director, PCS Diversity; and this year's class of Hausman fellows (in the first two rows).

(Photos by Walter Reeves)

Getting creative with fall-prevention strategies

—by Monica Staples, RN, clinical nurse specialist

In the United States, falls are the leading cause of injury in individuals 65 and older, and being hospitalized increases the risk of falling. A fall is defined by the NDNQI as a sudden, unintentional descent to the floor that may or may not result in injury. Illness, medications, equipment, and unfamiliar surroundings can all contribute to an increased risk of falling. That's why even patients who don't require a lot of help at home can be at risk for falling when they're in the hospital.

The Collaborative Governance Fall-Prevention Committee works to increase awareness about risk factors related to falling and educates patients, families, and staff about fall-prevention strategies. Every day, based on their knowledge of the patient and the clinical situation, staff use creative interventions to keep patients safe.

Seated: operations associates, Deanne Williams (left) and Jessie Lemos. Standing (l-r): PCA, Erin Donegan; Allie Fitzgerald, RN; Louie Rocha, RN; Jena Manthorne, RN; Nicole Cincotta, RN; and PCA, Kayla Murray.



In an effort to capture and share best practices related to fall-prevention, the Fall Prevention Committee sponsored a contest asking staff to submit ideas and strategies they've used to keep patient from falling. Responses were thoughtful and varied, ranging from ideas to protect individual patients to suggestions for systemic changes to make the entire environment safer. The winning submission was from the staff of the White 11 Medical Unit.

Says Susan Morash, RN, nursing director, "We wanted to increase our speed of responding to patients with toileting needs. Often, elderly patients wait until the last minute before asking for help to use the bathroom; they try to get up on their own, putting them at risk for falling. Now, operations associates on our unit call on the person closest to the nurses' station to assist, then they text a notification to the patient's nurse. So there are two layers of help. It has really decreased our response time, which has a significant impact on patients' risk of falling.

A poster mounted at the nurses' station reminds staff: "Bathroom need? Think speed! Locate nearby staff for help, then text it out."

The Phillips 22 Surgical Unit was recognized for having the most number of submissions. Ideas ranged from bold-font signage alerting staff to post-op delirium, to a case study focusing on a multi-disciplinary approach to fall-prevention, to incorporating alarm checks into the bed turn-over process.

For more information on fall-prevention, go to the Excellence Every Day Fall-Prevention Portal page: http://www.mghpcs.org/eed_portal/EED_fallprevention.asp, or call Patti Shanteler, RN, staff specialist, at 617-726-2657.

Team approach to fall-prevention an effective strategy on White 10

Mr. F was admitted to our unit for treatment of injuries suffered in a fall at home. Mr. F is 85 years old and hard of hearing. He reported that his memory is declining, at its worst in the evening, and he had fallen many times while at home.

My name is Ela Gilbride, and I'm a staff nurse on the White 10 Medical Unit. Mr. F was admitted to our unit for treatment of injuries suffered in a fall at home. Mr. F is 85 years old and hard of hearing. He reported that his memory is declining, at its worst in the evening, and he had fallen many times while at home. He lives alone in a two-family house and uses a walker to ambulate. He presented with a few bruises but no broken bones and was awaiting a physical-therapy evaluation.

Deconditioned, Mr. F felt somewhat weak and dizzy sitting on the side of the bed. He said he was very discouraged and feared that this development would keep him from going home. We activated his bed exit alarm at night to help guard against the possibility of him falling. However, the highly sensitive alarm sounded every time he moved (which it's supposed to do), and he became angry with the constant noise.

One morning the bed alarm sounded, and I ran to his room in response. Mr. F was frustrated with the noise and complained as I deactivated the alarm. I waited for him to finish speaking so I could introduce myself and begin my assessment.

Mr. F became increasingly distraught asking, "What is this place? How did I get here?" He looked around as if it was the first time he was seeing his surroundings.

