

Caring

Headlines

March 5, 2015

When it comes to talking about race, are we all on the same page?



How do different perspectives impact our interactions with people who are different from us?

(See stories on page 4 and 6)

2015 PCS Strategic Plan

Goal #2

In the February 19, 2015, issue of *Caring Headlines*, I began to articulate the tactics associated with each goal of our 2015 PCS Strategic Plan (see opposite page). In that issue, I focused on Goal #1, Excellence Every Day; in this issue, I'd like to talk about Goal #2.

Goal #2

- Partners eCare: implement and evaluate the use of standardized documentation tools to support the process of optimizing the patient experience and outcomes

Tactics:

- Identify, train, and deploy super users
'Super users' are direct-care staff who will become so knowledgeable in Partners eCare (Epic) that they'll be able to support their peers during training and throughout the transition to the new integrated information system. Super users are one component of our readiness and support strategy. They'll put in extra time in the classroom, participate in special sessions to hone their support skills, and be supervised by MGH and Partners eCare project staff. Super users will assist direct-care staff by providing classroom support during training, helping their peers practice, and modeling a positive attitude. As we go live in 2016, super users will provide 'at the elbow' support.

Super users are critical to a successful transition as they'll help retain and bring MGH expertise to the table, provide effective peer-to-peer coaching, and ensure that MGH gets its part of Partners eCare 'right.'



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

- Estimate, articulate, and plan for the costs associated with the implementation and evaluation process
No undertaking can be successful without a clear understanding of the financial impact. Implementation of a major system, such as Partners eCare, is multi-faceted, including training nearly 7,000 staff from Patient Care Services (all for a variable amount of time). We'll need to account for time spent by super users, practice time by end users, and back-fill staffing for those being trained. Cost sharing will be complicated by the fact that some expenses will be covered by the capital budget and others by the operational budget. We're already exploring ways to best capture and plan for these costs
- Develop and conduct readiness activities:
 - Engage direct-care staff
 - Engage unit-level leadership
 - Engage patients and families.

continued on next page

Readiness activities are the many efforts currently being planned and executed in preparation for the transition to Partners eCare. Direct-care staff will attend training sessions, have opportunities to practice with the new software, and have all their questions answered. As we get closer to the go-live date, staff will need to be able to communicate with patients and families in a positive way about the transition. We will rely on staff to help in assessing current workflows so we can identify any gaps in the new system.

Unit-level leadership will be asked to help assess our current computer inventory to determine future needs, identify users of eCare to determine training and access needs, enroll users in training, and keep users, patients, and families informed as we move forward.

Patient and Family Advisory Councils will be consulted for input into our communication plans. We'll need to understand the patient and family perspectives in order to ensure optimal participation and preparation.

An effective communication plan will be key to overcoming barriers, ensuring staff and leadership have the tools they need for a successful transition, and keeping training and preparation as high, ongoing priorities.

We have a 'checklist' of readiness activities to guide our work; our success will be reflected in the perceptions and satisfaction of patients, families, and staff. Partners eCare will be on the agenda at many meetings as we get closer to the go-live date (March 26, 2016). Look for updates in *Caring Headlines*, *PCS News You Can Use*, the *MGH Hotline*, e-mails, posters, the EED portal, and other avenues of communication.

- Provide training and skill-development Classroom training is scheduled to begin at the end of the year or early in 2016. Preparations are already un-

derway for this training. Efforts have begun to identify Partners eCare users and match them to course curriculum; enroll super users in early training and all others in training appropriate for their roles; develop MGH-specific training materials (including unit-specific practice exercises); identify MGH staff interested in becoming certified trainers. Certified MGH trainers would be able to more readily 'personalize' the curriculum and they'd have the advantage of already be acclimated to our culture and expectations.

- Adapt, adopt, or abandon current workflow and documentation tools in preparation for Partners eCare (self-explanatory)

I hope this gives you a better understanding of the tactics we'll be employing to prepare for, and ensure a smooth transition to, Partners eCare. As always, I'm interested in hearing your comments and suggestions as we move forward with this work.

