

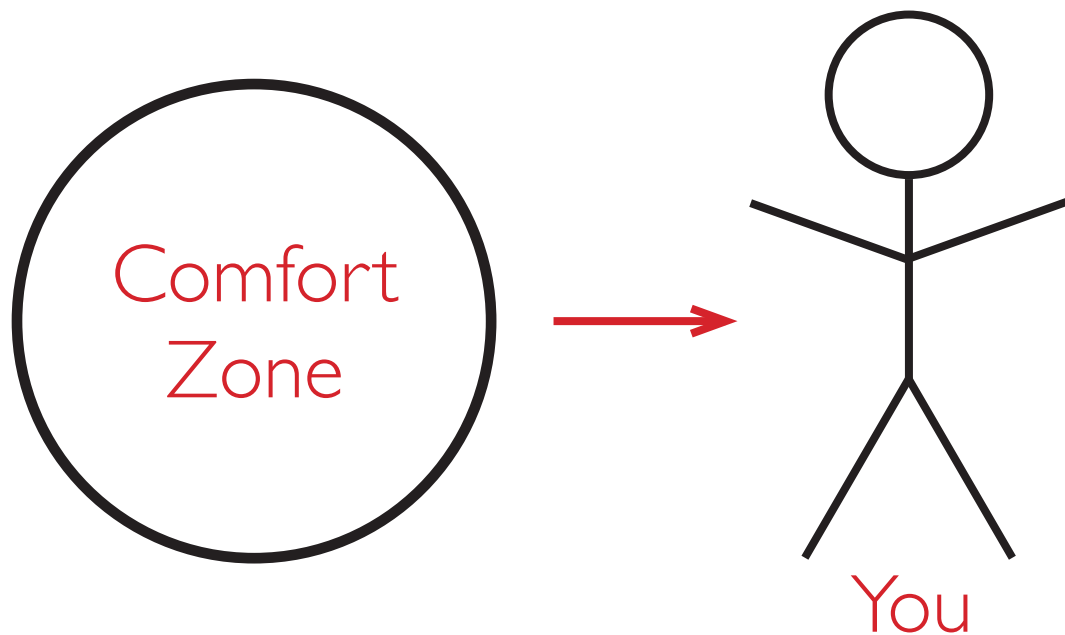
# Caring

Headlines

September 1, 2016

## Embracing diversity

*might mean making a few  
changes. Are you comfortable  
with that?*



*See commentary on page 5*

# Recovery Month at MGH

*bringing knowledge, compassion,  
and evidence-based care to the treatment  
of substance-use disorders*

Addiction is not a personal failing; rather, it's a complex illness with neuro-biological and genetic components often rooted in trauma or stress. Changing the culture to embrace this new paradigm requires education, commitment, collaboration, and planning.

**F**or those who've never experienced an addictive illness, it may be difficult to appreciate the extent to which these disorders impact the lives of those affected. Many addictive illnesses are accompanied by physical, spiritual, emotional, and psychological side-effects that can be devastating—and among the most devastating are those related to substance-use disorders.

Each September, the Substance Abuse and Mental Health Service Administration (SAMHSA), a branch of the US Department of Health and Human Services, sponsors Recovery Month to help raise awareness around mental illness and substance-use disorders and celebrate individuals in recovery.

This year, MGH is holding its first Recovery Month celebration to highlight the innovative care and interventions that make recovering from substance-use disorders possible at MGH. The month-long calendar of events (see schedule on page 4) officially kicks off Thursday, September 8th, from 12:00 to 1:00pm on the Bulfinch lawn, with remarks from MGH president, Peter Slavin, and Secretary of Massachusetts Health and Human Services, Marylou Sudders. The event is open to staff, patients, families, community members, and anyone interested in learning about addiction care and prevention.

Historically, addiction recovery programs have focused on the cessation of substance use, but abstinence-based models don't work for everyone. Fortunately, new approaches are being introduced as



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

health care embraces more holistic models of treatment thanks to research and knowledge gained through evidence-based practice.

I'm happy to say that MGH is at the forefront of this movement to promote innovative care and holistic approaches to recovery. In response to a recent assessment that identified substance abuse as a major concern among local communities, MGH has committed to addressing addiction as part of our ten-year strategic plan. We established the Substance Use Disorders initiative (SUDs) to expand treatment options and help drive the paradigm shift toward more holistic methods of care and prevention.

At the root of this shift is an understanding that addiction is not a personal failing; rather, it's a complex illness with neuro-biological and genetic components often rooted in trauma or stress. Changing the culture to embrace this new paradigm requires education, commitment, collaboration, and planning—qualities we're well acquainted with at MGH.

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Supported by the department of Nursing, 30 MGH nurses are currently enrolled in a pilot training program to prepare for the Registered Nursing Addiction Certification exam. Nurses are uniquely positioned to engage with, educate, and motivate patients to promote health and wellness.

Peer specialists, known as recovery coaches, are already supporting patients with substance-use disorders by accompanying them to appointments, recovery meetings, court appearances, or just sitting with them to have a cup of coffee and listen.

Supported by the department of Nursing, 30 MGH nurses are currently enrolled in a pilot training program to prepare for the Registered Nursing Addiction Certification exam. Nurses are uniquely positioned to engage with, educate, and motivate patients to promote health and wellness.

MGH physicians trained in addiction are leading efforts to provide access to pharmacotherapy for patients with opioid-use disorders. They're spearheading efforts to train their colleagues in the care and treatment of SUD patients.

Staff from the Emergency Department have worked hard to promote mindful opioid prescribing, safe monitoring of patients under the influence, thorough evaluation of substance-use disorders, and referrals for further treatment.

