

Caring

Headlines

March 19, 2015

Innovation in care-delivery

PCS Strategic Goal #3

(See Jeanette Ives Erickson's column on page 2)



Attending nurse, Venice Scott, RN, reviews discharge instructions with patient, Sheila Whigham, on the Ellison 12 General Medical Unit. The attending nurse role is one of the interventions introduced as part of the Innovation Unit initiative.

2015 PCS Strategic Plan

Goal #3

Continuing on with our series describing the goals of our 2015 PCS Strategic Plan (see opposite page), I'd like to focus this column on Goal #3, Innovation in Care-Delivery. This goal builds on the substantial work we've done to improve the Patient Journey on Innovation Units while trying to replicate that success in the ambulatory setting. This goal is driven by hard data and feedback from patients, families, and front-line staff.



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

Goal #3
Innovation in
Care-Delivery:
enhance the patient
experience, ensuring
a coordinated,
standardized, and
evidence-based
model of care-
delivery throughout
the Patient Journey

Goal #3

- Innovation in Care-Delivery: enhance the patient experience, ensuring a coordinated, standardized, and evidence-based model of care-delivery throughout the Patient Journey

Tactics:

- Re-examine the 15 Innovation-Unit interventions utilizing:
 - staff input from the Innovation Unit Retreat
 - input from the Interventions Survey
 - patient interviews

During the PCS Strategic Planning Retreat, considerable discussion centered around the 15 Innovation Unit interventions and whether they're being used to their greatest benefit; whether they should all carry forward as we implement Phase IV (non-inpatient) Innovation Units; and whether the value added outweighs any costs associated with the

interventions. We're talking about interventions such as: the attending nurse role; the Welcome Packet; inter-disciplinary rounds; smart-phones; quiet hours; and hourly rounding, to name just some of the original 15.

At our Innovation Unit Retreat, January 7, 2015, we reviewed our evaluation data and heard first-hand from staff about their perceptions of the interventions and their impact on patient-satisfaction; quality; cost; efficiency; and staff-satisfaction. We now have the advantage of three years of hind-sight in assessing the effectiveness of these interventions. We want to retain and support the ones that are working and adapt or discontinue the ones that aren't. Feedback from the retreat and data from many other sources will inform our work on this strategic goal as we move forward.

- Design an implementation and sustainability plan regarding results of the above tactic with a focus on standardization first, and customization as appropriate
 - Implement and evaluate the plan

continued on next page

When staff from different units come together and start talking as they did at the Innovation Unit Retreat, the variability in *how* these interventions have been implemented becomes very apparent. The attending nurse role doesn't look the same on the Ellison 12 Medical Unit as it does on the Lunder 9 Oncology Unit. There's variability in how inter-disciplinary rounds are conducted from unit to unit. One of the initial tenets of Innovation Units was to standardize processes wherever possible. Standardization contributes to both safety and efficiency. It's understandable that some variation will occur due to unit-specific needs, staffing fluctuations, and other factors, but we don't want to lose sight of our original intent to standardize processes when it makes sense to do so. This tactic is to ensure that standardization is always the first option, and customized alternatives are only used if the standardized approach doesn't work. Best practices will be identified and shared.

- Identify and implement interventions to promote throughput and safe hand-offs for patients in Phase IV (non-inpatient) settings

Inpatient and outpatient settings have different systems and different needs. Staff must be able to communicate, interact, and transfer patients from one setting to the other with no interruption of care or service. It makes sense that enhancing throughput and hand-over communication be part of the work of Innovation Units as we roll out Phase IV of this initiative. With input from staff and feedback captured at the Innovation Unit Retreat, we will identify and implement interventions to enhance throughput and ensure seamless hand-offs among and between inpatient and outpatient settings.

We are committed to the success of Innovation Units and enhancing the Patient Journey. This goal will help ensure that our decisions for the future are based on hard data and evidence. If you have comments or suggestions as we move forward, please don't hesitate to send them to me.