In the next issue of *Caring Headlines*, I'll share the tactics associated with Goal #3, Innovation in Care-Delivery: enhancing the patient experience, ensuring a coordinated, standardized, and evidence-based model of care-delivery throughout the Patient Journey.

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

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Let's talk about race

How to manage the conversation

—by Deborah Washington, RN, director, PCS Diversity Program

I wonder if some day humanity will look back on people's belief in racial categories in the same way that I shake my head at the olden days when people thought the world was flat."

—Debbly Irving, author of *Waking up White* and *Finding Myself in the Story of Race*

Events that generate this level of public protest typically set in motion a conversation about race... When similar events follow, the media barrage us with explanations of who, what, where, when, how; but seldom *why*.

Let's Talk About Race." Those words came to life on Wednesday, February 18, 2015, in O'Keeffe Auditorium. Having an open dialogue about the state of black-white relations comes at a critical time. Recent events in Ferguson, Missouri, and elsewhere have charged the national discussion in much the same way the Trayvon Martin case did. Black History Month provided an opportunity to seek deeper understanding of the underlying sensibilities that led to such public outcries as, "Black lives matter," "Hands up, don't shoot," and, "I can't breathe."

Events that generate this level of public protest typically set in motion a conversation about race. Stories emerge of racial bias and discrimination as a routine part of life for minorities and ethnic groups. When similar events follow, the media barrage us with explanations of who, what, where, when, how; but seldom *why*. And historically, blacks and whites divide along racial lines when explanations are offered.

So you can see why I thought it would be a good idea to bring people together to talk about race. This session was an attempt to understand what's at stake when conversations about race start to impact the work environment, team relationships, and our ability to create a diverse and inclusive place to practice, learn, and grow.



(Photos by Michelle Rose)

Black History Month (continued)

I began by asking every white person in attendance to sit beside a person of color for the duration of the presentation. The shuffling of seats and scurrying to comply was in itself telling as folks had ‘unconsciously’ seated themselves in homogeneous groups.

In an effort to make the point that all our actions, interactions, and reactions are the product of our backgrounds, cultures, and personal histories, I tried to demonstrate how perspectives differ greatly based on individual experience. A graphic of metropolitan Boston reminded us that populations remain very much clustered by race and ethnicity. Questions like: “How often do you talk about race with your family and friends?” or “Do you have black friends who come to your house for dinner?” drove home the

point that people of different races and cultures still lead largely separate lives.

So where do we get our information about people who are different from us? If we live in ethno-centric communities and don’t socialize with people who are different from us, what informs our perceptions of people of other races? In many cases, the workplace is our primary source of knowledge about people of other races and cultures. As a workplace, MGH is a melting pot of races, cultures, ethnicities, and backgrounds.

Because we’re so diverse, we often encounter situations where cross-cultural communication styles affect the interactions we have with co-workers. How would you describe your own cultural communication style? Are you animated, emotional? Do you use a lot of hand gestures? Do you tend to touch the other person when you talk? Are you direct, evasive, guarded? Do you stand close to the person you’re talking to?

In addition to different communication styles, other factors impact the way we’re understood (or misunderstood) by co-workers.

In my years as director of Diversity for Patient Care Services, I’ve identified four factors that can have a negative impact on cross-cultural interactions. They include:

- invalidation, when the input and perspectives of a person from a diverse background are dismissed or considered of lesser importance than those of non-minority individuals
- uncertainty, a lack of clarity about the meaning of a situation because the cultural context is not understood or often even taken into account
- affect, the presence of strong emotion that can cause feelings of unease, profoundly inhibiting communication, relationship-building, and rapport
- absence of affinity, a lack of familiarity with the other person’s cultural norms resulting in awkward or unproductive interactions

Do any of these traits sound familiar? Do they ring true of interactions you’ve had with staff or colleagues? Perhaps we could all benefit from a more conscious awareness of the communication styles and traits we all bring to our workplace interactions.

Talking about race can make us squirm. We worry about saying the wrong thing, being misunderstood, or hurting someone’s feelings. But being willing to enter into those conversations openly and without pre-conceived ideas is the only way to learn, to raise awareness, and to ensure our practice is equitable, inclusive, and ‘consciously unbiased.’