A multi-disciplinary, inpatient Addictions Consult Team was established two years ago to assist caregivers in providing evidenced-based, holistic treatment for patients with medical and mental-health co-morbidities. To date, the Addictions Consult Team has provided nearly 2,000 consults

with the goal of providing compassionate, evidence-based care in sync with the patient's readiness to receive treatment.

The newly established Bridge Clinic serves as a transitional walk-in clinic for patients who've been recently discharged. Patients are stabilized and eventually transition to long-term care in their communities.

The MGH Center for Addiction Medicine, a clinical research program within the department of Psychiatry, evaluates, consults, and provides study-related care for patients who want to stop smoking or control alcohol- and/or drug-related behaviors. The Addiction Recovery Management Service, part of the Center for Addiction Medicine, provides rapid access to information, support, and outreach for young people, 14 -26 years old, and their families dealing with substance-related issues.


Just as important as treating patients with substance-use disorders is trying to prevent addiction from developing in the first place. Prevention is the focus of a number of coalitions led by the MGH Center for Community Health Improvement. These coalitions engage with young people through school systems, advocate for treatment resources, and work with law enforcement to ensure a safe, supportive response to substance-abuse situations.

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(Photo on page 10 by Paul Batista)

# Recovery Month Calendar of Events

<div>JOIN THE VOICES FOR RECOVERY: OUR FAMILIES, OUR STORIES, OUR RECOVERY!</div>			<div>National Recovery Month <small>Prevention Works - Treatment is Effective - People Recover</small> SEPTEMBER 2016</div>	<div>Thu 9/1</div> <ul style="list-style-type: none"><li>11 AM: Blum Center Talk, "Engaging Youth with Substance Use Disorders in Care and Supporting their Parents," with James McKowen, PhD and Amy Yule, MD of Addiction Recovery Management Service (ARMS)</li></ul>	<div>Fri 9/2</div>
<div>Mon 9/5</div>	<div>Tue 9/6</div>	<div>Wed 9/7</div> <ul style="list-style-type: none"><li>8 AM – 6 PM: Information Table at Coffee Central</li><li>11 AM: Blum Center Talk, "Bridging the Gap: Meeting People Where They Are," with Laura Kehoe, MD, MPH of the Bridge Clinic and Dawn Williamson, PMHCNS-BC, CARN-AP of the Emergency Dept</li></ul>	<div>Thu 9/8</div> <div>Recovery Month Kickoff,</div> <div>Bulfinch Lawn</div>	<div>Fri 9/9</div>	
<div>Mon 9/12</div> <ul style="list-style-type: none"><li>12 PM: "Anonymous People" screening and Q&amp;A with Recovery Coaches, Haber Auditorium</li><li>1:30-6 PM: Half and Half Suboxone Waiver Training, Thier Building <i>(by registration, for clinicians only)</i></li></ul>	<div>Tue 9/13</div> <ul style="list-style-type: none"><li>12 PM: Narcan Training, Yawkey 2-230</li><li>12 PM: Dept of Psychiatry M&amp;M on Substance Use Disorders, Haber Auditorium <i>(MGH clinicians only)</i></li></ul>	<div>Wed 9/14</div> <div>MOAR &amp; Friends Statewide March and Celebration</div> <ul style="list-style-type: none"><li>8 AM: MGH employees meet at Bulfinch Lawn to join</li><li>1 PM: Blum Center Talk, "Addiction, Recovery and Quality of Life," with John Kelly, PhD and Randi Schuster, PhD of the Center for Addiction Medicine.</li></ul>	<div>Thu 9/15</div> <ul style="list-style-type: none"><li>8 AM – 6 PM: Information Table at Coffee Central</li><li>10 AM: Dr. Peter Grinspoon, author of "Free Refills: A Doctor Confronts His Addiction," O'Keeffe Auditorium</li><li>1:30 PM: Interdisciplinary Grand Rounds, "Law Enforcement's Response to the Opioid Epidemic: Creative Solutions to Accessing Care," O'Keeffe Auditorium</li></ul>	<div>Fri 9/16</div> <ul style="list-style-type: none"><li>1:30 PM: Patient Care Associates Education Series: "Understanding the Needs of Our Patients with Substance Use Disorders", Founders 325</li></ul>	
<div>Mon 9/19</div>	<div>Tue 9/20</div> <ul style="list-style-type: none"><li>1 PM: Blum Center Talk, "Beyond Traditional Treatment Options," with Sarah Wakeman, MD and Martha Kane, PhD of the Substance Use Disorders Initiative</li></ul>	<div>Wed 9/21</div> <ul style="list-style-type: none"><li>8 AM – 6 PM: Information Table at Coffee Central</li><li>6 PM: "Anonymous People" screening and Q&amp;A with Recovery Coaches O'Keeffe Auditorium</li></ul>	<div>Thu 9/22</div> <ul style="list-style-type: none"><li>6 - 7 PM: Narcan Training, Yawkey 2-210</li><li>8AM: "Evolution of the 12 Steps" with Christopher Shaw, NP in Yawkey 2-230</li></ul>	<div>Fri 9/23</div>	
<div>Mon 9/26</div> <ul style="list-style-type: none"><li>10 AM: Trauma Informed Care Symposium "How to weave trauma-informed care into everyday practice", with Dr. Carol Warshaw, O'Keeffe Auditorium</li></ul>	<div>Tue 9/27</div> <ul style="list-style-type: none"><li>12:30 PM: "Warzone: Opioid use disorders and considerations of treatments in military veterans" screening and Q&amp;A with Cally Lilley, NP and Nalan Ward, MD, Yawkey 2-210</li></ul>	<div>Wed 9/28</div>	<div>Thu 9/29</div> <ul style="list-style-type: none"><li>11 AM: Expert Panel on Medical Professionals with Substance Use Disorders, Thier Auditorium</li><li>1 PM: Blum Center Talk, "There is Treatment; Treatment Works," with clinicians and a patient panel from the West End Clinic</li></ul>	<div>Fri 9/30</div>	



