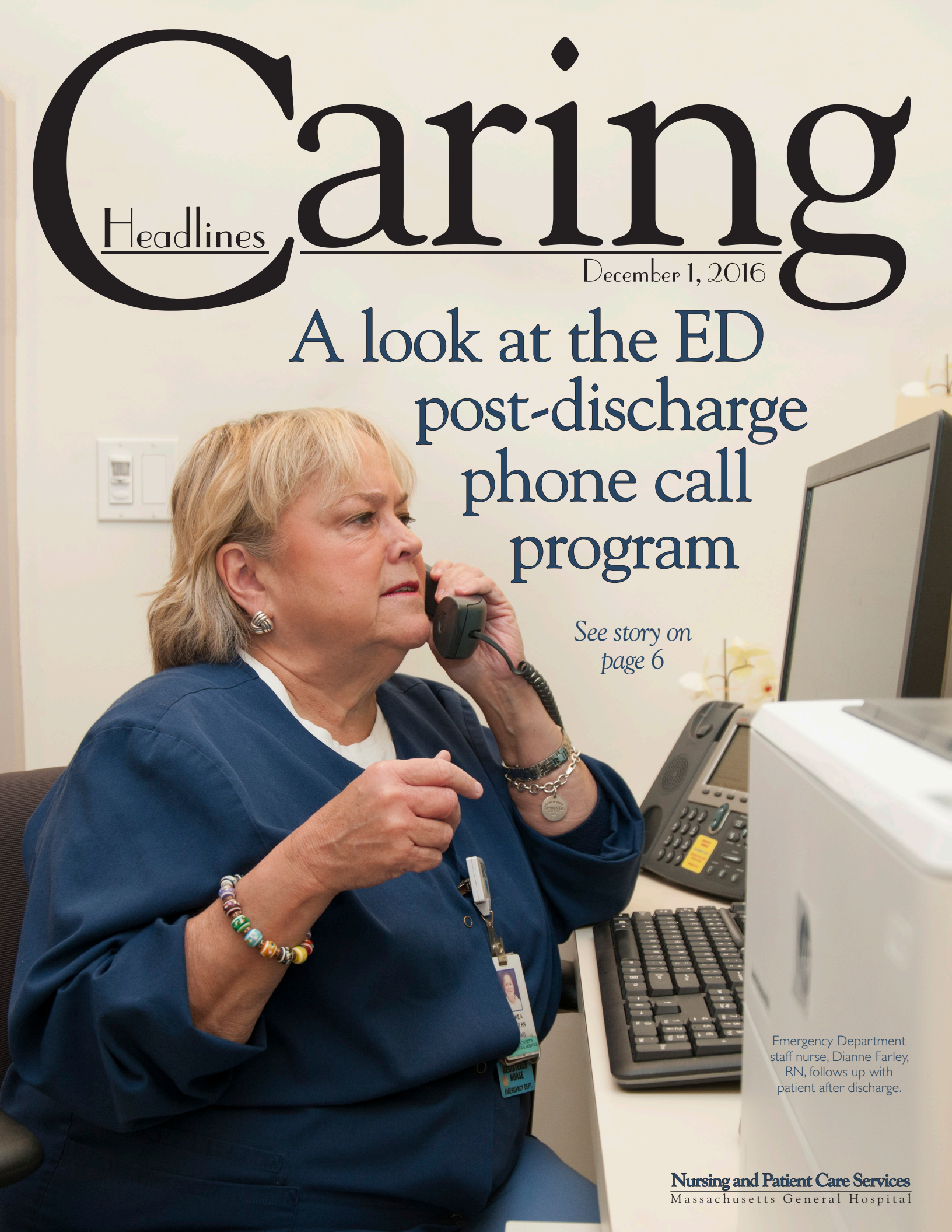
Caring Headlines
December 1, 2016

A look at the ED post-discharge phone call program

See story on page 6



Emergency Department staff nurse, Dianne Farley, RN, follows up with patient after discharge.

Nursing and Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Re-visiting our Professional Practice Model and other guiding documents

Nursing and Patient Care Services periodically reviews our guiding documents to make sure they continue to capture the essence and spirit of our practice and the philosophy and culture we work so hard to perpetuate.

Just as our country is guided by important documents like *The Declaration of Independence*, *The US Constitution*, and *The Bill of Rights*, most successful organizations are guided by documents that describe their governing policies, code of ethics, and reason for being. This is certainly true of MGH—with our mission statement, vision, values, and guiding principles. And just as the *Constitution* has been amended over the years to keep pace with our changing nation, so too, is it important for organizations to review and update their guiding documents to ensure they reflect current practice and prevailing knowledge.

Toward that end, Nursing and Patient Care Services periodically reviews our guiding documents to make sure they continue to capture the essence and spirit of our practice and the philosophy and culture we work so hard to perpetuate. With input from the Staff Nurse Advisory Committee, collaborative governance committees, managers, the PCS Executive Committee, and many others, we recently updated our Vision and Value statement to better reflect our current reality (see box at right; changes highlighted in color). Reviewers from all groups felt strongly that 'safety' and 'healing' needed to be included in our vision, and that our philosophy about diversity and inclusion needed to be more explicitly stated. So we revised our Vision and Value statement to incorporate this important feedback.

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

Nursing and Patient Care Services Vision and Values

As nurses, health professionals, and Patient Care Services support staff, our every action is guided by knowledge, enabled by skill, and motivated by compassion. Patients are our primary focus, and the way we deliver care reflects that focus every day. We believe in creating a healing environment—an environment that is safe, has no barriers, and is built on a spirit of inquiry—an environment that reflects a diverse, inclusive, and culturally competent workforce representative of the patient-focused values of this institution.