Yes, talking about race is difficult. But if this session was any indication, people at MGH are ready and willing to go there. And in true MGH fashion, they’re already asking for more.

Don’t hesitate to call me at 617-724-7469 to share your thoughts or impressions.



Director of PCS Diversity Program, Deborah Washington, RN, (top left and center) leads members of the MGH community in candid talk about race, cultural communication styles, and unconscious bias.

The MGH Community Dialogue on Race

How do we move forward

MGH leaders and diversity experts talk openly about race, unconscious bias, discrimination, and their impact on our ability to provide equitable care and create an inclusive workforce.

Biases can be dangerous, even deadly, as in the case of Michael Brown in Ferguson, Missouri, and Eric Garner, in Staten Island, New York. That sentiment was the impetus for a recent TED Talk by diversity advocate, Vernā Myers, entitled, *How to Overcome our Biases? Walk Boldly toward Them*, the centerpiece of the February 12, 2015, MGH Community Dialogue on Race. The session was moderated by MGH Diversity Committee members, Alexy Arauz-Boudreau, MD, associate director for the MGH Center of Diversity & Inclusion, and Sherri-Ann Burnett-Bowie, MD, co-chair of the Department of Medicine's Diversity & Inclusion Board and associate director for the Center for Diversity and Inclu-

sion. Panelists included MGH leaders and diversity experts:

- Alex Green, MD, associate director of the Disparities Solutions Center and senior scientist with the Mongan Institute for Health Policy
- Elena Olson, executive director of the Center for Diversity & Inclusion
- Utibe Essien, MD, member of the Residents and Fellows Committee of the Center for Diversity & Inclusion and a founding member of the Social Justice Interest Group
- Peter Slavin, MD, MGH president
- Bonnie Michelman, director of Police, Security & Outside Services
- Jeff Davis, senior vice president for Human Resources
- Deb Washington, RN, director of Diversity for Patient Care Services



Alexy Arauz-Boudreau, MD



Alex Green, MD



Elena Olson



Utibe Essien, MD



Peter Slavin, MD

Diversity (continued)

Said Slavin in his opening remarks, “I know we can’t solve the problem of race in an hour, but I’m hopeful that discussions like this can be a springboard for positive and lasting change.”

Burnett-Bowie urged attendees to, “suspend judgement and open your minds.” She explained that everyone has unconscious biases—it’s natural and involuntary. Unconscious bias is not racism. By uncovering our blind spots, we can ensure our unconscious biases don’t manifest themselves in inequitable care or unacceptable behavior toward colleagues, friends, or strangers.

Myers, in her TED talk, offered three broad suggestions to help people deal with unconscious bias and advance a meaningful diversity agenda. First, she said, get out of denial. Recognize that everyone has biases, including you, and try to do something about it. Pay attention to your feelings—think about who it is you normally avoid, and make a conscious effort to get to know those individuals.

Second, “bust your stereotypes.” Biases are the stories we make up about people *before we’ve even met them*. Choose a person you don’t know very well or may have some misconceptions about, and turn that acquaintance into an authentic relationship. Something powerful happens when you get to know someone who’s different from you.

And lastly, “When you see something, say something.” We’ve all been in a situation where someone (perhaps someone we love and respect) makes a racist comment or assumption. If we’re truly committed to overcoming unconscious bias and contributing to the betterment of society, we cannot let those comments stand. That’s how prejudice is passed on to our children. We cannot shelter [white] children from racism—black children have never had that luxury. We must speak up and make it known that we are not complicit with racism or racist comments.

The panel discussion was driven by questions submitted by employees prior to the event. Each panelist had an opportunity to comment on questions such as:

Why is race so hard to talk about?

How does unconscious bias influence hiring, career-advancement, and workforce diversity, and what can we do about it?

Recent events have resulted in tension between law enforcement and members of the community. What can we do to improve these relationships given the real and justified concerns about unfair treatment and the incredi-

bly difficult situations police face every day?