For more information, please visit: [www.massgeneral.org/recovery-month](http://www.massgeneral.org/recovery-month)

Reaching beyond our local neighborhoods, the Lunder-Dineen Health Education Alliance of Maine is part of the MGH Substance Use Disorders Task Force, sharing best practices in addressing substance-use disorders here at MGH and in my home state of Maine. The 'Time to Ask' program is an inter-professional education model designed by Lunder-Dineen to equip healthcare professionals with the knowledge, skills, and attitude needed to engage patients and families in conversations about alcohol misuse. Time to Ask is being piloted in three primary-care settings in Maine with the goal of expanding the program throughout the state. The Lunder-Dineen Alliance is the only one of its kind in the nation where knowledge and best practices are shared between a large academic medical center and a neighboring state.

MGH and the US Department of Health and Human Services recognize that behavioral health is essential to maintaining overall good health—and not just the health of the individual, the health of local communities, states, and society at large. Substance-use disorders represent a public-health crisis. As healthcare providers, we have opportunities throughout the continuum to impact this threat. We can and must seize all opportunities to educate and protect our patients and the communities we serve.

Our Recovery Month calendar includes educational offerings, presentations, Q&A forums, and much more. I urge you to find time in your busy schedules to attend as many sessions as possible. And to get the most out of these events, bring a friend or colleague... talk about what you've learned... and share those lessons with staff who were unable to attend. We can all play a part in spreading the message of recovery.

# Do we need to talk about race at work?

—by Deborah Washington, RN, director, PCS Diversity

Whom do you talk to when you have questions about race? Do those conversations happen often? Do you seek out friends or colleagues? Do you look to people of diverse backgrounds to have those conversations with? When we talk only to individuals who share our own racial identity, do we really learn anything about the day-to-day realities of people of other races? I know it can be difficult to reach outside our comfort zone to have those conversations. But when we're 'comfortable,' chances are we're not being challenged. And when it comes to diversity, we all need to challenge ourselves to do better.

Author, C.S. Lewis, once said: "I believe in Christianity as I believe that the sun has risen: not only because I see it, but because by it, I see everything else." Lewis saw the world through the filter of Christianity. What if we apply that metaphor to diversity. As a philosophy, diversity gives us a way to think about how we share our lives in an increasingly heterogeneous world. It raises the question: What do we see when we embrace diversity; and what do we miss when we don't?

From my observations, four things happen when we embrace diversity:

- Our ability to relate to one another across differences starts to matter more
- By eliminating uncertainty about what it takes to build positive relationships, our engagement with others increases
- We have more positive interpersonal encounters. We take advantage of opportunities to demonstrate our esteem for one another
- Our respect for different points of view is reinforced

A friend recently commented that what makes America great is that it makes room for 300 million different opinions. Like America, MGH is a melting pot, a place to come together, to exchange ideas in various forums, meetings, gatherings, or simply when we have a chat over a cup of coffee.



Deborah Washington, RN  
director, PCS Diversity

Dr. Martin Luther King once described the work of the civil rights movement as meeting, 'days of challenge.' Most of us are probably fairly homogeneous in our personal lives. But that all changes when we walk through the doors of MGH. Our hospital is a microcosm of a racially and ethnically diverse world. That being the case, we need the care we provide to be defined by the highest level of cultural competence and sensitivity. We need an informed and diverse workforce. We need every patient and family to receive the same high quality care and services. No one should feel under-served.

As a hospital, we're committed to zero tolerance for discrimination of any kind. If we truly 'live' our mission and values, our practice will speak for itself—there will be no doubt of our commitment to diversity, inclusion, and creating a place of healing for all. I urge you to talk about race with your colleagues. Ask questions. Get to know someone you might not ordinarily engage with.

Step outside your comfort zone.



# The MGH Global Nursing Fellowship

*spotlighting the importance of nursing mentorship*

—by Bethany Groleau, RN, staff nurse; Kara Olivier, RN, nurse practitioner; Pat Daoust, RN, nursing director; and Barbara Cashavelly, RN, nursing director

In the MGH Global Nursing Fellowship, nurse fellows in underserved areas provide instruction in the classroom and guidance on clinical units to foster both professional development and excellence in clinical practice.

For more than a decade, the MGH Center for Global Health has partnered with Mbarara University of Science and Technology in southwestern Uganda to enhance patient care and support local clinicians in managing a diverse range of medical conditions. Recently, the partnership expanded to include nursing mentorship and education through the innovative MGH Global Nursing Fellowship. In this new program, nurse fellows in underserved areas provide instruction in the classroom and guidance on clinical units to foster both professional development and excellence in clinical practice.

Earlier this year, Barbara Cashavelly, RN, nursing director for the Lunder 9 Oncology Unit, mentored staff nurse, Bethany Groleau, RN, to help prepare her to apply for the inaugural fellowship. In May, working with Pat Daoust, RN, nursing director for Global Health, Groleau was recruited, oriented, and deployed to Uganda as the first global nursing fellow.