It is through our professional practice model that we make our vision a demonstrable truth every day by letting our thoughts, decisions, and actions be guided by our values. As clinicians, we ensure our practice is caring, innovative, scientific, empowering, and based on a foundation of leadership and entrepreneurial teamwork

We took a close look at all components of our Professional Practice Model. It was invigorating to be part of these discussions; hearing feedback from all role groups in all disciplines throughout Nursing and Patient Care Services. The level of scrutiny was impressive; the observations, impassioned and insightful.

Our vision and values are just one part of our Professional Practice Model. In our review of important guiding documents, we took a close look at *all* components of our Professional Practice Model, asking ourselves whether each component is still meaningful and relevant in today's practice setting.

It was invigorating to be part of these discussions; hearing feedback from all role groups in all disciplines throughout Nursing and Patient Care Services. The level of scrutiny was impressive; the observations, impassioned and insightful.

Knowing that a professional practice model is only meaningful if it reflects the wisdom and expertise of clinicians at the bedside, in the June 16, 2016, issue of *Caring Headlines*, we invited staff to weigh in on their thoughts about the model. Many voices were heard. Many constructive ideas emerged. One question that received a lot of attention was whether 'reflective practice' was sufficiently captured in the existing model. After much deliberation, it was decided that, though reflective practice is not represented by its own piece of the puzzle, it *is* embedded in the model in various other components.

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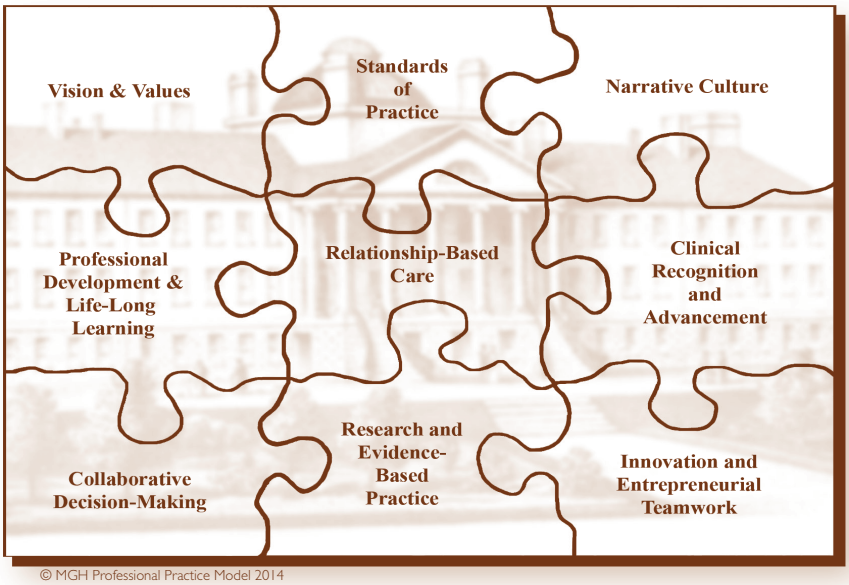
Nursing and Patient Care Services
Professional Practice Model



In this Issue

Relationship-based care is at the center of the Patient Care Delivery Model as it's at the center of our Professional Practice Model.

So, after much consideration and input from all disciplines, it was unanimously determined that the most recent iteration of our Professional Practice Model does accurately capture current reality. We'll continue to re-visit the model periodically to ensure it remains reflective of our practice in a dynamic and ever-evolving environment.

Any discussion of our Professional Practice Model naturally flows into a look at our Patient Care Delivery Model (see figure below). This might be the first time some of you are seeing this iteration of the model, so I'll call your attention to some of the more salient features.

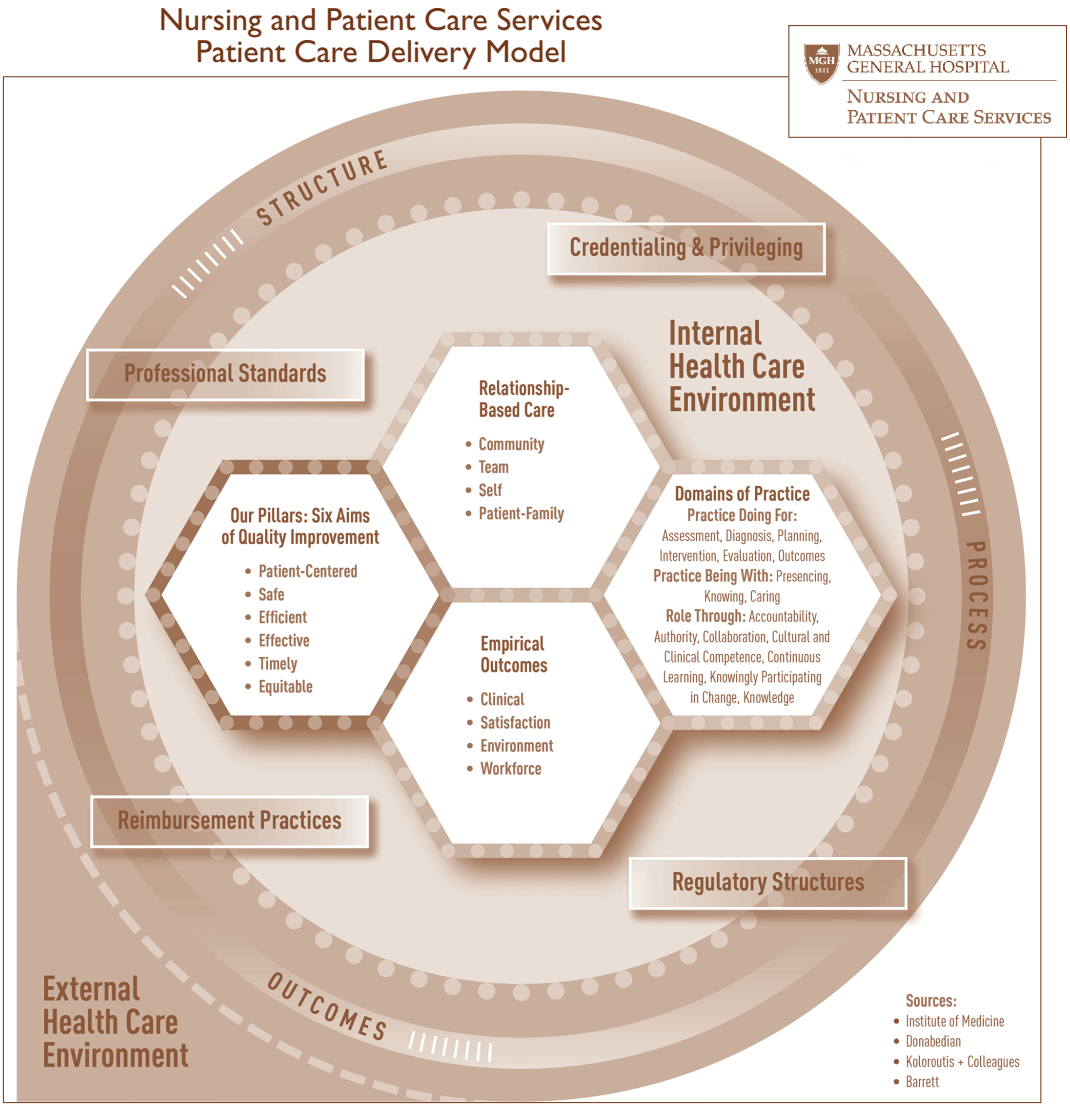
As you can see, relationship-based care is at the center of the Patient Care Delivery Model as it's at the center of our Professional Practice Model. This speaks to the importance of *knowing* patients in order to provide the highest quality care and service.