In the next issue of *Caring Headlines*, I'll share the tactics associated with Goal #4 of our strategic plan, Workforce.

2015 PCS Strategic Plan

- **Excellence Every Day:** optimize the patient experience by providing the highest quality, safest, most efficient care that meets or exceeds the expectations of patients, families, the hospital, or external organizations
- **Partners eCare:** implement and evaluate the use of standardized documentation tools to support the process of optimizing the patient experience and outcomes
- **Innovation in Care-Delivery:** enhance the patient experience, ensuring a coordinated, standardized, and evidence-based model of care-delivery throughout the Patient Journey
- **Workforce:** be an employer of choice known for embracing diversity, inclusion, and staff-engagement in order to foster an informed, self-sustaining, creative workforce

We are committed to the success of Innovation Units. This goal will help ensure our decisions for the future are based on hard data and evidence. If you have comments or suggestions as we move forward, please don't hesitate to send them to me.

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● Katie Murphy, LICSW			

Reducing length of stay one creative idea at a time

—by staff nurse, Candice Couture, RN, and the PCS Restraint Solutions in Clinical Practice Committee

When you're in need of acute care, the best place to be is in the hospital. But once the urgency has passed, patients recover better in their own homes or in a less-acute care facility. In her July 3, 2014, *Caring Headlines* column, senior vice president for Patient Care, Jeanette Ives Erickson, RN, wrote about a hospital-wide initiative to optimize patient flow and asked for suggestions on how to safely and efficiently reduce length of stay. Staff on Ellison 12 recently employed a strategy in caring for Mr. J that both improved care and reduced the amount of time he spent in the hospital.

Mr. J was a 64-year-old man admitted to Ellison 12 due to a problem with his hemodialysis catheter. He had a complex medical history, including hypertension, anoxic brain injury, and renal failure, which required dialysis. Due to these and other factors, Mr. J suffered a significant change in his mental status. He became combative, would climb out of bed and remove his IV and monitoring lines. Concerned for his safety but not wanting to resort to restraints quite yet, staff nurse Tamyka Brown, RN, and colleagues employed interventions such as re-orientation, bed alarms, moving him closer to the nurses' station, and distraction, but Mr. J continued to exhibit potentially risky behavior. After discussing it with the team, an order was obtained for restraint mitts.

With restraints, Mr. J couldn't harm himself, but he remained agitated. When his condition stabilized and he was medi-

cally ready to transition to the next level of care, he couldn't be transferred because facilities refused to accept a patient in restraints. Brown approached her clinical nurse specialist who suggested a new sensory mitt the Restraint Solutions Committee had championed to help keep patients safe and restraint-free.

The sensory mitts are soft, bead-filled mitts that allow free movement of the fingers and can be removed by the patient at any time. The beads offer a calming distraction while allowing more freedom of movement. The medical team supported removing the restraint mitts from Mr. J in favor of the sensory mitts. Mr. J was safer and calmer with the sensory mitts, and the restraints never had to be re-applied. Soon after, Mr. J was transferred to the next level of care, which in all likelihood would not have happened had he remained in restraints.

By staying focused on the patient, employing creative problem-solving and an alternative to restraints, Mr. J was able to receive the appropriate care in the appropriate setting at the appropriate time.

Sensory mitts are available through PeopleSoft (Order # 441959). For more information about restraint alternatives, contact any Restraint Solutions Committee champion.



Ellison 12 staff nurse and Restraint Solutions Committee champion, Candice Couture, RN, demonstrates the flexibility and less-restrictive (beaded) padding of sensory mitt.

MGH Back Bay safety reports trigger national product recall

—by Virginia Barret Clarke, RN; Rebecca Pierce, LPN; Erin Dart, LPN; and Denise Tompkins, RN

Staff of the MGH Back Bay Health Center recently learned first-hand the importance of filing safety reports when their actions led to the timely replacement and ultimately the national recall of a faulty product. After introducing a new hypodermic needle and syringe at their clinic, a nurse reported a critical incident to her manager. Two additional events were reported shortly thereafter, followed by a fourth.