Discussion was as thoughtful and though-provoking as the questions that were asked. As Slavin said at the outset, we can’t solve the problem of race in an hour. But judging from the attendance, the level of interest, and subsequent conversations throughout the hospital, there’s a genuine desire on the part of the MGH workforce to put their collective wisdom and resources into finding a solution, no matter how long it takes. For more information, or to offer suggestions or ideas, call the MGH Center for Diversity & Inclusion at 617-724-3832, or the Disparities Solution Center, at 617-724-7658.

Discussion was guided by questions submitted by employees, such as: “Why is race so hard to talk about?” and “How does unconscious bias influence hiring, career-advancement, and workforce diversity, and what can we do about it?”



Bonnie Michelman



Jeff Davis



Deborah Washington, RN



Sherri-Ann Burnett-Bowie, MD

Early mobilization and physical therapy help preserve patient's quality of life

MA is a 73-year-old woman who presented at a community hospital with shortness of breath. She was transferred to the Surgical ICU at MGH three days later for nasal intubation due to respiratory distress.

My name is Vanessa Dellheim, and I am a senior physical therapist. MA is a 73-year-old woman who presented at a community hospital with shortness of breath. She was transferred to the Surgical ICU at MGH three days later for nasal intubation due to respiratory distress. MA was unable to be intubated by mouth (which would normally be the case) due to a marked cervical kyphosis (curvature) associated with a history of rheumatoid arthritis. Her ICU work-up revealed tracheal stenosis (from a prior tracheostomy) and pneumonia resulting in upper and lower airway insufficiencies. After a week of antibiotics, MA underwent a 'controlled' extubation in the operating room and returned to the Surgical ICU; but she required emergent re-intubation due to persistent shortness of breath. Her physical therapy consult took place the day after she was re-intubated.

Upon entering MA's room, I immediately observed the joint deformities in her upper and lower extremities and cervical spine. She was unable to speak due to the nasal intubation, but she was able to mouth words. It was difficult to understand her, and her writing was illegible due to contractures in both hands. Upon examination, I saw she had severely impaired range of motion, but excellent strength despite having been bed-bound for ten days. The end range of her joint mobility felt hard, indicating her contractures had been chronically



Vanessa Dellheim, PT
senior physical therapist

present. I was unsure of MA's baseline status, including whether she had been able to ambulate prior to hospitalization, and it was difficult to ascertain this information given her communication challenges.

Both of MA's children were present for her next treatment session, and they explained that their mother had been able to ambulate short distances at home with assistance. Understandably, the family was concerned about MA's ability to re-gain function, including whether she'd be able to walk again given the prolonged amount of time she'd spent in bed dependent on a ventilator.

The aim of my initial treatment plan was similar to that of many of my ICU patients—help MA to become mobile again in accordance with her and her family's goals. But MA presented many unique challenges, including her diminutive stature (her feet didn't reach the floor when she sat down), range-of-motion deficits, and care coordination (primarily with the respiratory therapist for portable ventilation).

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Given her past medical history and prolonged intubation, she was at high risk for de-conditioning, but because of early mobilization and physical therapy and a multi-disciplinary, patient-centered approach, MA maintained her functional status... Because of her motivation and mobility, she was able to achieve her goal of returning home and maintaining a satisfactory quality of life.

When initiating mobility with any intubated patient, there's always a risk of losing the airway. I had never cared for a nasally intubated patient before, so I was particularly concerned about the stability of her airway. For that reason, I worked closely with MA's nurses and respiratory therapist, often gathering three or four clinicians to ensure safe movement when working with MA. Luckily, our attention and persistence paid off. Within one or two treatment sessions, MA was able to ambulate short distances with minimal assistance.

During the next six weeks, several extubation attempts failed, and MA underwent an unsuccessful tracheal stent procedure. Unfortunately, due to the anomalies of her anatomy, she wasn't a candidate for a tracheostomy. After each failed procedure, MA would become sad, frustrated, and more anxious about her breathing. I empathized with her having to endure such a prolonged, complex hospitalization. She was completely alert but unable to speak and had numerous tubes connected to her body. Her life was largely confined to her hospital room.