Sharing the center are the six aims of the Institute of Medicine: ensuring that care is patient-centered; safe; efficient; effective; timely; and equitable. These objectives have become the pillars of our care-delivery model and the mainstay of our culture at MGH.

The Domains of Practice hearken back to an earlier iteration of the model and speak to the importance of 'doing for' and 'being with' the patient in order to create an environment of optimal care and healing.

Finally, Empirical Outcomes refer to the critically important function of how we measure the impact of our work, encompassing clinical outcomes, patient satisfaction, the environment of care, and workforce morale. As represented by the model, these four central components are symbiotically related, each one vital to the effectiveness of care and each one inter-dependent on all the others.

I hope you'll take some time to familiarize yourselves with this model beyond the few points I've enumerated. As always, I'm interested in hearing your comments and observations. And I thank you for embodying the spirit of all these guiding documents in your practice every day.



Celebrating everyday heroes

—by Linda Akuamoah-Boateng and Brian Holt

On Tuesday, October 25, 2016, the MGH Employee Disability Resource Group hosted the fourth annual Employee Disability Breakfast of Champions to celebrate MGH employees who show exemplary commitment to disability advocacy. The celebration is held each October to coincide with National Disability Employment Awareness Month, and this year's theme was: #Inclusionworks. Senior vice president for Human Resources, Jeff Davis, spoke about the Working Partners program, a collaboration with the Massachusetts Rehabilitation Commission. The program pairs candidates receiving vocational rehabilitation through the Commission with MGH Human Resources to identify opportunities to hire individuals with disabilities and facilitate interviews. Davis shared that 2016 was our most successful year yet with the placement of 12 candidates in various roles throughout the hospital.

(Photos by Michelle Hoge)

At right: senior vice president for Patient Care, Jeanette Ives Erickson, RN (left), and associate chief nurse, Theresa Gallivan, RN (right), with disability champions (l-r): Jennifer Murphy, RN; Alice McConville, RN; Lindsey Ledoux, RN; and nursing director, Jennifer Sargent, RN. (Sophia Harden, RN, was unable to attend.)
Above: Employee Disability Resource Group chair, Linda Akuamoah-Boateng (left), and senior vice president for Human Resources, Jeff Davis (right), with disability champions and nominees: Leonard Debenedictis, Rebecca Coburn, and Janet Wozniak, MD.
Above right: guest speaker, James Kawuma, financial analyst for the Schwartz Center for Compassionate Healthcare.

Guest speaker, James Kawuma, financial analyst for The Schwartz Center for Compassionate Healthcare, spoke of his experience as an MGH employee who found his current position through the Working Partners program.

Disability champions from Phillips 20 were recognized this year, including staff nurses: Sophia Harden, RN; Lindsey Ledoux, RN; Ali McConville, RN; and Jennifer Murphy, RN, for going the extra distance to ensure adult patients with autism spectrum disorder had tailored care plans that not only reduced their anxiety but recognized their strengths and capabilities as individuals.

Other nominees included:

- Rebecca Coburn, Police & Security
- Leonard DeBenedictis, Employee Assistance Program
- Susan Doyle, Nutrition & Food Services
- Brennan Srisirikul, Parking & Commuter Services
- Kristen Sullivan, Allergy Associates
- Timothy Wilens, Psychiatry
- Janet Wozniak, Psychiatry

Chair of the Employee Disability Resource Group, Linda Akuamoah-Boateng, encouraged attendees to seek opportunities in their own lives to support and advocate for individuals with disabilities. The Employee Disability Resource Group is open to all. For information, e-mail: MGHEDRG@partners.org, or call Linda Akuamoah-Boateng at 617-643-2886.

