Caring Headlines
April 16, 2015

Certified Nurses Day

honoring nurses who foster high-quality care through certification in their specialty areas

See story on page 8

Executive director of The Institute for Patient Care, Gaurdia Banister, RN (right), moderates panel discussion with certified nurses (l-r): Dale Spracklin, RN; Corinna Lee, RN; Janet Actis, RN; and Christa Carrig, RN.

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

We're ready... We're *always* ready

That's what Excellence Every Day is all about

Regulatory readiness is not a special effort made every three years to impress the The Joint Commission—regulatory readiness is 'business as usual' at MGH... We can't wait for the Joint Commission to come so we can showcase our good work.

Excellence Every Day is MGH shorthand for perpetually fostering a culture of quality and safety for patients, families, and staff. We know that regulatory readiness is not a special effort made every three years to impress the The Joint Commission—regulatory readiness is 'business as usual' at MGH. We take pride in meeting and exceeding the expectations of patients and families. We can't wait for the Joint Commission to come so we can showcase our good work.

Maintaining a safe, clean environment is a critical part of Excellence Every Day. Not only does it foster a healing atmosphere for patients, it ensures we're able to respond rapidly in the unlikely event of an emergency, such as a fire. Toward that end, Patient Care Services has partnered with the MGH Safety Office to implement a robust fire drill program that includes a minimum of one fire drill per quarter, per shift, per building. Unannounced, interactive fire drills are conducted on units and evaluated for improvement opportunities. The drills give staff an opportunity to practice the RACE response, including simulated rescues; pulling the fire alarm and placing a mock call to 6-3333; closing doors; and simulating the use of fire extinguishers.

A challenging but critical component of life-safety management is ensuring corridors are free of equipment and furniture so patients can be readily evacuated in an emergency. An eight-foot clearance must be maintained; the only items allowed to be in corridors are:

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

- emergency equipment: code carts and defibrillators only
- precaution carts: only adjacent to rooms where precaution patients are receiving care
- beds, stretchers, and wheelchairs: only if actively awaiting a patient
- cleaning and supply carts: only if actively being used
- Workstations on wheels (WOWs): only if actively being used during rounds. WOWs are *not* allowed in corridors if they are:
  - idle for more than 30 minutes
  - plugged in
  - used as stationary work stations
    - Note: staff chairs are not permitted in corridors at any time

High-backed patient chairs and recliners cannot be stored, even temporarily, in corridors, and no equipment, regardless of whether it's on the permitted list, can block access to fire extinguishers, pull stations, gas shut-off valves, or be within three feet of fire doors.

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We've made tremendous progress in reducing clutter and creating an environment for patients that's safe, clean, and welcoming. We all play a part in maintaining that environment. If we see something broken, on the floor, or out of place, we fix it, pick it up, or make it right. And if we don't know how, we call someone who does.

Elevator lobbies and upper-story, connecting corridors (or bridges) also need to remain free of clutter. Perioperative Services, Materials Management, Environmental Services, Nutrition & Food Services, and the Safety Office have collaborated on a pilot program to help improve the flow of beds, stretchers, and wheelchairs to and from inpatient units. The initiative calls for beds, stretchers, and wheelchairs to be returned immediately after use, and when that's not possible, parking them *temporarily* in designated areas on connecting bridge corridors. This system is already working well to keep elevator lobbies and connecting bridge corridors free of clutter on pilot units (6th and 7th floors) and will soon expand to include the 8th through 14th floors. For more information about this initiative, call project specialist, Dan Dolan, at 617-643-9436.

Another way we keep the environment of care safe and welcoming is being careful not to bring food or beverages into areas where patients are treated. Food and drinks are prohibited anywhere there's a risk of exposure to blood or other potentially infectious material. We don't eat or drink in patient-care areas because we want to protect patients, co-workers, and ourselves from contamination; maintain a clean and professional environment; be respectful of those who may be fasting or sensitive to smells; and prevent infestations of insects or rodents.

In 2011, an Infection Control tiger team developed these guidelines for where food and drinks can be safely and appropriately consumed:

Where can we eat and drink?

Location	Food	Drink*
Staff lounges/lunch rooms	Yes	Yes
Conference rooms (where permitted)	Yes	Yes
Private offices	Yes	Yes
Inside nurses' station*	No	Yes
In hallways between patients' rooms	No	No

(*Inside nurses' station means on the low interior surfaces used *only* for clerical purposes. Drinks may *not* be stored or consumed near specimen pick-up bins.)

We've made tremendous progress in reducing clutter and creating an environment for patients that's safe, clean, and welcoming. We all play a part in maintaining that environment. If we see something broken, on the floor, or out of place, we fix it, pick it up, or make it right. And if we don't know how, we call someone who does. Because this is our hospital, and we're about excellence in everything we do.

Our next Joint Commission survey could occur at any time. We're ready. We're *always* ready. We know our patients. We know our practice. And we know how to talk about both. Lets make sure our Joint Commission surveyors feel the full force of Excellence Every Day, MGH style.

In this Issue

April is Occupational Therapy Month

performance-based testing helps facilitate safe, timely discharges

—by Jane Evans, OTR/L, clinical director, Occupational Therapy

Most patients admitted to MGH from home want to return home. Home is what they know—it's where their families are, their friends, their support. Despite shortening length of stay and doing everything possible to prevent re-admissions, ensuring an optimal discharge environment remains crucial. When a patient is deemed medically ready for discharge, it is the responsibility of the entire team to facilitate a safe discharge.

Natasha Frazier, OTR/L, staff occupational therapist, assesses Brittany DiCapua's cognition using performance-based "Kettle Test."