MGH is a champion of specialized nursing, recognizing it as an essential component of high-quality, patient-centered care. Partnering with local healthcare facilities where MGH enjoys long-standing relationships, MGH nurse educators work

with local staff to improve the quality of care in low-resource settings. During her time at Mbarara University, Groleau, worked with her Ugandan colleagues to provide oncology nursing education and develop culturally sensitive approaches to overcome the social stigma associated with cancer in that country. Groleau spent six weeks in Mbarara teaching a customized, oncology-focused curriculum and

*continued on next page*



(Photos provided by staff)

carrying for patients on inpatient and outpatient units. She worked closely with Sister Sarah Nabushawo, RN, charge nurse of the oncology unit at Mbarara Hospital.

As an oncology nurse at MGH, Groleau cares for patients with complex cancer diagnoses and supports patients focusing on symptom-management. Groleau's work on Lunder 9 inspired her to seek out opportunities to care for patients with similar diagnoses but who lack access to state-of-the-art resources. For cancer patients and families in Uganda, long distances, long waits for diagnoses and treatment, and inconsistent drug supplies complicate effective chemotherapy treatments that could potentially save many lives.

In the months prior to her departure, Groleau worked with Cashavelly and the MGH Global Health nursing team to better understand the needs of nurses and patients in resource-limited settings. Mindful of cultural differences and sensitive to communication barriers, she focused her preparation on

practice differences and the stigma associated with a cancer diagnosis.

When Groleau arrived in Mbarara and met the nurses who tirelessly care for patients lined up outside each day, they proudly shared their desire to improve care and welcomed her as a valued resource. During her six-week deployment, Groleau continued to reach out to Cashavelly and colleagues back home for clinical information to help the Mbarara team. While the challenges faced by patients, families, and providers in resource-limited settings can seem overwhelming, the collaboration between these remote facilities, MGH Global Health, and the MGH Cancer Center is a good reminder that the compassion and motivation to provide better care is universal.

Says Groleau, "Sharing knowledge and helping others grow in their clinical practice was a privilege. Through the Global Nursing Fellowship, I've been fortunate to build lasting professional and personal friendships with my Ugandan colleagues. I'm grateful to have had the opportunity to help educate such wonderful nurses and I thank them for all they taught me in return."

For more information about the Global Nursing Fellowship, contact Mary Sebert, RN, at 617-643-9197.

Opposite page: Mbarara nurses in oncology clinic during classroom presentation.

Below: Groleau (right) with Sister Sarah Nabushawo, RN.

Below right: Mbarara clinic nursing team





# Thank-you, Police & Security

To offset some of the negative stories in the news of late, staff on White 8 wanted to make it very clear that, “We love our colleagues in Police & Security.” So they held an appreciation luncheon on Wednesday, July 27, 2016, in the White 8 visitor’s lounge. They brought in home-made baked goods and invited members of Police & Security to

stop by. Says nursing director, Colleen Gonzalez, RN, “We work very collaboratively with Police & Security. They help us care for patients in so many ways, often putting themselves in harm’s way to keep us and our patients safe. We’re so appreciative to have such a competent, experienced, and responsive Police & Security team—we just wanted them to know that.”

Nursing director, Colleen Gonzalez, RN, (right) with staff of White 8 (seated) and several officers from MGH Police & Security at recent appreciation luncheon





# Concurrent graduating classes a milestone at MGH

**MGH** is a training site for professional chaplains through the Association of Clinical Pastoral Education. Pictured below are graduates of the 2016 graduating classes of Clinical Pastoral Education residents and summer Chaplaincy students. Residents are full-time clinicians on staff for 12 months; summer students fulfill a level-one unit in 11 weeks.

This represents a milestone in MGH history as they're the first residency and summer-unit classes to graduate concurrently in the almost 80 years since clinical pastoral education has been offered at MGH. In the 1930s, MGH became the first general hospital in the country to host a CPE unit, initiated by MGH physician, Richard Cabot, MD, and visiting minister, Rev. Russell Dicks.



(Photo by Paul Batista)

# Compassion and advocacy go hand-in-hand for RACU nurse

'John' had been diagnosed with ALS in his home state a year prior to his admission. Currently, he was able to breathe on his own for the majority of the day, requiring a BiPAP mask at night for respiratory support while sleeping.

**M**y name is Katie Perch, and I am a nurse in the Respiratory Acute Care Unit (RACU). Nurses in the RACU are constantly engaging with patients' emotional, psychological, and physical struggles. We're on the front lines of ethical decision-making and implementing medical decisions that affect patient's quality of life forever. These situations do not get easier with time. But after years of experience and better understanding, I've developed a deep compassion for this patient population.

'John' had been diagnosed with ALS in his home state a year prior to his admission. Currently, he was able to breathe on his own for the majority of the day, requiring a BiPAP mask at night for respiratory support while sleeping. John had been followed as an outpatient in the MGH ALS clinic, but was admitted to the RACU due to difficulty breathing after a fall from his wheelchair. It was discovered that John had aspirated during the fall and developed pneumonia.

Over the course of a week, John's pneumonia cleared with antibiotics, but his underlying disease was progressing, and so was his emotional distress. "What if I get back home and can't breathe again?" he asked me.

John and I had become quite close; I was one of his primary nurses. We often discussed his family, his home town, and things he and his wife enjoyed doing. I developed a therapeutic relationship with both John and his wife, 'Mary.' Mary was staying at a local hotel and was at John's side every day. We



Katherine Perch, RN  
staff nurse, RACU

discussed the nature of progressive illness, how he would soon require more non-invasive support. Eventually, they'd need to make a decision about whether John would want an artificial airway or focus more on comfort. As we spoke, I saw a look in John's eyes, a look I've come to recognize after years of experience, a look of fear and despair.