Emergency Department post-discharge phone call program

—by Ines Luciani-McGillivray, RN, and Maureen Beaulieu, RN

ED nurses at MGH make more than 100 discharge phone calls a day. These calls are made by experienced nurses over the course of a ten-hour period. ED post-discharge phone calls promote patient safety, decrease ED re-admissions, increase patient satisfaction, and help patients navigate the sometimes complex landscape of post-ED care.

ED post-discharge phone calls promote patient safety, decrease ED re-admissions, increase patient satisfaction, and help patients navigate the sometimes complex landscape of post-ED care.

One past-discharge phone call found a 30-year-old veteran with multiple neurological issues and a history of post-traumatic stress disorder unable to obtain an appointment with his primary care physician. He'd been to several EDs with numerous complaints. The post-discharge call nurse who spoke to this patient contacted the triage nurse at the outpatient neurological clinic and enrolled him in The Home Base Program. The Home Base Program is designed to help veterans who are returning to civilian life, and thanks to that referral, this patient received medical and psychiatric treatment as well as support from a social worker. This patient would not have known about The Home Base Program if not for the intervention of the ED post-discharge call nurse.

An unkempt 69-year-old woman diagnosed with pancreatic cancer was brought to the ED after falling out of bed and hitting her head. She was brought in by ambulance, and EMTs told staff that her home was in disarray. During her last admission, an Elder at Risk Form had been filed. A head CT scan came back negative for a bleed. Despite attempts to convince her to stay overnight, the patient wanted to go home. The next day, the nurse making the post-discharge phone call was unable to reach her. After several unanswered calls and reviewing her record, the decision was made to call the police and request a well-being check. The police found the patient unresponsive in her bed. She was immediately brought back to the hospital for follow-up care.

A 60-year-old man was seen in the ED for shortness of breath and leg pain. He had a history of pulmonary emboli and described his symptoms as similar to past episodes. He was given a comprehensive work-up but didn't want to stay in the hospital; he wanted to return home. When contacted by the discharge call nurse later, she noticed that he seemed short of breath. He said he was caring for an elderly parent and wasn't feeling any better. The call nurse notified the Partners Mobile Observation Unit who went to his home to assess him. They spoke to his primary care physician. The patient didn't need to return to the ED, but visiting-nurse services were arranged for him at home. The Partners Mobile Observation Unit provides home-based urgent care by nurse practitioners, minimizing the need for hospitalization and emergency services and improving patient outcomes.

An 80-year-old woman was brought in by ambulance after falling and hitting her head resulting in a laceration. The patient had macular degeneration and was legally blind. She was stitched up and discharged home with instructions to go to the surgical clinic for suture removal. During her discharge phone call, the patient said she couldn't see the instructions; she lived alone and had no way to get to her appointment; she hadn't seen a doctor in years. She couldn't see the incision site to check for heal-

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In this era of social, political, and healthcare flux, it's challenging to meet patients' needs, advocate for necessary resources, and provide timely documentation while caring for patients in a busy ED setting. Assessing patients in post-discharge phone calls involves checking on the physical, emotional, spiritual, and mental well-being of each patient.

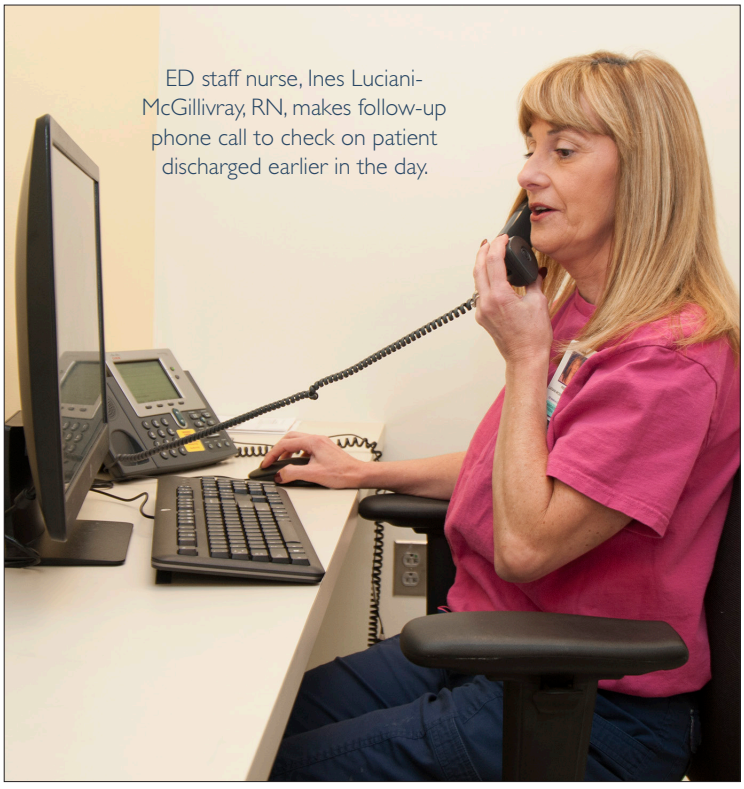
ing. Her providers had reviewed the instructions with her, and she thought she knew what to do—until she got home. We collaborated with the case manager. The ED discharge nurse obtained cab vouchers so the patient could get to and from the hospital for her surgical clinic appointment. On the same day, we arranged for her to be seen at Mass Eye and Ear. She was given an eye exam and a certificate deeming her legally blind so she'd be eligible for services from the Massachusetts Commission for the Blind. The nurse made herself available to help navigate her care that day and with the help of the case manager located a primary care physician closer to her home.

A 78-year-old woman came to the Emergency Department to have the swelling in her ankle evaluated. She was seen and sent home with increased medication. During the discharge phone call, the patient told the nurse that her aide hadn't shown up in weeks. She lived alone with no close contacts; she was hungry and had no food. When the nurse asked why she hadn't told anyone in the ED, she said she'd come in for her ankle and didn't want to bother anyone with her food problem. We reached out to Social Work and filed an Elder at Risk Form so someone would go to her home and assess her situation.