(Photo by Georgia Peirce)

Occupational therapists evaluate a patient's level of independence at performing daily activities. High-level cognitive processes such as memory, attention, insight, and problem-solving are required to safely perform activities of daily living, like bathing, dressing, medication-management, and household tasks. In a hospital setting, staff is available to assist with these activities; we need to assess whether a patient is able to perform these tasks once discharged. With shorter lengths of stay, the time to make these judgments is also shorter. Clinicians are challenged to efficiently identify subtle cognitive impairments that could impact performance when the patient returns to community living.

Occupational therapists use performance-based testing to evaluate a patient's cognitive abilities. Performance-based tests can reveal cognitive deficits that could go unnoticed by simply observing the patient perform activities of daily living. Integrating these test results with an assessment of the patient's physical, visual, and emotional functioning allows OTs to make an accurate estimation of the level of support needed for the patient to safely return to the community. The more accurately we can identify the 'just-right' level of support needed, the quicker patients can go home and the less likely they are to return to the hospital.

The following scenarios show how two occupational therapists used performance-based tests to assess cognition and help determine the best plan for discharge.

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Emily Firn, OTR/L staff occupational therapist, writes: 'Frances' arrived on the Psychiatric Unit needing assistance with the most basic daily tasks: walking, communicating, and caring for herself. Frances was experiencing a severe case of catatonia, a temporary neurologic decline triggered by recent changes to her psychiatric medication. She responded well to treatment, and we soon began to see the 'real Frances,' with her sense of humor, social nature, and fiercely independent spirit. Though she did improve greatly, as discharge approached, we were concerned about her ability to return home safely. Frances still demonstrated difficulties with balance, coordination, memory, and communication, but any talk of assistance at home was met with adamant resistance. We questioned whether Frances would be able to function in the community versus needing to go to inpatient rehabilitation. To better understand her capabilities, I needed to see her perform in a 'community' environment. To accomplish this, I utilized elements of our MGH environment. I asked Frances to navigate busy hallways, budget and problem-solve to purchase items in our gift shop and at Coffee Central. I assessed her ability to manage and sort her medications and cook in our practice kitchen. Frances used great adaptive and compensatory strategies such as asking for directions and asking store clerks for assistance. Based on her performance, we were able to make specific recommendations about the assistance she would need at home to perform everyday tasks and remain safe. We were *almost* as excited as Frances was that she was able to return home with home services and support from her sister.

Madeline Williamson, OTR/L staff occupational therapist, writes: During my rotation on a medical unit, I encountered many patients with cognitive impairments. More often than not, patients with significant cognitive impairments are discharged to inpatient rehabilitation or a home setting with 24-hour support from family and/or other caregivers. However, sometimes patients are unable to be discharged to rehabilitation or home with 24-hour assistance, and it's these situations where an occupational therapist's assessment and intervention can play a significant role in ensuring a safe discharge for patients.

Recently, I worked with, 'Steve,' who was able to walk independently around the unit and appeared to do very well from a physical stand-point. Yet Steve demonstrated significant cognitive impairments that affected his ability to perform everyday tasks such as writing a check or remembering the date. The care team and Steve's family all hoped Steve would be able to be discharged to an acute rehabilitation facility, but given that he was ambulating so well, this was a major challenge. I needed to demonstrate that Steve required 24-hour care given his level of cognitive impairments.

I considered many options and decided to administer the Multiple Errands Test (MET), which was developed by our department to help determine a patient's ability to safely perform high-level cognitive tasks, such as running errands or purchasing a cup of coffee. For this assessment, Steve was given written and verbal instructions to perform several tasks throughout the hospital, including locating the gift shop and purchasing a thank-you card. Steve found it challenging to follow the instructions and complete the tasks outlined in the test.

Ultimately, Steve was unable to successfully complete the MET. What stood out weren't just the significant cognitive impairments observed during his performance, but the fact that Steve believed he had done well with his assignment, actually saying, "I think that went well. I had a lot of fun."

Steve's lack of insight into his own impairments was evident during this MET assessment, which provided indisputable support of my recommendation that Steve needed 24-hour care. With several inter-disciplinary meetings and a final family meeting, we were able to create a successful discharge plan for Steve to go to a rehabilitation facility and a long-term plan for 24-hour care following rehabilitation.

For more information about performance-based testing or any of the services offered by occupational therapists at MGH, call clinical director, Jane Evans, at 617-724-0147.

Partners in Care

encouraging patients to take an active role in their care

—submitted by the PCS Patient Education Committee

Over time, there's been a shift toward patients taking a more active role in their care and clinicians encouraging them to do so. Participating in healthcare decisions is empowering for patients and can be beneficial to their health.

In the not-too distant past, the norm was that patients followed doctors' instructions without question and without any personal input into decisions about their care. Over time, there's been a shift toward patients taking a more active role in their care and clinicians encouraging them to do so. Participating in healthcare decisions is empowering for patients and can be beneficial to their health. The following scenario offers some good examples of the benefits of taking ownership of your health and illustrates how providers can help patients take a more active role in their care.

Mrs. P presents in the Emergency Department saying she, "hasn't been feeling well," for a few weeks. She tells the ED doctor she feels fatigued and is experiencing dizziness. Upon examination, the doctor learns that Mrs. P's heart rate is very low. She's admitted to the Cardiac Unit for monitoring and to be evaluated for a possible pacemaker.

Mrs. P has numerous medical issues and takes a number of medications. After reviewing her medication list, the doctor notices that Mrs. P's heart medication was increased three months ago. After the increase, Mrs. P wrote both the brand name and the generic name of the drug on her medication list, thinking it was two different drugs. The doctor is able to identify and fix the error while Mrs. P is in the hospital.