I sat in the chair facing him. Someone passing by might easily have thought his loud and abrasive



Elzbieta Gilbride, RN, staff nurse,
White 10 Medical Unit

words were being directed at me in an unkind way and that this exchange could escalate. Our medical team was rounding just outside and peeked in to make sure I was alright.

But sitting across from Mr. F and looking into his eyes, I could see the real meaning behind his words: this wasn't an attack, it was an expression of his emotional suffering, personal defeat, and disappointment. I let him continue to speak and get it all out.

He seemed to be distracted but finally he looked at me and said, "Are you just going to sit there, take a break, nothing better to do?"

He looked away for a moment, then back to me. "Are you are still here?"

"Why do people despair when they sit in this chair?" I said. His stern face relaxed, and I saw a small smile start to form in the corners of his mouth.

Finally he ordered, "Do what you have to do and leave me alone. Go find something better to do."

I think he was giving me an excuse to leave more than ordering me to go.

I looked at his white board where we write down all the basic information to help orient the patient

continued on next page

to his environment—the day of the week, the date, the names of his caregivers, and the plan for the day. I picked up the blue marker and updated the information on his white board. At the bottom, in a large empty space I wrote the word, ‘Walk,’ followed by a check-box.

Having a specific schedule for Mr. F allowed the team to meet his care needs and minimize the number of alarms sounding and upsetting him. Mr. F worked with a physical therapist to increase his endurance and was soon able to return home.

Mr. F saw what I was doing and said, “Do you think I can walk without falling when everyone keeps telling me not to move because I’ll fall? They put that blasted alarm on me like I’m a prisoner!”

Above the word, “Walk,” I wrote, “Stand,” with two check-boxes after it.

Mr. F followed along begrudgingly. “Are you going to be there when I stand?”

I kept writing. I wrote, “Sit,” with three boxes after it.

Mr. F said, “So, when do you want me to sit?”

I smiled, noting that Mr. F’s confusion was resolving; he fully understood my intentions without any explanation.

Our dietary aide brought in Mr. F’s breakfast tray, and I encouraged him to sit on the edge of the bed. I wanted to see if Mr. F would attempt to sit up by himself so I could assess his coordination and muscle strength. He popped right up and planted his feet on the floor. I pulled the table closer so he could reach his breakfast. I was pleased with how well he did.

Mr. F demanded that I leave him alone and leave the bed alarm off so he could eat in peace. I asked the patient care associate to remain in the room and let me know if she needed to leave for any reason. I came back a while later and checked Mr. F’s vital signs. He wasn’t a bit tired from eating. I asked if he needed to use the bathroom. With the help of a walker, we walked to the bathroom and back without difficulty.

On our way back to the bed, we stopped by the white board, and I checked off the boxes beside Sit, Stand, and Walk.

Mr. F huffed, “So, it is nine o’clock in the morning and I’m done for the day?”

I smiled and added several more boxes to each category.

Mr. F laughed. He turned toward the door, and we took a walk down the hallway. When we got back, he checked off another box on the white board with great satisfaction.

Before Mr. F sat down, I set up an alarm in his chair. Since he was so good at reading and following directions, I made a sign for him that said, “Do not get up without assistance.” I put one of the laminated LEAF (Let’s Eliminate All Falls) signs on the door to increase everyone’s awareness of Mr. F’s risk of falling.

Mr. F walked several times that day with a walker. I was puzzled as to why he had fallen so many times at home. After speaking with Mr. F, I found out that his falls usually happened in the evening or early morning hours, and that often he’d forget his walker until he was in the middle of the room, then lose his balance and fall.

Mr. F responded well to signage and consistently called for help when he needed it during the day. In the late afternoon and night hours, he was less conscientious, so I placed him on increased surveillance. In those later hours when his memory was foggy and lights were dimmed, he couldn’t see the signs to trigger his memory. During hourly rounds, we made note of his bathroom times and encouraged him to use the bathroom with assistance. We scheduled a 9:00pm walk and toileting before he settled in for the night.