A 40-year-old homeless man who suffered from alcoholism, was involved in an altercation and presented in the ED with a jaw fracture. His jaw was wired shut to facilitate healing. He was adamant about leaving the hospital. Because he was homeless, we were unable to reach him with a follow-up phone call. But we were concerned he was at risk for not following diet instructions and aspirating. The discharge call nurse made countless calls to other hospitals and homeless shelters to try to locate this patient. She solicited help from ambulance drivers and the police, and ultimately he was brought back to the ED for his own safety. He chose to have his jaw unwired so that he could leave the hospital.

In this era of social, political, and healthcare flux, it's challenging to meet patients' needs, advocate for necessary resources, and provide timely documentation while caring for patients in a busy ED setting. Checking on patients in post-discharge phone calls involves assessing their physical, emotional, spiritual, and mental well-being. There are many issues to keep in mind when discharging patients from the ED: how will the patient get home? Is she safe at home? Is he able to follow discharge instructions? Does he have the wherewithal to get his medications and get to follow-up appointments? Are home services necessary? These are just some of the factors that need to be considered when patients are discharged home. Collaboration among all healthcare professionals is a key part of discharge planning. The post-discharge ED nurse plays a vital role in patient safety and advocacy.

For more information about the ED post-discharge phone call program, call 617-643-7742.



ED staff nurse, Ines Luciani-McGillivray, RN, makes follow-up phone call to check on patient discharged earlier in the day.

Nursing in the Clinical Research Center

creating a safe and caring environment for every patient

Chantal Kayitesi earned degrees in Nursing, Midwifery, and Public Health in Rwanda where she first practiced in Maternal Health and later founded/led a non-profit organization supporting women and orphans affected by genocide. She came to the United States in 1999, earned a master's degree in Public Health from Boston University, and enrolled in a nursing refresher course so she could become licensed here. She earned an associate's degree in Nursing from Regis College and will complete her BSN in June, 2017. Kayitesi worked in Public Health supporting refugees and at the MGH Chelsea Community Health Center as the manager for Immigrant and Refugee Health. Earlier this year, Kayitesi was hired by nursing director, Kathy Hall, RN, and became part of the Clinical Research Center team.

Chantal Kayitesi, RN, staff nurse
MGH Clinical Research Center

I'd like to share my experience working with a baby who was being treated for pre-symptomatic spinal muscular atrophy. 'John' was 11 months old and had been traveling from another state with his mother to be treated with a new trial drug.

My name is Chantal Kayitesi, and I am a staff nurse in the White 13 Clinical Research Center. As I reflect on my journey over the past few months, I can't help but feel happy that I'm doing what I love—caring for patients. When I began looking for a nursing position last year, I never thought I'd end up working as a clinical research nurse; I'd never even heard of a clinical research nurse. After eight months in the Clinical Research Center, I've learned so much and continue to experience personal and professional growth every day.

I've had the opportunity to work with babies, school-age children, adolescents, and adults. I've worked on a number of studies, both old and new. Clinical research nurses are integral members of the research team. The role involves not only caring for research participants, it's also helping to maintain the integrity of the research protocol.

As an example, I'd like to share my experience working with a baby who was being treated for pre-symptomatic spinal muscular atrophy. 'John' was 11 months old and had been traveling from another state with his mother to be treated with a new trial drug. I first met John while I was still going through orientation. During our first encounter, I had the opportunity to observe a senior nurse work with John, his mother, and the study team. Since then, I've had two more opportunities to work with John, most recently last month.

One of the primary responsibilities of a clinical

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I was fortunate to have the opportunity to care for John as part of the clinical research team. I've learned so much in the short time I've been here, and I feel more confident in my skills as a clinical research nurse. There's still a lot to learn and I'm eager to acquire new skills and contribute in other ways to the work being done by my colleagues in the Clinical Research Center.

research nurse is helping the team prepare. That includes working with the principal investigator and study coordinator in preparing all the documents such as, physician orders, flow-sheets, laboratory labels, and writing a study synopsis for other nurses. As the associate protocol nurse, I help ensure that the study team and the unit are ready for implementation.

Another important role is protecting my patient as a research participant. In this case, my interactions regarding the protocol were with John's mother. My role was to build trust and rapport to ensure a comfortable and successful visit. I needed to make sure John's mother was fully aware of what the trial would entail and whether she wanted to proceed. John's mother had made the difficult decision to enroll her child in a clinical trial. I couldn't imagine what she must be feeling, but I could empathize with her and appreciate that she was trying to protect her child and give him a chance to receive a potentially life-saving drug. I wasn't there to judge, I was there to support her and make her and her baby comfortable.

Care always begins by doing a comprehensive nursing assessment followed by collecting blood and urine samples, then caring for and monitoring the infant after the procedure. I review all the safety measures with the mom and ensure she understands and agrees with them. Finally, I coordinate care with all the other professionals (nurse practitioner, principal investigator, study coordinator, dietician, and clinicians in the operating room and Post Anesthesia Care Unit) to ensure a successful visit.

During John's most recent visit, my first task was to carefully read the orders and capture every detail of the study procedures. This was even more critical because on this particular visit John was participating in two separate studies, and this was the first time the studies were being combined. Since the study is performed every three months, it's always important to review the details of the last visit and, if needed, check with the nurse who was on duty at the time. I double-checked the orders with a senior nurse.

John and his mother arrived on the unit at about 8:00am for a procedure that was scheduled to begin in the OR at 10:00. Orders included a nursing assessment, history and physical by the nurse practitioner or physician, sample collection, intrathecal (spinal) injection of the investigational agent, and assessment and monitoring post-procedure. I performed my assessment, took John's vital signs, and collected a urine sample; the principal investigator conducted a history and physical; and the dietitian measured height and weight.