Despite her medical plateaus, MA was progressing physically. She was able to increase her ambulation distance to 300 feet, ten times farther than her baseline. I began to think about how else I might be able to help her; I stepped back and looked at the big picture. I re-visited MA's goals. Now that she had re-gained some mobility, we were able to focus on some quality-of-life activities, such as walking to the waiting room to look at the aquarium, which MA enjoyed. She said it relaxed her. I thought MA was doing well. I was helping her address her impairments and quality of life, and her family was happy with her progress, especially since she was doing better than her baseline at home. But I soon learned my impressions were not completely accurate.

Given her lack of medical or surgical options, MA focused on physical therapy to improve her breathing and lung function. She and her family believed that if her scoliosis, joint deformities, and mobility could be improved, MA might be able to be extubated. Unfortunately, these were unrealistic expectations given that MA had suffered from these impairments for 30 years. Though I respected their optimism, I knew from the literature that physical therapy would not improve these chronic impairments.

MA's family was desperate and hopeful for anything to improve her condition. I explained that it would be dangerous to try manipulation as it would be painful and potentially harmful given her joint deformities, abnormal anatomy, and potential osteoporosis. The most difficult part was that MA's goals didn't match the aggressive treatment her children wanted. Together with MA and her children, I helped create a plan to continue to address MA's walking, balance, and transfers, which was in line with MA's goals and her family's concerns.

This was one of the most difficult cases I ever worked on. The most striking part was that MA was awake, alert, and able to make educated decisions about her care in the Surgical ICU, which is not typical. Though I wished I could fix everyone and that more physical therapy would change her long-term outcomes, my knowledge of anatomy, healing, and pathology told me otherwise. It was difficult to communicate this to the family as they struggled to come to terms with the end stages of their mother's life. They were hopeful for a full recovery and for their mom to come home again.

Ultimately, the team tried another attempt at a stent, and this time, it was successful. MA was successfully extubated. She was able to return home upon discharge despite four months in the hospital, mobilizing at baseline function with assistance from her family. Given her past medical history and prolonged intubation, she was at high risk for de-conditioning, but because of early mobilization and physical therapy and a multi-disciplinary, patient-centered approach, MA maintained her functional status. During her hospitalization, MA faced numerous challenges and pain every day. Because of her motivation and early and consistent mobility, she was able to achieve her goal of returning home and maintaining a satisfactory quality of life.

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

Like many clinicians, Vanessa had to balance the hope of full recovery with the limitations of MA's very complex medical reality. She recognized MA's potential to ambulate and helped her achieve her highest level of functioning. Because of early mobilization and focused physical therapy throughout her hospitalization, MA was able to sustain the gains she made and return home without any loss of function.

Thank-you, Vanessa.

NERBNA Excellence in Nursing Awards

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care

Three MGH nurses were honored with Excellence in Nursing Awards at the February 6th NERBNA celebration at the Boston Copley Marriott Hotel.

The New England Regional Black Nurses Association (NERBNA) is dedicated to investigating, defining, and determining the healthcare needs of African Americans throughout New England and implementing changes to ensure optimal care is available to all under-served communities. NERBNA's 27th annual Excellence in Nursing Award celebration was held February 6, 2015, at the Boston Copley Marriott Hotel, and MGH Nursing was well represented. Three of the

14 recipients were MGH nurses selected from a competitive field in the categories of Leadership, Teaching/Education, and Clinical Practice.

Keynote speaker, Marcia Wells, RN, gave a powerful and thought-provoking address using excerpts from the book, *Life in Motion: an Unlikely Ballerina*, the memoir of Misty Copeland, the only African American soloist in the prestigious American Ballet Theatre. Wells challenged attendees and award recipients to follow their passion, never take No for an answer, conduct themselves with grace and kindness, and always help others on their journey.

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At NERBNA Excellence in Nursing award celebration are (l-r): Jacquelyn Holmberg, RN; Maryfran Hughes, RN; Cathie Harris, RN; Tricia Mian, RN; Evelyn Joseph-Noel, RN; Tamyka Brown, RN; Shaunteal Hampton-Prince, RN, Gaurdia Banister, RN; Melissa Joseph, RN; Theresa Gallivan, RN; Mary Connaughton, RN; Michele O'Hara, RN; Beth West, RN; and Seheeda Mohammed-Kelly, RN.