Having a specific schedule for Mr. F allowed the team to meet his care needs and minimize the number of alarms sounding and upsetting him. Mr. F worked with a physical therapist to increase his endurance and was soon able to return home. When he left, he asked if he could take the sign I made that said, ‘Do not get up without assistance.’

“That’s all I need to cue me in,” he said. “It was the first thing I saw in the morning, and it helped me remember why I was here.”

On White 10, all staff are aware of strategies to reduce the risk of patients falling—strategies like early mobilization, signage, hourly rounding, bed and chair alarms, scheduled toileting, and a team approach to reducing falls. Sometimes the smallest interventions are the ones that make the biggest difference.

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

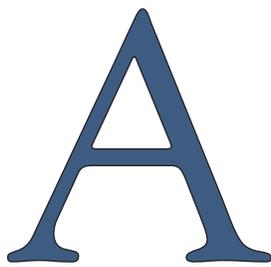
What a wonderful glimpse into Ela’s clinical decision-making as she came to understand Mr. F’s needs. Her care was completely patient-centered; she tailored her interventions not only to meet Mr. F’s physical needs but also to suit his personality. Despite an initially ‘grumpy’ start, Ela was able to earn Mr. F’s trust and build his confidence. She engaged the team to ensure all staff was aware of Mr. F’s safety needs, and she employed multiple strategies to guard against his falling.

Thank-you, Ela, for providing exceptional care and staying current with fall-prevention strategies and equipment.

The LEAF Program

a team approach to fall-prevention

In 2011, the LEAF program was launched on all inpatient units using a team approach to fall-prevention. One of the best strategies for minimizing the risk of patient falls is good communication (effective hand-overs) among team members.



All staff who come into contact with patients have a responsibility to keep them safe. Preventing falls is a big part of patient safety. In 2010, LEAF (Let's Eliminate All Falls), the MGH fall-prevention program, was developed to introduce an evidence-based approach to fall risk-assessment and intervention. In 2011, the LEAF program was launched on all inpatient units using a team approach to fall-prevention. One of the best strategies for minimizing the risk of patient falls is good communication among team members.

Beginning with a risk assessment by nurses, patients are classified according to their potential risk for falling while in the hospital. On inpatient units, the risk of falling is measured by The Morse Falls Scale®, a validated tool that utilizes six categories of risk. The LEAF program includes prevention and protection strategies based on these categories. Nurses use these indicators, in addition to the patient's clinical findings, to create an individualized plan of care. The plan is then communicated to the rest of the team and updated if changes occur.

Physical and occupational therapists are critical members of the team when the need for strengthening, balance, assistive devices, safe ambulation, and/or transfer techniques are necessary for a safe plan. Minimizing the effects of de-conditioning that can result from hospitalization is an important part of minimizing the risk of falling. Working collaboratively with nurses and other members of the team, therapists provide important safety strategies for patients and families.

Operations associates may be the first to respond to a request for help when answering a call from a patient's room. Communicating patients' requests for help to other members of the team in a timely manner is an important part of preventing falls.

Patient care associates play a crucial role in minimizing the risk of falling, assisting 'at-risk' patients to the bathroom, answering call lights, providing necessary care, and reinforcing the safety plan. Patient care associates are instrumental in communicating concerns about changes in a patient's status to the care team or relaying information about adherence to safety teaching.

Unit service associates are essential to maintaining a safe environment in and around the patient care area. Many falls are the result of items being moved by members of the care team or family members and not put back. Unit service associates help scan the room while cleaning to make sure patient equipment and personal items have been returned to their proper places.

The PCS Fall-Prevention Committee meets monthly to assess the effectiveness of the LEAF program, discusses case studies, and share lessons learned from patient-fall scenarios. They review data related to patient falls, evaluate trends, and identify areas for potential improvement. The committee continuously strives to reduce patient falls through staff-awareness and education, evaluation of equipment, and feedback about strategies clinicians are using to keep patients from falling.

National Fall-Prevention Awareness Day will be celebrated across the country on September 23, 2014. Visit the Fall-Prevention Booth in the Main Corridor, Friday, September 26th, from 10:00am–3:00pm. For more information about fall-prevention, call Patricia Shanteler, RN, staff specialist, at 617-726-2657.