As I was starting to gather supplies to bring to the OR, we received a call that the OR was free and we should bring John down earlier than anticipated. The plan quickly changed. We rushed John to the OR where the procedure began immediately. Once in the OR, I assisted the principal investigator during the collection of blood samples and the injection of the study medication. I documented all the times for each procedure. Then John was taken to the PACU for observation before returning to our unit.

All procedures were performed as planned and John and his mother were cared for in a safe and caring environment. I was fortunate to have the opportunity to care for John as part of the clinical research team. I've learned so much in the short time I've been here, and I feel more confident in my skills as a clinical research nurse. There's still a lot to learn and I'm eager to acquire new skills and contribute in other ways to the work being done by my colleagues in the Clinical Research Center.

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

Chantal's ability to create a safe and caring environment in a clinical research setting is reassuring for John and his mom and critical to the success of the study. Chantal's empathy and compassion are evident as she skillfully balances the challenges of a rigorous research protocol and data-collection with the need for a mother and child to feel safe and cared for.

Thank-you, Chantal.

Comfort and Support after Loss Memorial Service

—by Leslie Kerzner, MD

"Losing a child is an ongoing traumatic experience," said one parent at this year's annual MassGeneral Hospital *for* Children's Pediatric, Neonatal, and Obstetric Memorial Service, held November 6, 2016. "I walk with stones under my feet; sometimes they're sharp and painful, other times they're gentle."

Several parents wrote poems for their children who were, "not physically with us, but with us in so many other ways."

Families cherish this annual service that provides a sacred space to share with others who understand. Pediatric specialists, Jeanne MacDonald, MD, and Manuella Lahoud-Rahme, MD, reminded families, "We fight for your children to heal. And when we can't, we do everything we can to comfort them. We also grieve for your children."

(L-r): Kathryn Beauchamp, RN; Cathy Harris, RN; Clorinda Cottrell, LICSW (co-chair); Leslie Kerzner, MD; Nancy Leventhal, LICSW (co-chair); Jamie Lee Rossi, CCLS; Sandra Stokes, LICSW; Melissa Anne Tecci, CCLS; and Rebecca Warsofsky, CCLS. (Photo provided by staff)

Many families and staff return year after year to participate in this deeply meaningful event. Social worker, Nancy Leventhal, LICSW, moderated the service, saying, "We're a community of caregivers here to honor your children's lives."

Pediatric chaplain, Kate Gerne, offered a spiritual reflection. Lorrie Kubicek, music therapist, and Kimberly Khare provided live music during the service, including one song with the lyrics, "Love can build a bridge between your heart and mine."

Attendees participated in a naming ceremony and were given pewter hearts, roses, and daffodil bulbs in memory of their children. A slide-show depicting years of memories was presented by child life specialists, Jamie Rossi and Melissa Tecci. Staff and volunteers planned fun activities at the MGH Back-Up Child Care Center for younger attendees.

Following the service, a reception was held in the East Garden Dining Room where families had a chance to re-connect with providers and speak with other grieving families. Memorial quilts and scrapbooks from previous years were on display.

Members of the Comfort and Support After Loss Committee include:

- Nancy Leventhal, LICSW (co-chair)
- Clorinda Cottrell, LICSW (co-chair)
- Kathryn Beauchamp, RN
- Kate Gerne, chaplain
- Cathy Harris, RN
- Leslie Kerzner, MD
- Justine Romano, LICSW
- Jamie Lee Rossi, CCLS
- Sandra Stoke, LICSW
- Melissa Tecci, CCLS
- Rebecca Warsofsky, CCLS

Case Management Week at MGH

—by Laurene Dynan, RN, case manager

On October 26, 2016, in honor of Case Management Week, Paul Simmons, MD, assistant chief medical officer and physician advisor to Case Management, presented, "Repatriation is not deportation: one hospital's efforts to optimize capacity and do right by the patient," to an audience of nurses, therapists, social workers, physicians, and case managers. Simmons told attendees, "Hospitals are for patients. We need to think of hospital beds as valuable resources."

Simmons referred to the return of patients to their home hospitals as 'repatriation.' He spoke of the value of enhanced coordination, options for safe discharge planning, and best practices for ethical medical repatriation. When considering returning a patient to his or her home hospital or country of origin, think of the value of receiving care closer to home and, importantly, closer to family. Once a patient's acute tertiary needs are met at MGH, that patient may be better off closer to loving family members and community resources.

Simmons reminded attendees to think beyond the hospital stay. He compared the many discharge options we have to a sports 'play book' with multiple contingency plans depending on how situations unfold. One discharge option does not fit all. We should consult the play book whenever transitioning patients to home, to the care of another hospital, or to their country of origin. While Plan A may seem like the best option at first, we need to remain flexible to other options as care needs change. Perhaps Plan B (or C or D) is really the best choice. Often, original discharge plans become unattainable for one reason or another. Discharge options should be addressed in parallel processes involving many conversations with the care team, the patient, and the family.

Simmons recommends that repatriation decisions be made based on a thorough social history, actual verifiable facts, and early identification of the potential to repatriate. "Three criteria must be met for a successful repatriation," said Simmons, "clinical consensus, patient and family agreement, and a willing clinical partner."

For more information about the work of Case Management, call 617-726-3665.

Below: standing (l-r): Arme Gallanaro and Catherine O'Meara. Seated: Wendy Atamian and Janet Hill Heavey. At right: speaker, Paul Simmons, MD

(Photo provided by staff)

Professional Achievements

Caruso certified

Linda Caruso, RN, staff nurse, became certified as an oncology nurse by the Oncology Nursing Certification Corporation, in October, 2016.