Staff alerted nurse manager, Lisa Brugnoli-Semeta, RN, that the product leaked during injection because the needle separated from the syringe necessitating repeat injections. Staff was frustrated by these failures and concerned for the safety and comfort of their patients. Brugnoli-Semeta encouraged staff to submit safety reports while she worked to replace the needles.

Staff specialist, John Murphy, RN, of the MGH Center for Quality & Safety (right), presents MGH Back Bay nurses, (l-r): Virginia Barret Clarke, RN; Rebecca Pierce, LPN; Erin Dart, LPN; and Denise Tompkins, RN, with an FDA certificate of recognition for their efforts to keep patients safe.

When the safety reports were received by staff specialist, John Murphy, RN, in the MGH Center for Quality & Safety, he contacted Brugnoli-Semeta who had already reached out to the manufacturer. Murphy put Brugnoli-Semeta in touch with Ed Raeke, the director of Materials Management, who regularly reviews product-related safety reports. Together, they spoke with the manufacturer.

The Center for Quality & Safety submitted a report to the FDA alerting them of a potential problem. Says Murphy, “Companies benefit from this kind of feedback from front-line staff as it allows them to continuously improve their products based on performance in real patient-care situations.”

Two months after the reports were filed, MGH received a letter from the FDA commending staff for reporting this important issue. The product defect identified by staff triggered a nationwide, Class II, product recall, averting potentially unknown harm to patients.

Front-line staff play a critical role in helping companies identify product failings. Nurses, phlebotomists, technologists, and physicians are primary users of medical devices that can directly impact patient safety. It’s imperative that clinicians file safety reports whenever a safety risk or product defect is identified or even suspected.

Says Brugnoli-Semeta, “I’m so proud of MGH Back Bay staff and their actions to support a culture of safety. Their efforts truly made a difference for our patients and had an impact on national patient safety.”



(Photo provided by staff)

Core social-work values go a long way toward helping homeless patient

My name is Katie Murphy, and I have been a clinical social worker for an inpatient, house-medicine unit for the past year, which has afforded me an opportunity to work with a very diverse patient population.



Katie Murphy, LICSW, social worker

Recently, I worked with 'Jack,' a 54-year-old man with frequent admissions to MGH. Jack has been homeless for more than ten years.

Recently, I worked with 'Jack,' a 54-year-old man with frequent admissions to MGH. Jack has been homeless for more than ten years. He struggles with an opiate addiction and intravenous drug use following a motor-vehicle accident that required a total knee replacement. Due to Jack's challenging psycho-social situation, he's frequently re-admitted with joint infections requiring revisions and long-term antibiotic treatment. Unfortunately, Jack had been banned from the few facilities that accept homeless patients due to disruptive behavior and active drug use. During a recent admission, he required six weeks of intravenous antibiotics. With no facility to take him, and assuming he wouldn't leave against medical advice (which he had done in the past), Jack was here to stay.

The Addictions Consult Team was contacted to address his drug use, and I received a consult to assist with Jack's housing. In reviewing his record for past social-work interventions, I saw that several of my colleagues had met with Jack within the last year and given him a list of shelters, single-room-occupancy apartments (SROs), and information about public housing. Many of their notes reflected Jack's anger and frustration about the limited options for housing. My initial reaction was that there wasn't much more I could do. All the appropriate resources had been provided, unfortu-

nately, supporting Jack's impression that we were limited in our ability to provide suitable housing. I struggled with having to once again manage expectations and explain to the medical team about barriers to discharge and the extremely long waiting periods for public housing. I was frustrated that past efforts to provide assistance had been in vain, as it appeared Jack had not followed through with housing applications or community resources.

I reviewed the consult with the medical team who shared similar frustrations about Jack's non-compliance both with sobriety and medical treatment. Several members of the team who knew Jack from prior admissions were starting to feel Jack's situation was 'hopeless.' It was this comment that gave me pause and caused me to re-evaluate my feelings and my assumption that meeting with him would be futile.