Fall-prevention awareness

Question: In a hospital setting, what exactly constitutes a fall?

Jeanette: According to the National Database of Nursing Quality Indicators (NDNQI®), a fall is a sudden, unintentional descent to the floor that may or may not result in injury. We typically think of falling as someone tripping over something or losing her balance and landing on the floor. We call this an accidental or mechanical fall. But a fall can originate from any surface, including a stairway, a chair, or a low bed.

A physiological fall is one attributed to physiological factors, such as hypotension, stroke, dementia, physical instability, or visual impairment. ‘Culprit drugs,’ such as those that affect the central nervous system and certain cardiovascular medications, can be a factor in this type of fall.

Question: What fall-prevention efforts are in place at MGH?

Jeanette: MGH uses a program called LEAF (Let’s Eliminate All Falls). It’s designed for the adult inpatient population, but Pediatrics, Psychiatry, Imaging, and Ambulatory Care have tailored the LEAF principles to fit their patient populations. For information about LEAF, go to the Excellence Every Day Fall-Prevention Portal page: http://www.mghpcs.org/eed_portal/EED_fallprevention.asp.

Question: If a fall can’t be prevented, what is the primary goal?

Jeanette: Our fall-prevention program has helped us identify many protective and preventative strategies. For example, placing a patient in a low bed helps minimize the chance of sustaining an injury should the patient fall from the bed. An assisted fall is another strategy—that’s where a staff member minimizes the impact of the fall by slowing the patient’s descent to the ground. An assisted fall also helps protect the staff member, as trying to lift a patient can put them at risk for injury, as well.

Question: Is falling primarily an issue with elderly patients?

Jeanette: Absolutely not. Everyone is at risk for falling. As inpatients, people are in an unfamiliar environment. They may be ill or recovering from surgery; they’re most likely medicated. Patients often over-estimate their capabilities. An otherwise healthy 40-year-old man recovering from surgery will probably need help getting to the bathroom, even if he may not think so.

Outpatients, visitors, and staff are at risk, too. That’s why we must be vigilant in maintaining a safe physical environment—keep equipment away from elevators, stairways, and handrails wherever possible; use umbrella bags (located in lobbies) on rainy days; report spills to Environmental Services (6-2445); and never text while walking.

Question: What are some things we can do to prevent falls?

Jeanette: Every patient needs an individualized plan that’s re-assessed frequently, especially after a fall, after a near-miss, or when circumstances change. Helpful interventions include hourly rounding; bed and/or chair alarms; keeping the call bell, tray table, eyeglasses, and other items within reach for the patient; and keeping the pathway to the bathroom free of clutter. Consult Physical and/or Occupational Therapy to determine if assistive devices (such as canes or walkers) may be in order. Consult Pharmacy to review medications that may increase the risk of falling. Communicate the patient’s fall risk during handovers at change of shift and change of setting. And educate patients and family members about fall-prevention.

For more information about fall-prevention at MGH, call Patti Shanteler, RN, staff specialist, at 617-726-2657.

Getting ready for I-PASS

standardizing hand-over communication to ensure greater continuity and safer care

Some units at MGH have already adopted the I-PASS approach to patient hand-overs. Recently, as an organization, we adopted the I-PASS format for *all* patient hand-overs. I-PASS stands for:

- I — Illness severity
- P — Patient assessment
- A — Action list
- S — Situational awareness and contingency planning
- S — Synthesis by the receiver

Carpenter, Angelo Bordonaro, installs I-PASS posters in the Main Corridor to publicize this new approach to patient hand-overs.

Adhering to this format for all hand-overs enhances continuity across the continuum and increases patient safety. A recent Joint Commission (JC) report states that the most common cause of healthcare-related sentinel events is ineffective communication among providers, and most of those issues occur during change of shift between staff on the same unit.