I called John's nurse practitioner from the ALS clinic to come visit. Even though she's not part of the RACU team, I knew she had a strong rapport with John, and he needed someone he could trust. She told me that they'd had in-depth conversations about the possibility of a tracheostomy and ventilator support when he was in the clinic. I told her he was becoming anxious about his breathing, especially about returning home. Many patients in this population have similar fears. I asked the nurse practitioner to provide more information to John and his wife to help allay their fears.

I arranged a 'curb-side' meeting with John, his wife, the nurse practitioner, another nurse from the ALS clinic, and our social worker and respiratory therapist. We had an open, in-depth discussion

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I'll never  
forget the  
feeling I got  
when I heard  
he was able  
to go home  
with his family.  
I knew this  
wasn't the end  
of his journey,  
but having been  
able to care for  
John and his  
family during  
such an eventful  
time was a  
monumental  
milestone in  
my nursing  
career.

about what was involved with getting a trach and later requiring a ventilator. We explained that as his diaphragm became more impaired, the harder it would be to breathe on his own, at which point he'd need more invasive support. I stressed the importance of being able to communicate once he no longer had his voice.

In the next few days, our occupational therapist, speech language pathologist, and I worked with John and Mary to develop a communication system using his eyes to convey common phrases. We encouraged him to share his concerns with us so we could incorporate what was meaningful to him into a letter board for communication later.

Two weeks after being admitted, despite his pneumonia clearing, John had begun requiring longer periods of BiPAP. The skin on his face was beginning to break down from wearing the mask.

John's doctor advocated against performing a trach, noting that John's diaphragm was still working, and in light of his anxiety, losing his voice would not be in his best interest.

As his nurse, I advocated for the opposite. John's fear was that he was now requiring more non-invasive support. He was scared that if we didn't perform the procedure here, something would happen emergently, and it would be traumatic. "John wants the trach," I said. "It's within his goals of care. He'd rather have it placed here, electively than be emergently intubated in front of his family."

After days of discussion with his entire team, John was scheduled for the procedure.

On that day, as John was about to be taken to the OR, the nurse anesthetist asked, "Is this patient able to tolerate lying flat?"

"No," I said. "He can't."

"Will we be able to Ambu-bag him en route to the OR?"

I knew John wouldn't be able to tolerate that. I shook my head. "No. He's requiring constant non-invasive support." I told her.

"We can't take him to the OR on BiPAP," she said.

I grabbed our respiratory therapist and told her the dilemma. She agreed that he couldn't tolerate lying flat or being Ambu-bagged.

I suggested a controlled intubation at the bedside for airway protection until he could get to the OR for the trach procedure. The nurse anesthetist agreed and called her attending and the intubation team.

As the anesthesiologist explained what was about to happen, I looked at Mary, one of the strongest women I've ever met, and she looked terrified. I ushered her out of the room and explained exactly what was happening.

"Are we doing the right thing?" she said.

I knew she was struggling with the idea that her husband's life was about to change dramatically. We sat together and talked and hugged.

"I can't imagine how hard this must be," I said. "But you and John have discussed this. If this is what he truly wants, who's to say what's 'right'?"

I confirmed that this was the safest way for John to travel to the OR, that he'd be well medicated, and would come right back to the unit after the procedure. She gave me one of the tightest hugs I've ever received. Mary chose to step out during the intubation after giving her husband a kiss. It was so clear to me why John had wanted the procedure done at MGH. He was safely intubated by the anesthesiologists at the bedside, then off to the OR he went.

The first few days post-trach were the hardest. A sore and swollen John was visibly frustrated. But I told him the soreness from the surgical site would go away, that he'd just had major surgery. Emotional encouragement goes a long way with this population—it's easy to get depressed with such a chronic, progressive illness. John became more comfortable with his new style of communication and was eventually able to laugh and smile with his family again.

The day John was discharged was bitter-sweet. I wasn't on duty the day he left, but I'll never forget the feeling I got when I heard he was able to go home with his family. I knew this wasn't the end of his journey, but having been able to care for John and his family during such an eventful time was a monumental milestone in my nursing career.

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

Living with a terminal illness requires numerous course-corrections along the way. Decisions made early on are sometimes questioned when the reality of diminished capabilities sets in. John and his family were lucky to find themselves in Katie's care in the RACU. She was a compassionate guide and strong advocate during those difficult, uncertain times. This narrative is a wonderful example of relationship-based, patient- and family-centered care. Katie was right—these situations don't get easier with time, but her nursing practice becomes more informed with every patient she cares for.

Thank-you, Katie.



# The Ben Corrao Clanon Memorial Scholarship

—by Mary Ellin Smith, RN, professional development manager

The Ben Corrao Clanon Memorial Scholarship was created by Jeff Clanon and Regina Corrao as a tribute to their son, Ben, who died in the NICU in 1986. Corrao and Clanon established the scholarship to recognize NICU nurses who

demonstrate exemplary practice, a commitment to primary nursing, and ongoing support and advocacy for patients and families. This year's recipient of the Ben Corrao Clanon Memorial Scholarship was NICU staff nurse, Cheryl Slater, RN.

On Tuesday August 2, 2016, Corrao, Clanon, and their son, Sam, returned to MGH for the

30th presentation of the scholarship that recognizes excellence in primary nursing. In her comments, NICU nursing director, Peggy Settle, RN, observed, "When you walk in and see that Cheryl is working, you know that patients, families, and staff are being well cared for. Her practice reflects primary nursing at its absolute best."

Said one colleague of Slater, "When it comes to advocating for her patients, Cheryl never has a half-day day. She's all in, every day, all the time."