Coakley certified

Amanda Bulette Coakley, RN, staff specialist, became certified as an advanced holistic nurse by the American Holistic Nurses Credentialing Corporation, in October, 2016.

Annese certified

Christine Donahue Annese, RN, staff specialist, became certified as an advanced holistic nurse by the American Holistic Nurses Credentialing Corporation, in October, 2016.

Dwyer certified

Ann Marie Dwyer, RN, director, Nursing and PCS Clinical Informatics, became certified in Nursing Informatics by the American Nurses Credentialing Center, in September, 2016.

Informatics analysts honored

Nursing and PCS eCare Go-Live Informatics Analyst team of Patricia Grella, RN; Meilssa Lantry, RN; and Michelle Stuler, RN, was awarded the 2016 Nesson Award for Excellence, October 1, 2016.

Chisari and Ives Erickson present

Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development, and Jeanette Ives Erickson, RN, senior vice president for Nursing and Patient Care Services, presented, "Inter-professional Compassion, Teamwork, and Managing Conflict," at the The Schwartz Center for Compassionate Care event, October 28, 2016.

Flanagan certified

Jane Flanagan, RN, nurse scientist, became certified as an advanced holistic nurse by the American Holistic Nurses Credentialing Corporation, in October, 2016.

Arnstein presents

Paul Arnstein, RN, clinical nurse specialist, presented, "Opioid Prescribing: Safe Practices to Change Lives," at the 26th annual conference of the American Society for Pain Management Nursing, in Louisville, Kentucky, September 9, 2016.

Chisari and Brown present

Gino Chisari, RN, and Elizabeth Brown, RN, presented, "Innovation in Leadership," and "Transformational Leadership," at the Asia Nurse Leaders Seminar, in Singapore, in September, 2016.

Chisari presents

Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development, presented, "Nurse Empowerment, Privilege, and Responsibility," at Newton Wellesley Hospital, in October, 2016.

Convery presents

Mary Susan Convery, LICSW, social worker, presented, "Caregiver Fatigue in Healthcare Providers," at the Phoenix Society for Burn Survivors, in Providence, Rhode Island, October 21, 2016.

Chisari presents

Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development, was a panel facilitator and presented, "Innovation in Education," at the Asia Nurse Leaders Seminar, in Singapore, in September, 2016. Chisari also presented, "Innovation Units—Framework for Change," and "Professional Practice: Peer Review," at the same seminar.

Zwirner a panelist

Mary Zwirner, LICSW, social worker, was a panelist for the, "Lawyers and Bio-Ethicists: Collisions and Congruity," discussion at the Boston Bar Association, October 20, 2016.

Social workers present

Social workers, Anne LaFleur, LICSW, and Pat Dennis, LCSW, presented, "Mentor Training," at the annual international conference of the Society for Transplant Social Workers, in San Diego, October 8, 2016.

Luby presents

Barbara Luby, LICSW, social worker, presented, "Increasing Peer Support as a Means of Improving Adherence in Adolescent Transplant," at the annual international conference of the Society for Transplant Social Workers, in San Diego, October 6, 2016.

Penzias presents

Alexandra Penzias, RN, clinical nurse specialist, presented, "The Perception of Nursing Presence in Patients Experiencing MRI-Guided Breast Biopsy," at the 22nd conference of the International Caring Consortium, in Boston, October 28, 2016.

Project managers present

PCS Informatics project managers, Patricia Grella, RN; Melissa Lantry, RN; and Michelle Stuler, RN, presented, "Creating a Go-Live Support Model Using End Users," at Epic UGM, in Verona, Washington, September 22, 2016.

Social workers present

Social workers, Karen Tanklow, LICSW, and Anne LaFleur, LICSW, presented, "Challenges of Support Groups: Managing Group Dynamics While Enhancing Opportunities for Improved Patient-Team Experiences," at the annual international conference of the Society for Transplant Social Workers, in San Diego, October 6, 2016.

Nurses publish

Sara Astarita, RN; Linda Caruso, RN; AnneMarie Barron, RN; and Patricia Rissmiller, RN, authored the article, "Women's Sexuality After Stem Cell Transplant," in the November, 2016, *Oncology Nursing Forum*.

Inter-disciplinary team publishes

Jeffry Shaefer, DDS; Antje Barreveld, MD; Paul Arnstein, RN; and Ron Kulich, authored the article, "Interprofessional Education for the Dentist in Managing Acute and Chronic Pain," in the October, 2016, *Dental Clinics of North America*.

Nurses publish

Kevin Whitney, RN; Barbara Haag-Heitman, RN; Margery Chisholm, RN; and Sharon Gale, RN, authored the article, "Nursing Peer Review Perceptions and Practices: a Survey of Chief Nurse Executives," in the October, 2016, *Journal of Nursing Administration*.

Nurses present poster

Jennifer Clair, RN, clinical nurse specialist; Debra Whitaker, RN, staff nurse; and Kelley Gramstorff, RN, staff nurse, presented their poster, "Precaution Screening Project for Transplant Patients," at the 25th annual symposium of the International Transplant Nurses Society, in Pittsburgh, October 14-16, 2016.

Inter-disciplinary team presents poster

Leslie Milne, MD; Dawn Williamson, RN; Ines Luciani-McGillivray, RN; Rebecca Klug, RN; Kim Cosetti, RN; Jane Reardon, RN; Patricia Mian, RN; and, team members from MGH Psychiatry and Boston EMS presented their poster, "Improved Management of Intoxicated Patients in the Emergency Department," at the national conference of the Emergency Nurses Association, in Los Angeles, September 22, 2016.