The last two components of I-PASS are particularly important: situational awareness and synthesis by the receiver. Situational awareness and contingency planning are key aspects of patient safety because they engender true understanding of the patient's condition, and contingency scenarios are clearly articulated. Research tells us that staff receiving hand-overs may synthesize information differently from staff doing the handing over. An opportunity for dialogue and discussion between giver and receiver is built into the I-PASS format, creating a 'shared mental model,' which reinforces understanding and patient safety.

Education around I-PASS will be a combination of unit-based learning and classes offered through the Norman Knight Nursing Center. Training sessions are scheduled on the following days in the Thier Conference Room:

- Thursday, October 16th, 2:30–5:00pm
- Tuesday, November 18th, 3:00–5:30pm
- Tuesday, December 9th, 3:00–5:30pm

To register, go to: <https://limesurvey.partners.org/limesurvey/index.php/295172/lang-en>.

For more information, call Gino Chisari, RN, director, the Norman Knight Nursing Center, at 3-6530.



For disability-related resources, try going to MARS

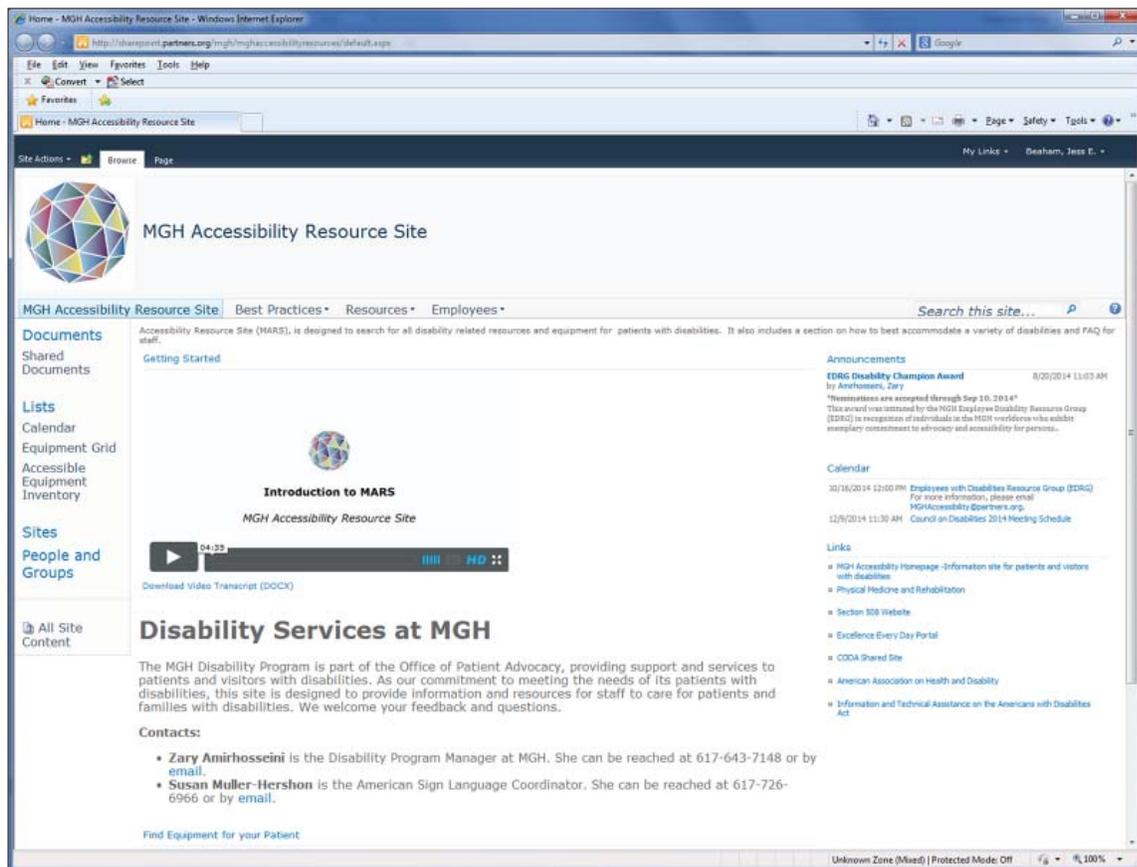
MARS provides a central link to all resources and equipment that may be of assistance to patients and families with disabilities. You can search for specialty equipment, such as adaptive call bells, portable lifts, and hearing amplifiers. Bookmark the site and visit it often.