Said Clanon,

"When your baby is brought to the NICU, it's like being dropped off on another planet. But you were always there for us, and for Ben. You helped and guided us with such compassion, the same way you've helped all the families who've come here for the past thirty years. Thank-you so much."

Slater acknowledged her colleagues saying, "You taught me how to be a better nurse. Primary nurses guide families through some of their most stressful times and help the team know and understand these newborns and their parents."

For more information about the Ben Corrao Clanon Memorial Scholarship, call Mary Ellin Smith, RN, at 617-724-5801.

(L-r): Peggy Settle, RN; Sam Clanon; Regina Corrao; Jeff Clanon, and scholarship recipient, Cheryl Slater; RN. At right: Slater and Settle.



# Dwyer joins PCS leadership team

Dwyer came on board, August 14, 2016, and had an opportunity to work with outgoing director, Van Hardison, RN, to ensure a smooth transition. One of Dwyer's first priorities was attending a two-week training program at Epic headquarters to prepare for the eCare upgrade scheduled for October.

**N**ursing and Patient Care Services is pleased to welcome Ann Marie Dwyer, RN, to the position of director of Clinical Informatics. Dwyer comes to us with a wealth of experience throughout the Partners network, most recently as the senior eCare nurse leading the team that dealt with clinical content and process re-design, biomedical device-integration, clinical informatics, and quality and safety during the highly successful launch of Partners eCare.

Says Jeanette Ives Erickson, RN, senior vice president for Patient Care, "I've had the pleasure of working with Ann Marie in her role as senior nurse for Partners eCare, as co-leader of the Partners eCare Clinician Team, and when she served as chief nurse for the Spaulding Rehabilitation Network. Ann Marie is also a key member of the Partners Chief Nurse Council's Nursing Informatics Leaders Group."

Dwyer came on board, August 14, 2016, and had an opportunity to work with outgoing director, Van Hardison, RN, to ensure a smooth transition of leadership. One of Dwyer's first priorities as new director was attending a two-week training program at Epic headquarters to learn and prepare for the eCare upgrade scheduled for this October.

Says Ives Erickson, "I want to thank Van for his stellar leadership through the preparation and implementation phases of MGH eCare. We're fortunate to



Ann Marie Dwyer, RN, new director,  
Nursing and PCS Clinical Informatics

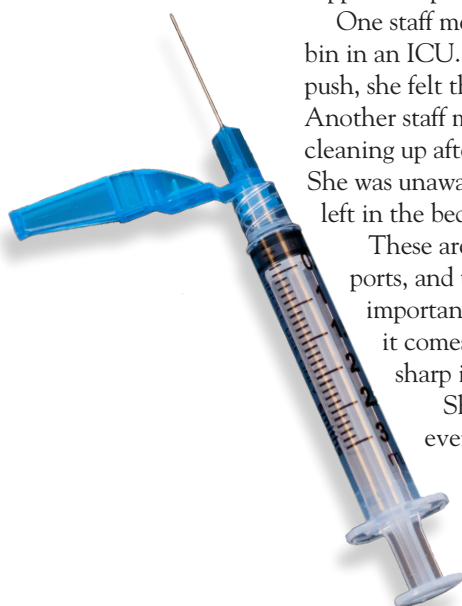
have two such accomplished informatics specialists guide us through these times of great technological change. Thank-you, Van. And welcome, Ann Marie."

Says Dwyer, "I'm honored and excited to be part of the Nursing and Patient Care Services team. While at Partners eCare, I had the pleasure of seeing first-hand the high level of professionalism and engagement among the MGH team. It was both motivating and inspiring. I look forward to working with all my new colleagues across the organization on the evolution of clinical information systems at MGH."

# Reducing the risk of needlesticks

—by Georgia Peirce, project manager, and Andrew Gottlieb, director, Occupational Health Services

The total number of needlesticks at MGH is relatively low. But for the person who experiences a sharps injury, one stick can change their life.



**M**ary' was a nurse who'd been doing administrative work. One busy day, she stepped in to help a colleague who asked her to give an injection to a patient. Using a needle the patient had brought from home, Mary gave the injection then began to re-cap the needle. That's when she felt the pinch. Followed by panic. "I was terrified I might've just given myself HIV. I learned the hard way that you never re-cap needles."

'John' was an experienced nurse and role model. One day, after giving an injection, he began to close the needle's safety device. He knew he should brace it against a hard surface, but he was in a hurry, so he pressed it against his forearm. The needle slipped and penetrated his skin.

One staff member had trouble closing a sharps bin in an ICU. When she gave the cover a quick push, she felt the pinch of a needle she hadn't seen. Another staff member felt a pinch when she was cleaning up after a procedure in a patient's room. She was unaware that an exposed needle had been left in the bedding.

These are real examples from MGH safety reports, and they're compelling reminders of the importance of 'sticking' to best practice when it comes to handling needles and other sharp instruments.

Sharps represent a hazard in virtually every setting. According to 2015 data gathered by MGH Occupational Health Services, needlestick injuries most often happen when:

- holding a hypodermic needle that has a safety device
- disposing of a needle or cleaning up after a procedure
- inserting or withdrawing a needle from a patient

While sharps devices are ever-present and used hundreds of thousands of times throughout the hospital each year, the total number of needlesticks at MGH is relatively low. But for the person who experiences a sharps injury, one stick can change their life.

When a needlestick or sharps injury occurs, the source patient should be tested for hepatitis and HIV if their status is not known at the time of injury. In cases where that testing cannot take place, injured staff are assumed to have been exposed to HIV and/or hepatitis and need to make certain lifestyle changes until infection can be ruled out. Those changes can include delaying pregnancy or discontinuing breast-feeding for up to six months. The injured person should begin immediate prophylactic treatment for HIV and have their blood tested at regular intervals.