Caregivers should encourage patients to participate in discussions and decisions about their care. You can encourage patients and family members to take an active role in their care by suggesting they:

- *call their physician about their symptom.*
  If Mrs. P had called her physician when she first noticed her symptoms, he could have caught the medication error sooner and helped her understand her medication
- *understand their medications*
  Patients should keep a list of their current medications and the reasons they're taking them. It can be hard to keep track of more than one medication, especially if the prescription changes in any way. Mrs. P kept a list, but she didn't have a clear understanding of the medications she was taking. She should plan to review the list with her physician the next time she sees him to make sure the list is accurate and to reinforce her understanding of what the drugs are and why she's taking them. It's also helpful for patients to write down any questions they have before going to their appointments. Keeping all health information in a notebook is a good strategy as it allows patients to bring everything they need to future appointments
- *use one pharmacy to fill prescriptions*
  By using just one pharmacy, medications can easily be cross-checked for potentially adverse interactions. The pharmacist can review medications a second time, and he/she is a good resource for questions about medications
- *use prompts as reminders to take medications*
  It's easy to forget to take medications. Setting up reminders, like alarms or sticky notes, can help remind patients to stick to their medication regi-

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men. This would be helpful for Mrs. P because she takes numerous medications that can be difficult to keep track of

- *be honest with their providers*
  Physicians ask personal questions to ensure they have all relevant information so they can provide the best possible care. Patients shouldn't feel embarrassed about answering these questions. In Mrs. P's case, she shouldn't feel embarrassed about misunderstanding her medications; she's not a doctor. Her physician is there to clarify, answer questions, and help her understand her medical needs and treatments
- *ask questions*
  It's important for patients to ask questions if they don't understand their condition, treatment, discharge instructions, or any other part of their care plan. If Mrs. P was unsure of how to take her medications, she could have asked her physician to clarify for her and the medication misunderstanding could have been avoided

How providers interact with patients can have a big impact on a patient's health. There are many ways to encourage patients to take an active role in their care:

Staff nurse, Lindsey Genovese, RN, helps patient, Marilyn Cooke, understand how to use incentive spirometer on the White 10 Medical Unit.

- *Put yourself in your patient's place*
  It's important to try to understand where your patient is coming from. Mrs. P had many medical issues and took numerous medications, which can be overwhelming and confusing. Understanding the patient's perspective is helpful in order to ease their concerns and provide the most meaningful care possible
- *Learn about your patient by asking open-ended questions*
  Patients don't always elaborate when asked 'Yes-No' questions. By asking open-ended questions, you can gain information that could lead you to understand your patient's concerns on a deeper level. If Mrs. P's physician had said, "Do you have any questions for me? Do you understand your plan of care and feel confident you'll be able to follow it?" Mrs. P might have asked about her medications, and the doctor could have clarified her misunderstanding
- *Use plain language and be concise*
  Patients often forget or mis-hear what's said during an office visit. They can be anxious, overwhelmed, or have low health literacy. A good strategy is to use plain language, avoid medical jargon, and focus on the three most important pieces of information first. This would have been helpful for Mrs. P because she had a lot going on with all her medical issues and medications
- *Use teach-back to make sure patients understand their treatment and instructions*
  The teach-back method helps patients solidify their understanding of how to take medications, test blood-sugar levels, and perform other tasks related to maintaining their health. If Mrs. P had been asked to teach-back the change in her medication dosage, it would have given her physician an opportunity to identify her misunderstanding and correct it. And that would help avoid medication errors in the future.

If patients and providers use these few tips, it can go a long way toward strengthening patient-provider relationships and improving health outcomes for patients.

For more information, contact any member of the PCS Patient Education Committee.

MGH celebrates Certified Nurses Day

—by Gino Chisari, RN, director, and Tricia Crispi, RN, professional development specialist, The Norman Knight Nursing Center for Clinical & Professional Development

On Thursday, March 19, 2015, MGH celebrated Certified Nurses Day with a series of events. The day began with every certified nurse in the MGH community receiving a congratulatory e-mail from senior vice president for Patient Care, Jeanette Ives Erickson, RN, who became certified herself this year. Certified nurses were given special lapel pins so they could be easily identified as nurses who've earned certification in their specialty areas. Several certified nurses in collaboration with The Norman Knight Nursing Center for Clinical & Professional Development staffed an educational booth in the Main Corridor that attracted hundreds of nurses interested in learning more about becoming certified.

Staff nurses, Connie Moss, RN, Cheryl Avitabile, RN, and Michael Tady, RN, staff Certified Nurses Day educational booth in the Main Corridor.

Nursing Grand Rounds featured a panel discussion with four certified staff nurses: Janet Actis, RN; Corrina Lee, RN; Dale Spracklin, RN; and Christa Carrig, RN, facilitated by executive director of The Institute for Patient Care, Gaurdia Banister, RN. Panelists shared stories of how they prepared for certification exams, what the exams were like, and how certification has had a positive effect on their practice and professional identity. The day concluded with a raffle, where nurses had an opportunity to win gift cards to an on-line certification prep course of their choosing.

The Norman Knight Nursing Center announced the launch of the ANCC Medical-Surgical Study Group and ANCC Success Pays Program. The study group begins in mid-April and will run for eight weeks, facilitated by Cheryl Avitabile, RN, professional development specialist. The study group is an opportunity for staff nurses to learn together and support one another on the journey toward certification. Study group presentations will be videotaped and made available to nurses interested in starting their own study groups. The Success Pays program is the result of a partnership between MGH and the ANCC to pay the application fee for any ANCC certification exam. For more information, speak to your nursing director or manager.