The hospital recently announced the launch of the new MGH Accessibility Resource Site, also known as MARS. The site provides a central link to all resources and equipment that may be of assistance to patients and families with disabilities. MARS allows you to search for specialty equipment, such as adaptive call bells, portable lifts, and hearing amplifiers. It includes a 'Learn About' section where you can see examples of how to accommodate individuals with a variety of disabilities, as well as some frequently asked questions that may be of help to employees with disabilities.

MARS connects you to a number of internal and external sites, including the PCS Excellence Every Day Disabilities Portal that houses information, policies, updates, a calendar of events, and news articles.

The MGH Accessibility Resource Site can be accessed at: <http://sharepoint.partners.org/mgh/mghaccessibilityresources/default.aspx>.

Bookmark the site and visit it often. For more information on MARS or any aspect of caring for patients with disabilities, call Zary Amirhosseini, disability program manager, in the Office of Patient Advocacy, at 617-643-7148.



Announcements

Come to the PCS Bed Fair

Help select new mattresses

Help select new mattresses for beds on general care units

Attend the PCS Bed Fair

September 25, 2014

11:00am–4:00pm

Thier Conference Room

Vendors will be on-site displaying mattresses on general-care-unit bed frames.

Staff are encouraged to attend to have a voice in evaluating and selecting two mattresses to pilot for final consideration.

For more information, call Christine Annese RN, staff specialist, at 617-726-3277.

Mentors Make a Difference

Encourage and empower a motivated student

The MGH Youth Programs team is seeking volunteers to mentor Boston middle school students through creation and presentation of their science-fair projects. Mentors meet with students at MGH or the Charlestown Navy Yard two Friday mornings each month from October through January.

No expertise in mentoring or science is needed. The MGH Youth Programs team provides ongoing mentor training and support.

For more information, contact Tracey Benner at 617-724-8326.

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

Re-certification (one-day class):

October 8th

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.

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.

Trauma Care: Preparation, management and recovery

Presented by the MGH Nurses' Alumnae Association

Friday, September 26, 2014

8:00am–4:30pm

O'Keeffe Auditorium

Presenters: Stephanie Kwornick RN; Joseph Blansfield, RN; Marc DeMoya, MD; Peg Baim, RN; Constance Cruz, RN; Donna Slicis, RN; and members of the MGH Chaplaincy

A continuing-education program \$40 for MGH alumnae and employees.

\$50 for non-Partners employees.

For more information, or to register, by September 14th, call the Alumnae office at 6-3144.

Marjorie K. Ionta Symposium

The MGH Institute of Health Professions and MGH Physical Therapy present the annual Marjorie K. Ionta Symposium. This year's theme: "Innovations in Rehabilitation of Lower-Extremity Amputees from Blast Injuries."

Target audience is rehabilitation caregivers, including physical therapists, occupational therapists, physical therapy assistants, occupational therapy assistants, and nurses.

\$125 for the general public \$75 for MGH Institute alumni, employees, and MGH employees. Includes registration, continental breakfast, lunch, and networking event

September 27, 2014
8:00am–5:00pm
MGH Institute of Health Professions
Charlestown Navy Yard

CEUs are available
For more information, call Stephanie Gomez at 617-643-3821

Disability Champion Award

Call for Nominations

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

Breakfast of Champions
October 21, 2014
8:00am

East Garden Dining Room

Nominate someone who:

- goes above and beyond to help individuals with disabilities
- always takes time to make sure patients have the resources they need

Nominees must have at least one year of continuous service and be full- or part-time employees in good standing. Nominees must meet at least one of the following criteria:

- Shows extraordinary commitment to disability issues/persons with disabilities beyond the duties and responsibilities associated with their job
- Enhances the experience of patients, staff, families, and visitors with disabilities
- Fosters relationships to strengthen the hospital's commitment to persons with disabilities

Nominations due by September 10, 2014

To nominate a colleague, go to: sharepoint.partners.org/mgh/mghedrg, or e-mail MGHEDRG@partners.org for more information.