Needlestick injuries can be extremely stressful and inconvenient with individuals sometimes having to wait months to find out if/when their lives will return to normal.

When handling sharps devices, to reduce your risk of injury, stick to best practice.

Needles:

- **Always** engage the needle safety device (hinged) immediately after removing the needle from the patient

*continued on next page*





# STICK TO BEST PRACTICE.

**A needlestick injury to staff in a critical care unit at Mass General most often happens\* when:**

- holding a hypodermic needle that has a safety device
- disposing of a needle or cleaning up after a procedure
- inserting or withdrawing a needle from a patient

**Reduce your risk.  
Stick to best practice.**

 MASSACHUSETTS  
GENERAL HOSPITAL

**NURSING AND  
PATIENT CARE SERVICES**

\* Based upon Mass General Occupational Health sharps injury reports in 2015.

- **Always** listen for or feel the click that tells you it's activated
- **Always** activate the needle safety device (hinged) against a hard surface; **never** use your finger or other body part
- **Always** activate needle safety device (retracting) before removing the needle from the patient

**Hands:**

- **Never** re-cap a syringe
- **Never** put your hand near a needle/sharp device, including during disposal

**Sharps bins:**

- **Always** dispose of a sharps device immediately after use, even if the safety device has been engaged
- **Always** request a new sharps bin as soon as the current one starts to fill up; don't let it get beyond  $\frac{3}{4}$  full

For more information or to register concerns or suggestions related to needlestick safety, speak with your supervisor or unit or department leadership, contact MGH Occupational Health at 6-2217, or e-mail [occhealth@partners.org](mailto:occhealth@partners.org).

# Trauma-informed care

## *what is it, and how does it affect my practice?*

*Question:* I've been hearing the term, 'trauma-informed care' lately. What is this?

*Jeanette:* Trauma refers to the experience of abuse, neglect, violence, or discrimination, especially in childhood. Trauma-informed care is based on our increasing understanding that many patients, families, and colleagues have endured traumatic experiences that have lasting impact. The landmark, Adverse Childhood Experiences study, and other research shows that exposure to trauma heightens health risks throughout the life span, including the risk of chronic lung, heart, and liver disease, depression, sexually transmitted diseases, and substance-use disorders.

*Question:* What is trauma-informed care?

*Jeanette:* Trauma-informed care recognizes the prevalence of trauma and seeks to avoid re-traumatizing patients by inadvertently triggering reminders of traumatic experiences. Traumatic memories can interfere with a patient's ability to receive care or cause emotional and biological stress. Trauma-informed care can potentially improve patient engagement, adherence to treatment, health outcomes, and reduce costs.

*Question:* What does trauma-informed care look like?

*Jeanette:* Patients may not reveal their trauma history for a variety of reasons, so experts recommend assuming everyone (patients, families, and co-workers) may have a history of trauma. Some strategies for making patients feel safe include giving them a choice, allowing them to have some control, avoiding surprises, informing them of what you're going to do, and getting their permission before proceeding. Think about making your communication consistent, open, respectful, and compassionate.

The physical environment is also important. Ensure that indoor and outdoor spaces are well-lit, people aren't loitering near entrances and exits, and patients have access to the door so they can exit easily if desired.

*Question:* How does trauma-informed care help our colleagues?

*Jeanette:* Trauma-informed care also means taking care of ourselves and one another; recognizing when staff or colleagues experience stress due to trauma at home or secondary trauma at work. Hearing about the first-hand trauma of others can lead to symptoms of fatigue, disturbing thoughts, poor concentration, exhaustion, avoidance, absenteeism, and physical illness. Staff experiencing these symptoms may struggle to provide high-quality care or experience burn-out. Preventing secondary traumatic stress can increase morale and allow staff to function at their best.

*Question:* What are we doing to raise awareness?

*Jeanette:* Ensuring we provide trauma-informed care is a Partners-wide initiative. Later this month, MGH will host the 4th annual Partners Trauma-Informed Care Symposium. Sponsored by the Knight Nursing Center, the MGH Social Service Department, and Partners HealthCare, the symposium will be held September 26th in O'Keeffe Auditorium. Keynote speaker, Carole Warshaw, MD, director of the National Center on Domestic Violence, Trauma & Mental Health, is a widely recognized expert in the field. A panel discussion on integrating trauma-informed care into practice will be part of the symposium. All are welcome to attend; registration is required.

*Question:* How can I learn more?

*Jeanette:* To learn more about trauma-informed care, contact Debra Drumm, LICSW, director of HAVEN, at 617-724-0054.

For more information about the symposium or to register, go to: <http://www.cvent.com/d/dvqk26> Panel- <http://www.cvent.com/d/dvqk26>

# Announcements

## SAFER Fair and community outreach event

Join collaborative governance champions to learn how they're working to make a SAFER environment for patients, families, and staff.

### And bring socks!

Please bring a pair (or two) of new socks to be donated to a local community shelter.

There will be games, refreshments, and prizes.

Wednesday, October 19, 2016  
12:00–2:00pm  
Under the Bulfinch Tent

For information, call Mary Ellin Smith, RN, at 4-5801.

## ACLS Classes

Certification:

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

Day one:  
November 10, 2016  
8:00am–3:00pm

Day two:  
November 11th  
8:00am–1:00pm

Re-certification (one-day class):  
October 12th  
5:30–10:30pm

Location to be announced.  
For information, send e-mail to:  
[acsl@partners.org](mailto:acsl@partners.org), or call  
617-726-3905

To register, go to:  
[http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS\\_registration%20form.pdf](http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf).