A certification 'tool kit' has been created, and is available on the Excellence Every Day portal under the Professional Development tab.

Nurses seek professional certification for many reasons; perhaps most important among them is the fact that it raises the quality of patient care. For more information about the ANCC Medical-Surgical Study Group or the Success Pays program, call the Knight Nursing Center at 6-3111.

Continuing education key to career advancement

—by Alexa Gedies, training associate

Applications for the 2015 MGH Support Service Employee Grant Program are being accepted through Tuesday, May 13, 2015. Grants are available to eligible, non-exempt employees in administrative, clinical, service, and technical-support roles.

Manju Chettry immigrated to the United States from Nepal in 2005. Motivated to improve her English, she began taking English classes in her community. Soon, Chettry leveraged her healthcare experience and passion for helping others and came to work at MGH as a patient care associate in the Gastrointestinal (GI) Unit.

"People were so nice," says Chettry. "I felt very comfortable and welcomed. I wanted to keep improving my language skills, so I decided to go back to school." Chettry continued her education with on-site English for Speakers of Other Languages (ESOL) classes through the hospital's Workplace Education Program. Eventually, she moved on to English for Academic Success, which focuses on building skills for college.

Determined to go to college, Chettry took Pre-College English and math classes and ultimately passed the college placement exam.

"I learned a lot in those classes," says Chettry. "My English wasn't good before, but I improved a lot. It really helped with my school work in college."

In 2013, Chettry was accepted into the Surgical Technology Certificate Program at Bunker Hill Community College. After hearing about the MGH Support Service Employee Grant Program from her academic coach, Danielle Asselin, she applied for and received a grant. And she applied for tuition assistance to help finance her education.

Chettry graduated from the program with a 4.0 GPA and passed the national certification exam shortly thereafter. A month later, she accepted a position as surgical technologist in the GI Unit.

Manju Chettry
surgical technologist

Chettry is a wonderful example of how continuing education and support programs at MGH can help advance career aspirations. Says Chettry, "MGH offers so many resources that helped me with school and my career. And now that I'm a surgical technologist, I still learn new things every day."

Applications for the 2015 MGH Support Service Employee Grant Program are being accepted through Tuesday, May 13, 2015. Grants are available to eligible, non-exempt employees in administrative, clinical, service, and technical-support roles. For more information about the grant program, tuition assistance, upcoming financial-aid workshops, or the annual education fair, go to the MGH Training Workforce and Development website on the intranet: http://is.partners.org/hr/New_Web/mgh/mgh_training.htm, or send e-mail to: MGHTraining@partners.org.

Medical nurse inspired by relationship-based care

My name is Heather Evoniuk, and I am a nurse on the White 9 Medical Unit. I met RK when he was admitted after sustaining a pathological fracture of his left humerus. He's 42 years old with progressive multiple myeloma. On his way to chemotherapy treatment, RK had felt a 'pop' and now needed surgery to repair the fractured bone. I met him the morning after he was admitted from the Oncology Unit.

I met RK when he was admitted after sustaining a pathological fracture of his left humerus. He's 42 years old with progressive multiple myeloma.

I meet many young patients, but RK particularly affected me. Maybe because he's the same age as my husband, and I could imagine myself in his wife's position. This is part of working on White 9—some patients tug at your heart.

RK didn't want to talk to me when we first met. When I introduced myself, he wouldn't make eye contact. He didn't want the lights on or the blinds open. He responded to questions with one-word answers and soon rolled over and turned away from me. I wasn't surprised he didn't feel like talking—it was 7:30 in the morning, and he was probably hungry. He hadn't eaten since last night and was NPO (no food by mouth) for surgery. But over and above this behavior, he seemed anxious. His voice was a bit high-pitched and his morning vital signs were elevated. When I brought RK his medications, I asked about his pain level. He reported minimal pain (only when he moved his left arm), so I knew pain wasn't causing the elevated vital signs.

Heather Evoniuk, RN, staff nurse, White 9 Medical Unit

Experience has taught me that most patients appreciate a caring, non-judgmental nurse who listens. I knew RK's wife would be arriving soon, so I sat with him briefly and chatted. I told him I understood his anxiety about surgery. I reassured him that I'd be with him all day and do everything I could to control his pain and keep him informed about the day's activities.

RK's wife arrived around 10:00am. She had a few questions, so I sat with them and talked about what would happen. I told them I'd call the OR and try to find out when the surgery was scheduled. RK expressed some concern about pain-management after surgery, so we talked about some medication options.

RK wanted me to stay with him after his wife arrived, which gave me a chance to learn more about him and develop a relationship. He began to open up to me. He shared some of the frustrations and challenges he'd faced since being diagnosed. He and his wife told me about their lives. They had two children, one in high school. They joked about his mood swings, curfew violations, arguments, and the excitement of seeing him learn to drive and plan for college. They were living a happy life with joys and struggles—house payments, school sports, vacations, hospital bills, insurance, and the increasing challenges associated with RK's disease. I learned that RK had had a stem-cell transplant six months before. He'd recently experienced vocal-cord paralysis that required a tracheostomy and

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felt things were starting to 'spiral downhill.' He'd lost ten pounds in the last few months and couldn't seem to gain weight. I told them I'd initiate a nutrition consult given what they told me about his weight-loss.