My role is to have a greater understanding of the social disparities that perpetuate homelessness and challenge the stigma associated with this population. Respecting human dignity is the core value at

continued on next page

We have many chronically homeless patients who circulate in and out of the hospital suffering from mental-health and/or addiction problems... Our role as social workers is to help shift attitudes and beliefs away from old stereotypes and reinforce the belief that no patient population is 'hopeless.'

the forefront of social work practice. Despite a perceived lack of effort on Jack's part to maintain sobriety and follow through with medical care and housing, I felt a renewed sense of motivation to assess Jack's needs and achieve a better outcome for him. Unfortunately, Jack wasn't as motivated to meet with me as I was to meet with him. Similar to interactions with previous social workers, Jack was agitated.

"What are you going to do?" he barked. "You can't help me. No one can."

Despite attempts to validate his frustration, Jack wasn't willing to engage any further. He was angry, distrustful, and shared some choice words about the state of services available to help the homeless. I knew my work was cut out for me. And because of his impending treatment, I knew I had six weeks to try to make a difference.

As in any good social work practice, I needed to begin the process by establishing a trusting relationship. I knew this would be challenging because the psychological trauma of homelessness makes it difficult for homeless individuals to trust anyone. I provided Jack with a safe, non-judgmental space. I wanted to meet him where he was and let him share his story. I listened empathetically as he expressed frustration with substance use, being homeless, and the loss of social supports along the way. I tried to validate and normalize his feelings of isolation. I tried to help him see how public policies affected his situation so he could escape the self-blame that often accompanies homelessness. I focused on his strengths, acknowledged that it takes resourcefulness and tenacity to survive on the streets, and commended his resiliency over the years. Jack thanked me for listening and appeared validated that I appreciated the social, personal, and administrative factors that played into his situation.

I continued to meet with Jack to gain further appreciation of his situation and strengthen our therapeutic alliance. Once I felt a trusting relationship had been established, it was time to discuss goals. Together, we acknowledged the barriers to obtaining subsidized housing upon discharge and explored other options. We reviewed lists of SROs, sober houses, and rest homes in the Boston area. I encouraged Jack's involvement in the process and provided him with a notebook to document his phone calls and a folder to organize the materials he received. I continued to work with Jack with the goal of enhancing his capacity to effect change and address his own needs. I wanted to empower him to take control of his situation by fostering a nurturing environment and

building on his strengths. As the weeks passed, Jack's mood appeared brighter, and his negativity began to fade. The Addictions Consult Team social worker also noticed a change in Jack's attitude and his perspective on how he was addressing his own needs. Jack started sketching during his free time, something he had been passionate about prior to becoming homeless.

Eventually, I was able to secure an interview for Jack at a local rest home. The interviewer shared with me that they found Jack pleasant, interesting, and motivated. It was difficult to imagine those words being used to describe Jack after my initial meeting with him. I shared with him the positive impression he'd made. Jack was accepted to the rest home on his social merits but still needed medical approval. One of the facilities from which Jack had previously been banned offered him a bed in the interim, saying he seemed like a 'new person.'

We have many chronically homeless patients who circulate in and out of the hospital suffering from mental-health and/or addiction problems. Despite the rise in this patient population, there continues to be stigma and negativity. As social workers, we know that negative attitudes and stereotypes contribute to health disparities among vulnerable populations. Some providers continue to be unaware of how their own attitudes influence their practice. Working with Jack taught me never to underestimate the power of a therapeutic relationship. Instilling hope and enhancing a patient's ability to address his or her own needs is empowering. Our role as social workers is to help shift attitudes and beliefs away from old stereotypes and reinforce the belief that no patient population is 'hopeless.'

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

When Katie entered Jack's world, she resolved to listen and understand. By acknowledging Jack's strengths and the role society plays in the plight of homelessness, Katie removed the burden of personal failure and allowed Jack to engage more fully in the broader struggle of survival. With newfound trust and confidence, Jack was able to marshal the ability to see to his needs and participate in his own care-planning. Simple kindness and respect for human dignity made all the difference.