Continuing education on organ and tissue donation

More than 20 MGH nurses attended a day-long conference at the New England Organ Bank (NEOB), October 13, 2016. The conference focused on nursing education around organ and tissue donation to support clinical management of donors, emotional support for families, and broader awareness of organ and tissue donation. The conference was held at the NEOB facility in Waltham, where the Donor Memorial Giving Tree stands as a tribute to those who've 'donated life.'

Sessions at the conference featured an overview of the NEOB notification process, organ and tissue donation, and best practices. Mary Guanci, RN, Rosie Jean-Mary-Thomas, RN, and Brian Edlow, MD, presented a case study of a challenging donation involving a young woman transferred to MGH from an outside hospital. The case highlighted how good communication and establishing a trusting relationship led to a positive donation experience.

For more information about organ and tissue donation, call Mary Guanci, RN, clinical nurse specialist, at 857-238-5649.

(Photo provided by staff)

MGH nurses in front of the donor memorial giving tree at the New England Organ Bank in Waltham.

How do we monitor quality of care?

Question: What quality measures do we monitor in Patient Care Services?

Jeanette: We measure and report nursing-sensitive indicators on a quarterly basis. We evaluate our performance both internally and against national benchmarks. The nursing-sensitive indicators we measure are:

- falls with injury
- pressure ulcers (stage 2 or greater)
- CAUTIs
- CLABSIs

Question: What performance-improvement projects are we currently engaged in?

Jeanette: Patient Care Services has a number of performance-improvement projects in place that track aspects of patient care known to be associated with nursing interventions:

- Falls: Let's Eliminate All Falls strategies aimed at eliminating falls and falls with injury
- Pressure Ulcers: the Save Our Skin program that includes the use of specialty beds and skin-care products
- CAUTIs: the adoption of the Nurse Driven Protocol
- CLABSIs: the use of Scrub the Hub, Curos caps, hand hygiene, and the insertion checklist

Question: Are there performance-improvement projects specific to my unit?

Jeanette: Individual units have projects to improve outcomes for their unique patient populations, such as, baby-friendly, post-partum depression, and pain-management initiatives.

Question: How is the quality of care communicated to staff in their clinical areas?

Jeanette: Quality data can be found:

- on the Excellence Every Day portal page
- in *Caring Headlines* (see HCAHPS on page 16)
- in communications with unit leadership
- posted on unit quality communication boards
- through collaborative governance champions

Question: What is QA/PI?

Jeanette: QA/PI is a term often heard during Joint Commission surveys. It stands for Quality Assurance/Performance Improvement.

Quality assurance is the process of meeting quality standards and ensuring our care meets or exceeds national benchmarks, as we do when we monitor and report nursing-sensitive indicator data.

Performance improvement refers to continuously evaluating our performance and developing systematic efforts to improve it. The performance improvement process at MGH is Plan, Do, Check, Act. This is the guiding framework used by unit leadership as they develop and revise performance-improvement projects to ensure we're providing the highest quality care to patients and families.

For more information, contact Colleen Snydeman, RN, director of the PCS Office of Quality & Safety, at 617-643-0435.

Announcements

Blum Center Event

"Healthy Skin and Looking Your Best at all Ages"
Thursday, December 1, 2016
12:00–1:00pm
Join Mathew Avram, MD, for a discussion on how to keep your skin healthy.

"Healthy Holiday Eating"
Friday, December 9th
12:00–1:00pm
Join dietetic intern, Melanie Schermerhorn, for a discussion on healthy eating during the holiday season.

Shared Decision Making
"Help for Anxiety: Treatments that Work"
Monday, December 12th
12:00–1:00pm
Join Susan Sprich, MD, for a presentation, short video, and discussion on anxiety and treatments for anxiety disorders.

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:
February 6, 2017
8:00am–3:00pm

Day two:
February 22, 2017
8:00am–1:00pm

Re-certification (one-day class):
January 11, 2017
5:30–10:30pm

ACLS Instructor Class
December 2, 2016
7:00am–3:00pm

Location to be announced.
For information, send e-mail to: acls@partners.org, or call 617-726-3905

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

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday,
7:30am–5:30pm

Friday, 8:30am – 4:30pm

(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday, Thursday,
7:30am–5:00pm

Friday, 8:30am–3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

APRN/PA credentialing website

Visit the new APRN/PA credentialing website at http://intranet.massgeneral.org/pcs/

The site is located under the Credentialing tab in the PCS Resources Portal in Partners Applications.

The website contains information on APRN/PA credentialing, guidelines for new hires and managers, necessary forms, and much more.

New materials will be added to the site in the coming months. For more information, call Julie Goldman, RN, at 617-724-2295.

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For more information, call: 617-724-1746

Next Publication
December 15, 2016

Inpatient HCAHPS

Current data

HCAHPS Measure	CY 2015	CY 2016 Year-to-date (as of 11/11/16)	% Point Change
Nurse Communication Composite	83.0%	82.7%	-0.3%
Doctor Communication Composite	83.5%	82.4%	-1.1%
Room Clean	72.9%	71.4%	-1.5%
Quiet at Night	50.8%	49.9%	-0.9%
Cleanliness/Quiet Composite	61.8%	60.6%	-1.2%
Staff Responsiveness Composite	65.8%	64.5%	-1.3%
Pain Management Composite	73.1%	72.2%	-0.9%
Communication about Meds Composite	66.6%	65.9%	-0.7%
Care Transitions	62.4%	60.3%	-2.1%
Discharge Information Composite	91.1%	91.5%	0.4%
Overall Hospital Rating	81.2%	81.5%	0.3%
Likelihood to Recommend Hospital	90.9%	89.5%	-1.4%

All results reflect Top-Box (or 'Always' response) percentages

The data are complete through August, 2016, with partial data through November. MGH is performing well in Overall rating and Discharge Information.

Caring Headlines
December 1, 2016

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