Within the hour, RK and his wife were speaking to a dietician. The dietician on our unit is calm and knowledgeable, so I knew she'd be a good person for RK to speak with before surgery. They spoke about foods high in protein and calories and snacking between meals to help gain weight. It gave RK and his wife something positive and goal-oriented to focus on. I hoped it would take RK's mind off his surgery.

RK was on his way to the OR by mid-day. I monitored the computer system to make sure his surgery proceeded as planned. As my shift ended, I noticed that RK had been brought to the PACU. I looked forward to hearing how surgery had gone when I returned the next day. But the next morning I learned that RK had had a rough night. He was in a lot of pain and had required a few doses of intravenous pain medication. I was sorry to hear it, but glad RK had informed the night nurse that he needed something. He seemed to be gaining trust in staff; the day before he'd been stoic about his pain.

I knew RK wanted to go home that night to attend a parent-teacher conference at his son's school. But if he continued to require intravenous pain medication, he wouldn't be cleared to leave. When I entered RK's room, he appeared to be in pain but said, "Good morning. I'm glad to see you're taking care of me today."

I could tell by his demeanor that he trusted me. He was open and initiated conversation without any prompting. He reported a four out of ten on the pain scale and wanted to try some oral medication. He was currently receiving OxyContin every eight hours, but he clearly needed something more. I had explained the day before that intravenous pain medication was available, but I suggested we try the short-acting oral agent, oxycodone. With orders from the medical team, we started with the smallest dose and waited about 20 minutes to assess its effect. It was only minimally effective, so the team increased his dosage, which seemed to alleviate much of his pain after about 30 minutes.

As the morning progressed, RK reported his pain was, 'Okay.' He was able to move his arm slowly and delicately, and soon both physical and occupational therapy cleared him to go home. We spoke about how continued pain might be part of the healing process. I gave him some educational materials and explained that it would take time for the ligaments, tendons, and muscles to build strength again and it would likely be painful as they began to work again. My chief concern was ensuring his pain was under control with movement and activity before he went home. It took some time for RK to understand that some pain would be part of the healing process but that it should continue to get better.

By lunch time, it was clear that RK would be going home once his oncologist approved his discharge. RK's wife arrived, and we talked about tracheostomy care, the importance of RK moving his arm and monitoring his range of motion, his diet and goals for weight gain, and post-op care for the incisions on his arm. I answered their many questions, and RK and his wife were very happy to be leaving the hospital.

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When RK's wife went to get the car, he turned to me and appeared nervous again. I remembered this look from before his surgery. I asked if he was ready to go home. He said he was, "nervous about the days and months to come." He was worried about being a burden and not being able to care for his family. We spoke about the healing process, the course of his disease, and how strong and resilient he'd been. He reminded me he'd begin downsizing his tracheostomy in the next week and hoped to de-canulate soon after that. A volunteer arrived to escort him out. We shook hands and said goodbye, and RK was discharged from White 9.

Even after six years of nursing, certain patients make a lasting impression. Nursing can be emotionally challenging and tiring at times, but I'm motivated by all the patients I care for. With RK, I felt especially vulnerable because I related to him and his family so well. His situation could have been mine. It was a good reminder to treat RK and his wife as I would my own family, something I aim to do with all my patients.

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

Heather's narrative is a wonderful example of the power of relationship-based care. She saw RK's whole demeanor change as she cared for and about him and sought to fully understand his experience. Heather's active engagement with RK and his wife and her ability to provide a safe space for them brought them to a place where they could process their feelings, begin to grieve, and begin to heal.

Thank-you, Heather.

New director of Nursing Research and Innovation

Bourbonniere, an accomplished nurse leader with a background in academia, clinical service, and operations management, comes to MGH with an impressive record in translational research, inter-disciplinary leadership, and teaching and mentoring nurses at all levels.

Patient Care Services is pleased to welcome Mary 'Meg' Bourbonniere, RN, to the role of director of Nursing Research and Innovation, effective March 30, 2015. Bourbonniere, an accomplished nurse leader with a background in academia, clinical service, and operations management, comes to MGH with an impressive record in translational research, inter-disciplinary leadership, and teaching and mentoring nurses at all levels.

Most recently, Bourbonniere served as vice president of Nursing Research at Thomas Jefferson University Hospital in Philadelphia where she provided leadership in nursing research, evidence-based practice, informatics, continuing education, patient education, professional development, the nurse residency program, and international programs. She developed and led inter-disciplinary teams in obtaining research funding and advised and mentored nurses through research projects.

Bourbonniere's own research includes studies related to inter-organizational relationships and post-surgical cancer care; the transfer of care; hospital staffing, restraints, and older adults; and the Hartford Centers of Geriatric Nursing National Nursing Home Collaborative.

Prior to Thomas Jefferson University Hospital, Bourbonniere led an inter-disciplinary initiative to reduce hospital-acquired pressure ulcers at Rhode Island Hospital. Since 2010, she has led or participated in approximately 100 research studies, published two works, secured externally funded grants, and participated in numerous regional and national poster and/or podium presentations. She has served on advisory boards and search committees and is well published in nursing and research journals.

Mary 'Meg' Bourbonniere, RN, director of Nursing Research and Innovation

Says Bourbonniere, "As a relatively new employee, I'm still somewhat speechless. But, I'm impressed with everyone I've met and everything I've seen at MGH. With such a strong foundation of research and evidence-based practice, I'm confident that working with clinical nurses and nurse leaders, we'll continue to innovate, generate new knowledge, and create an exciting new future in the Munn Center."

Dorothy Jones, RN, will continue as director emerita of the Yvonne L. Munn Center for Nursing Research, and Jeff Adams, RN, will continue as associate director of the Center for Innovations in Care Delivery.