Thank-you, Katie.

Improving the hospital experience for patients with autism

The Autism Care Collaborative, led by Peter Greenspan, MD, and Debbie Burke, RN, has developed a number of videos focusing on the care of patients with autism.

Question: Can you tell me more about the new autism videos I'm hearing about?

Jeanette: The Educational Task Force, a sub-group of the Autism Care Collaborative, led by Peter Greenspan, MD, and Debbie Burke, RN, has developed a number of videos focusing on the care of patients with autism. The first video was included in Patient Care Service's annual regulatory training. The second will be assigned to all licensed clinical staff, including physicians, within the next several weeks. And two others are still in development. Gino Chisari, RN, director of The Norman Knight Center for Clinical & Professional Development, leads the Educational Task Force.

Question: What other initiatives have been developed by the Autism Care Collaborative?

Jeanette: The Administrative Sub-Group, led by Melissa Joseph, RN, is focused on streamlining the admission process for patients with autism. This group has worked closely with staff in the Admitting Department to identify inpatient units where adult patients with autism will primarily be admitted. These units are: Phillips House 20, Ellison 19, and Bigelow 9.

Question: How can I learn more about the Autism Care Collaborative?

Jeanette: The Autism Care Collaborative SharePoint site (<http://sharepoint.partners.org/mgh/autismcollaborative>) houses all pertinent information about the group. Information can also be found on the MGH Accessibility Resource Site (<http://sharepoint.partners.org/mgh/mghaccessibilityresources/default.aspx>) and the Lurie Center website (www.LurieCenter.org).

Question: It sounds like this group has done a lot of work to improve the experience for patients with autism. What else have they done?

Jeanette: One sub-group developed the 'Check with Nurse' sign that can be placed outside a patient's room. This alerts families, visitors, and staff to check with the nurse for any special instructions before entering the room of a patient with autism.

The sign can be used for patients with any special needs, but it was developed for use by patients with autism.

Question: If I'm caring for a patient with autism, how can I access the Autism Care Questionnaire (ACQ) for the family?

Jeanette: The Autism Care Questionnaire is accessible on the Lurie Center website (on the Support and Wellness Tab), the Autism Collaborative SharePoint site, and the MGH Accessibility Resource Site, all referenced earlier on this page.

Question: If an Autism Care Questionnaire has already been completed, how can I find it?

Jeanette: Completed questionnaires can be found in the Notes sections of LMR as a Questionnaire. To upload an ACQ, scan completed ACQ into LMR and upload into Notes as a Questionnaire. Name the document Autism Care Questionnaire with the date the ACQ was completed.

If you would like to get involved with the Autism Care Collaborative, contact Mandi Coakley, RN, project manager for the Autism Care Collaborative, at 617-726-5334.

Health Care and the Gordian Knot

preparing to lead through unprecedented challenges, change, and complexity

Question: What is the Health Care and the Gordian Knot symposium?

Jeanette: Patient Care Services and The Institute for Patient Care are sponsoring their third international symposium, entitled, Health Care and the Gordian Knot, June 15 and 16, 2015. The first two symposia in 2011 and 2013, focused on our Professional Practice Model and Innovation Journey, respectively. This event will explore the ever-changing healthcare landscape and how we can prepare for the future.

Question: Why the Gordian Knot?

Jeanette: According to Greek and Roman mythology, the Gordian knot, when tied by the king of Phrygia, was impossible to untie. It was ordained that the person who could figure out how to untie the knot would become king of Asia. Alexander the Great ultimately sliced through the knot with his sword and went on to conquer the continent, thereby fulfilling the prophesy. The Gordian knot has become synonymous with a complex problem considered impossible to solve (See the similarity to health care?) Like Alexander the Great, we need to act quickly and decisively to cut through our Gordian knot.

Question: Who is the target audience?