Recognition (continued)



Melissa Joseph RN,
nursing director, Ellison 12 General Medicine
recipient of NERBNA award for Nursing Leadership

MGH nurses who received NERBNA Excellence in Nursing Awards this year, were, Melissa Joseph RN, nursing director of the Ellison 12 General Medicine and Acute Inpatient Care unit; Evelyne 'Evie' Joseph-Noel, RN, staff nurse in the Emergency Department; and Shauntel Hampton-Prince, RN, staff nurse on the Blake 14 Labor & Delivery Unit.

Joseph received the award for Excellence in Nursing Leadership. According to her letters of nomination, Joseph is an exemplary nurse leader with 16 years of experience in community hospitals, ambulatory settings, and large academic medical centers. Using a participatory leadership style that emphasizes accountability, staff engagement, and excellence, Joseph has led teams to achieve impressive quality, satisfaction, and efficiency outcomes. She promotes graduate education, certification, and participation in institutional and departmental opportunities. Joseph is a compelling role model and mentor to tomorrow's nurse leaders.



Evelyne 'Evie' Joseph-Noel, RN
staff nurse, Emergency Department
recipient of NERBNA award for Nursing
Education/Teaching

Joseph-Noel received the award for Excellence in Nursing Education/Teaching. For more than ten years, she has provided exquisite care to patients and families across the spectrum of emergency nursing, including adult and pediatric patients of all ethnic, racial, and cultural backgrounds and all levels of acuity in collaboration with the multidisciplinary team. Early in her career, Joseph-Noel expressed an interest in ethics and sought opportunities to advance her knowledge and expertise. In addition to being a member of the Ethics in Clinical Practice Committee, she participated in the Clinical Ethics Residency for Nursing. Because of Joseph-Noel's teaching, there has been a shift in how nurses conceptualize ethical problems and questions faced by patients, especially the more vulnerable patients who may lack resources and support and pose numerous challenges for staff.



Shauntel Hampton-Prince, RN
staff nurse, Blake 14 Labor & Delivery
recipient of NERBNA award for Nursing Practice

Hampton-Prince received the award for Excellence in Nursing Practice. According to nursing director, Michele O'Hara, RN, Hampton-Prince is a critical-thinker who epitomizes the term, 'patient-centered care.' This year, Hampton-Prince completed the distinguished International Board Certified and Lactation Consultant course to become a certified lactation consultant. In that role, she is a tremendous resource to colleagues on the Labor & Delivery Unit and a wonderful support to new and expectant parents who choose to breast-feed. Hampton-Prince has been instrumental in educating colleagues and the organization as we strive for Baby Friendly designation, a global program that encourages and recognizes hospitals and birthing centers for offering an optimal level of care for infant feeding and mother-baby bonding.

The Estimated Date of Discharge Tool

helping to facilitate timely discharge

If staff use the EDD tool consistently to capture and communicate this important information we can both improve the patient experience and achieve our length-of-stay goals.

Question: I've seen a few articles in *Caring Headlines* about strategies to optimize patient flow. Can you tell me more about the new Estimated Date of Discharge (EDD) tool?

Jeanette: The EDD tool was rolled out in early December as one of many interventions to help safely reduce length of stay. It was created to facilitate communication among the inter-disciplinary team about patients' readiness for discharge, current disposition, and issues that need to be resolved before they can be discharged.

Question: Aren't those issues discussed in inter-disciplinary rounds?

Jeanette: Those issues are discussed during inter-disciplinary rounds. But even though the EDD tool is used in rounds to capture information necessary to facilitate discharge, some clinicians cover numerous units and aren't able to attend multi-disciplinary rounds on all of them. This, coupled with the dynamic and complex nature of patients' conditions, requires a process that captures discharge-planning information throughout the patient's stay. The EDD tool makes this information more accessible and transparent to the care team.

Question: Since implementation of the EDD tool, have we seen an impact on patient progression?

Jeanette: Yes. Feedback from clinicians has been very positive. The tool has helped us identify factors that impede timely discharge. For example, the availability of post-acute resources, insurance restrictions, and processes related to post-acute-care placement have emerged as obstacles to timely discharge.