Bourbonniere can be reached at 617-724-4934.

New director of Volunteer Department and Information Associates

On March 30, 2015, Patient Care Services was fortunate to welcome Jacqueline Nolan as the new director of the Volunteer Department and Information Associates. Nolan comes to MGH from Boston-based, John Snow, Inc. (JSI), a public-health management consulting firm dedicated to improving the health of under-served communities and providing a space where people of similar passion and commitment can come together to advance the cause. A beautiful fit for the work she'll be doing at MGH. Nolan served as program consultant for JSI for the past 17 years, primarily responsible for project-management and developing and overseeing multiple teams and long-range projects.

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Nolan worked for the Department of Health and Human Services' Office of HIV/AIDS Policy as managing director of its national AIDS.gov Project, an initiative designed to leverage new media technologies to promote Federal HIV policies and programs. She served as project director for the Massachusetts Department of Public Health's Comprehensive Cancer Prevention and Control program to award and support three Massachusetts community-based organizations in implementing practice and evidence-based strategies to reduce cancer health disparities throughout the state. She was director of the COOP project for the Emergency Preparedness Division of the Massachusetts Department of Public Health, working with 12 state bureaus to develop a department-wide cooperative that would be simple, effective, and in compliance with Federal Emergency Management Agency (FEMA) standards.

Jacqueline Nolan
director of the Volunteer Department and Information Associates

Nolan's extensive experience with program assessment, development, and oversight will be an invaluable asset as she takes the helm of the multi-faceted Volunteer Department and Information Associates.

Says Nolan, "I am delighted to be part of MGH, and I'm looking forward to working with volunteers, staff, and the entire hospital community."

Nolan replaces out-going director of the department, Wayne Newell, who'll be stepping down at the end of April. She will work closely with Milton Calderon, volunteer coordinator, and Michael Stone, manager of Information Ambassador Services.

Nolan can be reached at 617-724-1753.

Revised MGH Acute In-House Stroke Protocol

—by Priya Vader, senior consultant, MGH Center for Quality & Safety
and Natalia Rost, MD, director, Acute Stroke Services

Time is brain. When a patient suffers a stroke at MGH, it's imperative that he/she is evaluated and treated as quickly as possible. Strokes that qualify for acute interventions must be reviewed extremely carefully in order to deliver brain-saving treatment in a safe, effective manner.

The Acute Stroke Quality Task Force recently approved a revision to the In-house Stroke Protocol. The goal of the revision is to improve communication between team members and simplify the workflow for all participants.

IN-HOUSE STROKE PROTOCOL

FACE DROOPING
ARM WEAKNESS
SPEECH DIFFICULTY
TIME TO CALL 6-3333

	FLOOR UNIT 5 MINUTES	GROUP PAGE 10 MINUTES	ED CT SCANNER 25 MINUTES
Clinical Nurse	•Check fingerstick glucose •***Call 6-3333 & "Patient has Stroke"*** •NO OVERHEAD PAGE •Obtain Last Seen Well (LSW) time •Notify Floor Physician	•***Reminder : Stroke Fellow responds in 10 mins*** •Confirm LSW time to Stroke Fellow •Do not place lines, foley, NGT •Monitor Vital Signs Q15 •Bring pump and travel monitor	•Transport patient to CT scanner and continue to monitor vital signs Q15 •Once Stroke confirmed, give report to Neuro ICU Nurse •Fellow and Pharmacist calculates dose, mix tPA and 10% bolus dose •Start 90% tPA (Alteplase) infusion using BASIC MODE on pump to infuse over 1 hour under Triage Supervisor's supervision
Operator	•After "Stroke" call from floor page Stroke Fellow (34-CVA) and say to caller "The fellow will be with you within 10 mins" **(Do not Overhead)**	•If repeat page requesting for same patient/ same unit, then page Stroke Attending	
Floor Physician	•Provide patient history to responding Stroke Fellow	•Order the weight-based tPA dosing with Stroke Fellow's input	•Accompany patient to CT scanner •Transfer patient to Neurology Service •Remain with patient until transferred
Stroke Fellow	•Receives page from Operator •Contacts unit by phone and/or In-person to examine patient •If unavailable, dispatch Neuro Resident (20202) STAT	•Confirm Stroke with all parties involved •***SEND GROUP PAGE G422 activating Inhouse Stroke Protocol team*** (Patient Name, Location and if enroute to CT scanner) •Transport patient to ED CT scanner	•Determine NIHSS, Patient weight and calculate tPA dose •Complete Inclusion/Exclusion criteria and manage strict BP control •Review CT Scan •Provide initial dose of tPA bolus •Confirm if other Radiology tests (MRI) or IAT procedure are required
Neuro Resident	•Respond to Stroke Fellow request and STAT assess patient if Fellow not available	•Assess patient with Stroke Fellow •If Stroke Fellow unavailable, perform all tasks as Stroke Fellow (see above) under supervision •Report back to Fellow and/or Attending	•Assist Stroke Fellow to calculate weight-based tPA dose •Review with Nurse and Pharmacist •If Stroke Fellow unavailable, stat page Attending and perform all tasks as Stroke Fellow (see above) and review with Stroke Attending
Radiologist		•After receiving page, assures CT is scheduled	•Discusses with Stroke Fellow regarding imaging sequences
Clinical Supervisor	•Arrives at bedside	•Supports Clinical Nurse in patient care and transport to ED CT scanner •Arrive to scanner with patient and clinical team	•Confirm tPA dosing with Fellow and Pharmacist •Guide Clinical Nurse in tPA delivery and process for patient transfer •Arrange ICU bed for transfer
Pharmacist		•After receiving page, arrive to CT scanner	•Review tPA order with Stroke Fellow •Mix the IV tPA for administration •Assist team with BP medication administration if needed
IV Team Nurse		•After receiving page, arrive to CT scanner	•Place right anticubital IV and second IV if patient lacks 2 IV sites •Send Labs, Chem-8, CBC, Coags if needed
Resource Nurse/ Neuro ICU		**RESOURCE RN:** •Deploy tPA kit to ED CT Scanner •Assign ICU nurse •Arrange bed with supervisor	**STAFF NEURO ICU RN:** •Arrive in ED CT scanner •Confirm transfer and receive report from Clinical Nurse •Confirm tPA pump infusion rate