Professional Achievements

Staples licensed

Monica Staples, RN, was the first clinical nurse specialist to be licensed in the Commonwealth of Massachusetts, by the Professional Credential Services, in August, 2014.

Capasso receives scholarship

Virginia Capasso, RN, clinical nurse specialist, The Institute for Patient Care, received the Clinical Scholarship Award for the Support Surface Standards Initiative (S3I) of the Research Committee of the National Pressure Ulcer Advisory Panel, on August 26, 2014.

Inter-disciplinary team publishes

Ajay Sharma, MD; Eszler Vegh, MD; Jagdesh Kandala, MD; Mary Orencole, RN, nurse practitioner; Cardiac Arrhythmia Service; Lukasz Januszkiewicz, MD; Lukasz Januszkiewicz, MD; Abhishek Bose, MD; Alexander Miller; Kimberly Parks, DO; Kevin Heist, MD; and, Jagmeet Singh, MD, authored the article, "Usefulness of Hyponatremia as a Predictor for Adverse Events in Patients with Heart Failure Receiving Cardiac Resynchronization Therapy," in the *American Journal of Cardiology*, July 1, 2014.

Capasso publishes

Virginia Capasso, RN, clinical nurse specialist, The Institute for Patient Care, and Christine Pontuso, RN, staff nurse, Vascular Center, authored the chapter, "Overview of Topical Wound Treatments," in *Core Curriculum for Vascular Nursing*.

Sullivan and Meisenhelder present poster

Sharon Sullivan, RN, staff nurse, Cardiac ICU; and Janice Meisenhelder, RN, presented their poster, "Two Strategies for Standardizing Clinical Evaluation: Benchmarking and Clinical Concern Forms," at the 22nd annual conference of nurse educators at St. Anselm's in Falmouth, in June, 2014.

Social workers publish on-line

Peter Maramaldi, LCSW; Alexandra Sobran, LICSW, Social Service; Lisa Scheck, LICSW, Social Service; Natalie Cusato, LICSW, Social Service; Irene Lee, LICSW; Erina White, LICSW; and Tamara Cadet, LICSW, authored the article, "Interdisciplinary Medical Social Work: a Working Taxonomy," in *Social Work in Health Care*, published on-line, July 22, 2014.

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.

Inter-disciplinary team publishes

Mary Orencole, RN, nurse practitioner, Cardiac Arrhythmia Service; Carly Crocker; and Sanjeev Francis, MD, authored the article, "Cardiac Resynchronization Therapy in the Treatment of Chemotherapy-Induced Cardiomyopathy," in *EP Lab Digest* in July, 2014.

Inter-disciplinary team publishes

David Ring, MD; Arjan Bot, MD; R. Malcolm Smith, MD; Paul Arnstein, RN, clinical nurse specialist, Pain Relief; and Stijn Bekkers, authored the article, "Opioid Use After Fracture Surgery Correlates with Pain Intensity and Satisfaction with Pain Relief," in *Clinical Orthopaedics and Related Research*, in August, 2014.

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Submissions

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

Next Publication

October 2, 2014



Plaku prevents contamination of patient records by writing temporary notes on an erasable board in the patient's room, then uses Cal Stat before transferring the information to the patient's record in the hallway ... and encourages others to do the same.

Bardha Plaku, Lunder 8 Patient Care Associate,
SPEAKS UP
for good hand hygiene

 A message brought to you by the  (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.

Bardha Plaku, patient care associate on Lunder 8 is committed to good hand-hygiene and isn't shy about reminding others to be just as vigilant.
See something, say something.

Caring Headlines

September 18, 2014

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