Jeanette: Current and emerging leaders from all disciplines would benefit from this symposium. Leaders should consider bringing staff who possess future leadership potential.

Question: What will be covered?

Jeanette: The agenda will encompass many areas impacted by healthcare reform. Changes in care-delivery, quality, technology, innovation, reimbursement, policy, and the socio-economics of health care will all be discussed. All clinicians are affected by these changes. We must continue to consider the big picture if we're to remain successful.

Question: Who will be speaking?

Jeanette: In addition to Dr. Slavin and myself, experts from across the country will share their expertise on education, politics, finance, technology, and healthcare reform. A listing of faculty and speakers is available on the event website (www.cvent.com/d/54qyfn/4W).

Question: Where and when will it be held?

Jeanette: Health Care and the Gordian Knot is a two-day symposium. It will be held at the Joseph B. Martin Conference Center at Harvard Medical School, Monday, June 15th, and Tuesday, June 16th. To register, go to the Health Care and the Gordian Knot website (www.cvent.com/d/54qyfn/4W); the site can also be found through:

- The Institute for Patient Care website (www.mghpcs.org/ipc/)
- MGH Hotline Online: What's Happening
- MGH All User broadcasts

For more information about Health Care and the Gordian Knot, or assistance with registration, contact Jane Keefe, RN, at 617-724-0340.

The Gordian knot has become synonymous with a complex problem considered impossible to solve (See the similarity to health care?) Like Alexander the Great, we need to act quickly and decisively to cut through our Gordian knot.

Announcements

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

“Constipation”
Thursday, May 7th
11:00am–12:00pm

Haber Conference Room, MGH
Speaker: Daniella Donoso Pena, MD, MGH geriatric fellow

For more information, call 4-6756.

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.

ACLS Classes

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

Day one:
April 13, 2015
8:00am–3:00pm

Day two:
April 27th
8:00am–1:00pm

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.

IHP seeking nominations for Distinguished Alumni Award

Do you know an MGH Institute of Health Professions alumni doing great work?

MGH Institute of Health Professions is seeking nominations for the Bette Ann Harris '83 Distinguished Alumni Award and the Emerging Leader Alumni Award, both of which will be presented during the Institute's commencement ceremonies, May 11, 2015.

Nominations can be submitted on-line, year-round. Nominations received by March 20th will be considered for 2015 awards. Past award recipients are listed on our website. For more information, e-mail: alumni@mghihp.edu.

Save the Dates Local NENIC educational events

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.

Benson-Henry Institute for Mind Body Medicine

Online Course:

“Stress and The Relaxation Response”

Next class starts April 6, 2015

For information, go to: <http://bensonhenryinstitute.org/professional-training/online-training>.

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.

MGH Safety Reporting

Same system, new look

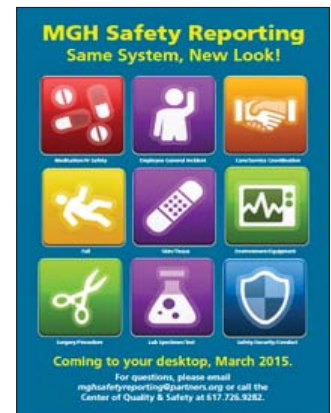
It's an exciting time for MGH safety reporting. In 2006, an electronic safety reporting system was introduced. This year, it's getting a new look and feel.

Using the MGH Safety Reporting System, safety events, concerns, and near-misses are entered into the system and immediately sent to the Center for Quality & Safety (CQS). Reports are triaged with the most serious events investigated by CQS and unit-based quality staff (and/or reported to external agencies if necessary). Less acute events are sent to department representatives for follow-up. All reports help identify safety concerns and set the agenda for quality and safety improvements.