Question: How can staff support this initiative?

Jeanette: The three fields most critical to effective discharge planning are: determining when the patient will be medically ready for discharge; identifying where the patient will be discharged to; and articulating the issues that need to be resolved before the patient can be discharged. If staff use the EDD tool consistently to capture and communicate this important information we can both improve the patient experience and achieve our length-of-stay goals.

Question: Who can I contact if I have questions?

Jeanette: For more information about the EDD tool consult your department or nursing director.

Blood transfusion and patient safety

understanding the finer points of this important National Patient Safety Goal

Question: Why do we need two signatures on the Blood Transfusion Record (BTR)?

Jeanette: This is an important measure for patient safety. Patient-identification continues to be a National Patient Safety Goal (NPSG) because mis-identification continues to occur in hospitals across the country.

NPSG #1 was created to, “Eliminate transfusion errors related to patient mis-identification.” Documenting both signatures provides evidence that this important safety step has been performed.

Question: I know our documentation system for blood transfusion has been revised to include all the information on the Blood Transfusion Record. Is it acceptable to document the end time and vital signs on the patient’s flow sheet?

Jeanette: Vital signs may be documented on the flow sheet as well as the Blood Transfusion Record, but the safety standard is not being met if they’re documented only on the flow sheet. All fields on the Blood Transfusion Record must be completed. The Blood Transfusion Record is the source of truth for information about transfusions. That means the following information needs to be documented on the Blood Transfusion Record:

- signatures of two clinicians who have performed the bedside verification
- date of transfusion
- blood-bag ID sticker
- documentation, including the time of each of the specified vital signs

Question: Can I hang a blood product that two of my colleagues verified?

Jeanette: No. The clinician hanging the blood must be one of the two clinicians providing verification. And the American Association of Blood Banks (AABB) requires that the transfuser be one of the clinicians who verified the blood product.

Question: How often are vital signs needed during transfusions?

Jeanette: Most adverse reactions occur within the first 30 minutes of a transfusion. American Association of Blood Banks standards require observation for potential adverse events during and after transfusion. The patient’s condition and clinical judgment guide the monitoring of every patient. The vital signs listed on the The Blood Transfusion Record are the minimum recommended for routine transfusion; if checking vital signs more frequently is clinically indicated, they should be recorded in the patient’s medical record.

Question: Who can I call for information about blood transfusion and blood-transfusion documentation?

Jeanette: For more information, call staff specialist, Judi Carr, RN, at 617-643-3006.

Announcements

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.

Blum Center Events

Shared Decision Making:
"Colon Cancer Screening"
Wednesday, March 11, 2015
12:00–1:00pm
Speaker: Daniel Chung, MD

National Health Observance:
"Nutrients 101: carbs, fats, proteins, and balancing them all"
Tuesday, March 17th
12:00–1:00pm
Speaker: Laura Kim

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.

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):
March 11th
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.

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.

Senior HealthWISE events

All events are free for seniors 60 and older

"A Tisket, a Tasket, What's in Your Medication Basket?
A Discussion of Polypharmacy Issues"

Thursday, March 5,
11:00am–12:00pm
Haber Conference Room
Presented by Joanne Petrongolo Doyle, PharmD, and Laura Carr, PharmD, discussion will focus on polypharmacy, taking multiple medications at the same time.

For more information, call 4-6756.

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

The graphic features a blue background with the title "MGH Safety Reporting Same System, New Look!" in yellow and white. Below the title is a 3x3 grid of icons representing various safety reporting categories: Medication Safety (red pill icon), Hospital Control System (purple person icon), Emergency Coordinator (orange hand icon), Fall (yellow person falling icon), Near Miss (purple bandage icon), and Reporting System (green ECG icon). Below the grid are three more icons: Safety Hazard (green scissors icon), Lab (purple flask icon), and Safety Hazard (blue shield icon). At the bottom, it says "Coming to your desktop, March 2015." and provides contact information: "For questions, please email mghsafetyreporting@partners.org or call the Center of Quality & Safety at 617-726-9282."