The above protocol can be downloaded at: http://www2.massgeneral.org/stopstroke/pdfs/inHouseStroke.pdf.

For more information, contact Mary Guanci, RN, clinical nurse specialist, at 857-238-5649, or Tara Tehan, RN, nursing director, at 857-238-5607.

Organizational Readiness

work groups forming for Partners eCare

Organizational readiness is the name of the initiative under way to prepare MGH and the MGPO for the transition to Partners eCare. The director of Organizational Readiness for MGH is Marcy Bergeron, RN.

Question: What is 'organizational readiness?'

Jeanette: Organizational Readiness is the name of the initiative under way to prepare MGH and the MGPO for the transition to Partners *e*Care. This work is being led by the MGH *e*Care project team. The director of Organizational Readiness for MGH is Marcy Bergeron, RN.

Question: What activities does that encompass?

Jeanette: Readiness activities include reviewing workflows in *e*Care, identifying the impact of changes in our work, and managing those changes proactively. 'Workflow' refers to the series of steps that overlaps the care of the patient with documentation. For example, the initial nursing assessment, or an ambulatory-practice office visit, or placing orders for a surgery. Other readiness activities include preparing direct-care staff for *e*Care. We need to identify all future users and match them with their roles and appropriate access, identify and train super users, register and train all users, provide opportunities for practice and personalization of *e*Care, ensure all printers and other devices are mapped properly—do all of that and be ready for the day that *e*Care goes live.

Question: In terms of *e*Care, what is a 'work group' and how will they help?

Jeanette: A work group represents a high-level coalition of areas within MGH and the MGPO that shares type of work, patient populations, and leadership. Most work groups will likely have sub-groups, and each sub-group will have a lead to manage that work. The leads will report to the leadership and executive sponsors. The organizational structure is still being drafted, but we expect there to be 12–14 groups. This creates a structure for accountability, communication, and management. All the activities of organizational readiness are occurring as a result of work groups.

Question: How does one work group know what the others are doing?

Jeanette: MGH is a big place, and patients move across many areas. Work groups will send representatives to other work group sessions, especially as we validate workflows. The MGH *e*Care project team will help coordinate this work and ensure that the right representatives interact with the right work groups at the right time. And sub-group leads will have ample opportunity to meet and confer with leaders and/or sponsors. We'll have a strong communication plan to update work groups and the entire organization about concerns, discoveries, and progress made. You've heard me say many times, "Never worry alone." This is definitely one of those situations. We're all in this together. Talking to colleagues, working together, and supporting one another will be key to our success.

Question: Whom can I contact for more information?

Jeanette: Your nursing and departmental directors will know more about the readiness activities in your area as we get closer to implementing them. Marcy Bergeron is available to answer any questions about organizational readiness. She can be reached at 617-726-7923.

Announcements

Mid-Life Women's Health Conference

Staying healthy and well

Free educational event, presented by The Mass General Mid-Life Women's Health Center, focuses on the unique and complex health needs of women at mid-life.

Tuesday, May 5, 2015
4:00-6:30pm
O'Keeffe Auditorium

Topics will include cardiovascular health, nutrition, hot flashes, and insomnia.

To register, e-mail Emilia O'Brien. For more information, go to: www.massgeneral.org/obgyn/CommunityHealthEvent

ACLS Classes

Certification:

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

Day one:
June 15, 2015
8:00am–3:00pm

Day two:
June 16th
7:00am–1:00pm
(Note early start time)

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

Locations to be announced.
Some fees apply.
For information, contact Jeff Chambers at acls@partners.org

To register, go to: http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf.

Creating a safe, comfortable workspace

Learn about office ergonomics

If you're experiencing pain from sitting in the same position for hours at a time, come learn about office ergonomics.

Wednesday, April 29
10:00am–3:00pm
Main Corridor

Learning about office ergonomics can help you be more productive and lead a healthier life. Event is free and open to all.

Hosted by The Maxwell & Eleanor Blum Patient and Family Learning Center.

For more information, call 617-724-7352.

Free one-day bereavement program for children and families

MGH, in partnership with Comfort Zone Camp (CZC), is holding a free one-day bereavement program for children ages 5–17 and their families. Children who've experienced the death of a parent, sibling, or guardian are invited to register for a day of mentorship, support, and group activities. Parents are encouraged to attend the parent/guardian program held at the same location.

Saturday, July 25, 2015
8:30am–4:00pm
MGH Institute of Health Professions

Volunteers are also needed. (Call 781-756-4840)

For more information or to register on-line go to www.comfortzonecamp.org/MGH-CZC., or call Todd Rinehart, LICSW, at 617-724-4525.

Blum Center Events

Shared Decision Making:
"Sleeping better: help for long-term insomnia"
Tuesday, April 28, 2015
12:00–1:00pm
Join us for a short video and a presentation by Kathleen Ulman.