The new system offers:

- access for all MGH employees
- improved ease of use
- same questions, better design
- training
- resources available on how to use the system

For more information, call the Center For Quality & Safety at 617-726-9282 or email: mghsafetyreporting@partners.org



Let's Talk Health

Celebrating LGBT Health Awareness Week

—by Mallory Hillard and Gregg Clapham of the LGBT Employee Resource Group

March is here, and it's time to celebrate. On Monday, March 23, 2015, the MGH Lesbian, Gay, Bisexual & Transgender (LGBT) Employee Resource Group will kick off a week-long series of events for LGBT Health Awareness Week.

Health has been defined by the World Health Organization as, "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Unfortunately, that definition of health is not always attainable, especially for individuals who identify as LGBT.

Because of a shortage of resources, outreach, and awareness, and the stigma that still surrounds LGBT individuals, disparities in health care still exist at hospitals across the country. These disparities have a negative impact on health and quality of life for LGBT individuals. According to the US Department of Health and Human Services, rates of cancer, HIV/AIDS, obesity, and mental illness are higher on average among the LGBT population, an indicator of how social determinants have a direct impact on health.

To help bring attention to the many concerns surrounding LGBT health, the MGH LGBT Employee Resource Group will host several events the week of March 23rd, including an LGBT Health Week social, a Health Week education booth in the Main Corridor, a movie screening, guest speaker, and a number of employee communications. All events are aimed at promoting awareness of LGBT health issues, providing reliable health information for LGBT patients and families, educating staff on how to create a sensitive and inclusive environment for LGBT patients, and encouraging and empowering patients and families to take an active role in their health care.

For more information on LGBT health and resources, go to: <http://www.healthhiv.org/>. For more information on the MGH LGBT Employee Resource Group, including how to get involved, go to: <http://www.massgeneral.org/lgbt/> or e-mail: LGBTmgh@partners.org.

We begin to shape the healthcare experience of patients and families the moment they walk through our doors. Let's do our best to show the world that MGH is an inclusive and welcoming community that celebrates the diversity of all who look to us for their care, and that their trust in us is well-founded.

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Next Publication

April 2, 2015

MGH Celebrates Certified Nurses Day

—by Tricia Crispi, RN, professional development specialist

Each year, National Certified Nurses Day is celebrated on March 19th to honor nurses who contribute to better patient outcomes through national board certification in their specialty areas. March 19th was selected by the American Nurses Credentialing Center to honor Margrette ‘Gretta’ Madden Styles, who was a strong advocate for nursing certification. Certification affirms advanced knowledge, skill, and practice to meet the challenges of modern health care. As nurses at a world-class Magnet hospital, we continually strive to expand our knowledge and improve our practice. Becoming certified in our nursing specialties assures the public of our commitment and expertise in our respective fields.

An on-going priority of The Norman Knight Nursing Center for Clinical & Professional Development is supporting nurses seeking certification. Some of the ways the Knight Nursing Center is promoting certification this year, include:

- Nursing Grand Rounds, March 19th, 1:30–2:30pm, O’Keeffe Auditorium (and via video stream) “Certified Nurses Day: how and why nurses benefit from certification”
Learn why certification matters and how professional certifica-

tion benefits nurses and patients. This presentation will include a panel discussion with staff from different specialties who’ve been through the process and will share their experiences

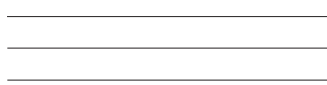
- Certified Nurses Day display and booth
Stop by the booth in the Main Corridor between 10:00am and 2:00pm, March 19th, for information on how to become certified and the supports in place to assist nurses. Several of our certified colleagues will be on hand to answer questions
- Certified Nurses Day raffle
Each year the Knight Nursing Center holds a raffle for nurses to win a chance to participate in an on-line certification prep course. You must enter to win. Call the Knight Nursing Center for details (6-3111)
- Certified Nurses buttons
Be sure to congratulate anyone you see wearing a Certified Nurses button. These nurses are recognized for achieving and maintaining an advanced level of nursing knowledge, skill, and practice

For more information about nursing certification in your specialty or practice area, contact Tricia Crispi, RN, professional development specialist at 617-643-8613.

Caring Headlines

March 19, 2015

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