Staff Perceptions of the Professional Practice Environment Survey

March 15-April 11, 2015

Every 18-24 months, Patient Care Service (PCS) conducts a survey of front-line clinicians within PCS, the MGH health centers, and ambulatory care clinics to identify ways to improve the practice environment for clinical staff. The 2015 Staff Perceptions of the Professional Practice Environment (SPPPE) Survey will be distributed between March 15 and April 11, 2015, to nurses, physical therapists, occupational therapists, speech-language pathologists, respiratory therapists, social workers, child-life specialists, and chaplains in inpatient and outpatient settings.

The Staff Perceptions of the Professional Practice Environment Survey measures staff perceptions of and satisfaction with the professional practice environment by examining eight organizational characteristics: autonomy; control over practice; relationships with physicians; teamwork; communication; conflict-management; internal work motivation; and cultural sensitivity. Data is analyzed quantitatively and qualitatively to help PCS leadership

highlight trends, identify opportunities to improve the practice environment, and monitor the impact of unit and organizational changes on staff. Results are shared in staff meetings, committee meetings, and other forums throughout the hospital.

Staff are encouraged to complete the on-line survey. Broad participation ensures greater depth of information, and it's critical to hear from clinicians in all PCS disciplines and practice settings. Survey participation is voluntary, and all answers are completely confidential. The randomly generated ID number affixed to each survey is used only for data-analysis and data-organization purposes by the survey team in The Yvonne L. Munn Center for Nursing Research. The ID numbers and survey responses are shared with no one, and there is no way to link responses to individual names.

Please watch for details in the coming weeks. If you have questions or comments about this survey, please contact Gaurdia Banister, RN, at 617-724-1266, or Dorothy Jones, RN, at 617-724-9340.

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Distribution

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Submissions

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

Next Publication

March 19, 2015

Inpatient HCAHPS

2014 year-end results and 2015 targets

Measure	2013	2014 Year to Date	2013- 2014 Change
Nurse Communication Composite	81.9	82.1	0.2
Doctor Communication Composite	82.5	81.6	-0.9
Room Clean	74.5	72.2	-2.3
Quiet at Night	50.2	49.7	-0.5
Cleanliness/Quiet Composite	62.4	60.9	-1.5
Staff Responsiveness Composite	64.7	63.8	-0.9
Pain Management Composite	72.3	71.7	-0.6
Communication about Meds Composite	65.5	65.8	0.3
Discharge Information Composite	91.8	91.6	-0.2
Overall Rating	81.2	79.8	-1.4
Likelihood to Recommend	90.4	90	-0.4

Data complete through December, 2014
 All results reflect Top-Box (or 'Always' response) percentages
 Pull date: February 17, 2015

Survey Measure	Baseline 2014 Score	Target – 2015 Score	
Pain Management	72.5 (FY 14)	73.5 (Baseline + 1 point)	74.3
Staff Responsiveness	63.8 (CY 14)	64.8 (Baseline + 1 point)	66.8
Quietness	49.5 (FY 14)	50.5 (Baseline + 1 point)	51.9

Patient-experience data has been finalized for 2014. Nurse Communication scores rose and met target. Communication about Medications also rose and, although scores for Overall Rating, Likelihood to Recommend, and Discharge Instructions dipped slightly, they remain among the highest in the nation. The chart at left reflects a challenging year for MGH, including implementation of Partners eCare revenue cycle; responding to the Ebola virus, and continued roll-out of our Innovation Units. 2014 results are considerably higher than in years past, but efforts to improve must continue.

MGH has chosen new HCAHPS targets for 2015, including areas where we fare less favorably compared to other hospitals in the country. We'll continue to focus on Pain-Management, Staff Responsiveness, and Quiet. Baseline 2014 and target 2015 scores appear in the table at left.

We have shown that MGH can reach and exceed targets for patient experience. Focusing on our chosen interventions, including Quiet, Hourly Rounding, Discharge Calls and others, will help us improve care and better respond to the needs of patients and families.

For more information about the HCAHPS survey, our results, or future targets, call Rick Evans, senior director and chief experience officer, at 617-724-2838.



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



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