National Health Observance:
"Alcohol Awareness Month"
Thursday, April 30
12:00–1:00pm
Join Emine Nalan Ward to learn about the effects of alcohol and ways to recognize and treat alcohol problems.

Programs are free and open to MGH staff and patients.
No registration required.
All sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

Fourth annual MGH Global Health Expo

Wednesday, May 6, 2015
12:00–3:00pm
under the Bulfinch Tent

The MGH Global Health Expo will showcase more than 30 departments, divisions, and organizations working in global health at MGH.

- Learn more about international and domestic opportunities for all staff
- Network with colleagues and meet new collaborators
- Food and refreshments
- Stop by any time throughout the afternoon

Sponsored by the MGH Center for Global Health: www.massgeneralcenterforglobalhealth.org.
For more information, call Rachel Rifkin at 617-724-3194.

Local NENIC educational event

April 30, 2015
8:00am–4:00pm
"Trends in Clinical Informatics: a Nursing Perspective"

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

For more information, contact Mary Kennedy, RN, at program@nenic.org; or Joanna Jung, RN, at 617 549-2812.

Senior HealthWISE events

All events are free for seniors 60 and older

"Living with Hearing Loss"
Thursday, April 16, 2015
11:00am–12:00pm
Haber Conference Room, MGH

Speaker: Ellen O'Neil, associate director, Department of Audiology, Mass Eye and Ear Infirmary; Instructor, Harvard Medical School

For more information, call 4-6756.

Benson-Henry Institute for Mind Body Medicine

Live CME course:
Mind Body Medicine and Cardiovascular Disease
May 1st
8:30am–4:30pm
Newton-Wellesley Hospital, Bowles Conference Center
For information, go to: http://mghcme.org/courses/course-detail/mind_body_medicine_and_cardiovascular_health.

Or call 617-726-5387 for more information on either class.

Nurse Week Schedule

Nurse Recognition Week

May 3–8, 2015

Sunday, May 3rd

Staff Nurse Breakfast
7:00–9:00am
The Trustees Room, Bulfinch 2

Monday, May 4th

"The Wisdom of Experience:
Advancing Practice through Narratives"
facilitated by Colleen Snydeman, RN, director,
PCS Office of Quality & Safety,
and Jana Beth Deen, RN, senior director
of Patient Safety,
MGH Center for Quality & Safety
10:00–11:30am
O'Keeffe Auditorium, Blake 1

Chief Nurse Address
presented by Jeanette Ives Erickson, RN,
chief nurse
1:30–2:30pm
O'Keeffe Auditorium and
Haber Conference Room, Blake 1

Staff Nurse Reception and
Military Cake-Cutting Ceremony
2:30–4:00pm
The Trustees Room, Bulfinch 2

Tuesday, May 5th

"Understanding Biases Can Make You a
Better Caregiver and Co-Worker"
presented by Vernā Myers
diversity advocate and principal of the
Vernā Myers Consulting Group
1:30–2:30pm
O'Keeffe Auditorium, Blake 1

Wednesday, May 6th

Research Day

Interactive Nursing Research
Poster Session
10:00–11:30am
O'Keeffe Auditorium Foyer
(Research posters on display throughout
Nurse Recognition Week)

Yvonne L. Munn Nursing Research Lecture
and Presentation of 2015 Research Awards
"Advancing Nursing Research at MGH:
Views and Vision"
presented by Meg Bourbonniere, RN,
director of Nursing Research and
Innovation
1:30–3:00pm
O'Keeffe Auditorium, Blake 1

High Tea immediately following this session
in The Trustees Room, Bulfinch 2

Thursday, May 7th

"Making Florence Proud: Using Nursing
Informatics in Your Daily Practice"
presented by Emily Barey, RN, director of
Nursing Informatics, Epic
1:30–2:30pm
O'Keeffe Auditorium, Blake 1

Friday, May 8th

"Reflect, Re-Fuel and Re-Balance"
presented by Margaret Baim, RN, director
of the Center for Training at the Benson
Henry Institute of Mind Body Medicine,
and Kathleen Miller, RN, adjunct assistant
professor of the Mind Body Spirit Nursing
Program at the MGH Institute for Health
Professions
11:00–12:00am
O'Keeffe Auditorium, Blake 1

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Next Publication
May 7, 2015

The meaning behind mechirat chametz (the sale of the leaven)

—by Rabbi Ben Lanckton

Throughout history, Christians and Jews have lived in shared lands, sometimes at odds but often in harmony. One Jewish tradition that dates back to a harmonious time is mechirat chametz, the sale of the leaven. Leavened bread and other leavened products are prohibited from being owned or eaten by Jews during Passover, so the rabbi of a Jewish community would sell his leavened products to a leader of the non-Jewish community to be in adherence with Judaic law. Jews would eat or donate as much of their chametz as they could before the holiday, then sell the rest. Tradition has it that the Christian or non-Jewish leader would buy the chametz with a small, symbolic down-payment to establish ownership, then as a sign of good will 'fail' to complete the transaction after Passover, reverting the chametz to its original owner.

This springtime ritual, performed in hundreds of communities around the world, demonstrates the long history of cooperation and understanding between Jews and Christians.

For more information about mechirat chametz or any religious traditions and practices, contact the MGH Chaplaincy at 617-726-2220.

Rabbi Ben Lanckton, gives symbolic gift to non-Jewish chaplaincy resident, Barbara Schreur, in gratitude for sale of leaven, as witnesses, Bessie Manley, RN, and Ed Andrews, look on.

Rabbi Lanckton and Schreur seal the deal with a handshake.

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