## MGH Nurses Alumnae Association fall reunion and educational program

This year's theme:  
"Nurse Leaders Making a Difference"

Friday, September 23, 2016  
O'Keefe Auditorium  
8:00am–4:30pm

Sessions will include: "The Development of the Nursing Leadership Academy," "Doctor of Nursing Practice Program," "Global Nursing," "Advancing Peer Review," and more.

For more information or to register, call the MGH Nurses Alumnae Association at 617-726-3144.

## Submit an abstract for MGH Clinical Research Day

On Thursday, October 6, 2016, MGH will celebrate the 14th annual Clinical Research Day. The Division of Clinical Research invites investigators to submit abstracts by September 6th.

Research must have been conducted at MGH and may include manuscripts published after September 1, 2015.

Awards for best abstracts:

- \$5,000 team award
- \$1,500 translational research award
- \$1,000 individual award
- Departmental awards

Clinical Research Day will begin at 8:00am with a keynote address by Sandra Glucksmann, chief operating officer, Editas Medicine.

To submit an abstract, go to:  
<https://crp2016.abstractcentral.com/>

For more information, e-mail Jillian Tonelli or call 617-724-2900.

## Blum Center Events focus on Recovery Month

"Engaging Youth with Substance-Use Disorders in Care and Supporting their Parents"  
Thursday, September 1, 2016  
11:00am–12:00pm

This program will focus on current trends in youth substance use, treatment, and strategies for engaging youth in treatment by involving their parents.

"Bridging the Gap: Meeting People Where They Are"  
Wednesday, September 7th  
11:00am–12:00pm  
Learn about the MGH Bridge Clinic.

"Addiction, Recovery, and Quality of Life"  
Wednesday, September 14th  
1:00–2:00pm  
Hear the latest findings in addiction science.

"Beyond Traditional Treatment Options: Innovations to Engage Patients"  
Tuesday, September 20th  
1:00–2:00pm

Providing patients with options is the most effective form of treatment. This program will review this new treatment philosophy.

"There is Treatment. Treatment Works"

Thursday, September 29th  
1:00pm–2:00pm  
Providers from the MGH West End Clinic will discuss treatment and recovery. A panel of patients will share their experiences.

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.

## Global Nursing: a Force for Change Improving Health System Resilience

October 14-15, 2016  
9:00am–5:00pm  
at MGH

Join nurse leaders, clinicians, and educators to discuss the critical role of nursing in strengthening health systems around the world.

Abstract submission deadline is September 1, 2016. Acceptance notifications will be sent via e-mail by September 15, 2016.

For more information, or to submit an abstract, go to:  
<http://www.massgeneral.org/globalhealth/>

Open to the public

## Collaborative Governance Call for applications

Applications are now being accepted for Collaborative Governance, the decision-making body that places the authority, responsibility, and accountability for patient care with practicing clinicians.

Committees seeking membership include:

- Diversity,
- Ethics in Clinical Practice
- Informatics
- Patient Education
- Patient Experience
- Policy, Procedure, and Products
- Quality and Safety
- Research and Evidence-Based Practice
- Staff Nurse Advisory

For more information on the committees or how to join, contact Mary Ellin Smith, RN at 4-5801.



# Professional Achievements

## Folger presents

Abby Folger, PT, physical therapist, presented, "Clinical Integration," at Northeastern University, July 5, 2016.

## Abreau certified

Paige Abreau, RN, became certified in Medical Surgical Nursing by the American Nurses Credentialing Center, in June, 2016.

## Folger presents

Abby Folger, PT, physical therapist, presented, "Clinical Integration," at Northeastern University, in July 5, 2016.

## Penzias publishes

Alexandra Penzias, RN, authored the article, "Speaking Up in Real Time: Skills for Education and Safety," in the *Journal of Radiology*, in June, 2016.

## Brunelle honored

Cheryl Brunelle, PT, physical therapist, received the One Hundred award from the MGH Cancer Center, in May, 2016.

## Downing certified

Catherine Downing, RN, became certified in Adult Medical Surgical Nursing by the American Nurses Credentialing Center, in June, 2016.

## Arnstein publishes

Paul Arnstein, RN; Katharine Koury; Hang Lee; and Padma Gulur, MD, authored the article, "Morphine Before Hydromorphone—Results of a Quality Improvement Initiative," in *Global Anesthesia and Perioperative Medicine*.

## Rosa publishes

Katherine Rosa, RN, authored the article, "Integrative Review on the Use of Newman Praxis Relationship in Chronic Illness," in *Nursing Science Quarterly*.

## Foley honored

Kimberly Foley, RN, staff nurse, received the SGNA Gabriele Schindler Clinical Excellence Award, from the Society of Gastroenterology Nurses and Associates, in June, 2016.

## Mulgrew presents

Jackie Mulgrew, PT, physical therapist, presented the webinar, "Physical Therapy Management of Patients with Heart Failure," at Allied Health, Inc., March 14, 2016.

## Nurses present poster

Linda Caruso, RN; Sara Astarita, RN; Anne Marie Barron, RN; and Patricia Rissmiller, RN; presented their poster, "Women's Sexuality after Stem Cell Transplant," at the Oncology Nursing Society's annual congress, in Austin, Texas, April 30, 2016.

## Lipkis-Orlando honored

Robin Lipkis-Orlando, RN, director, Office of Patient Advocacy, received the Cyrus C. Hopkins, MD, Patient Safety Leadership Award, July 15, 2016.

## Sullivan honored

Caitlin Sullivan, RN, staff nurse, received the Nursing Recognition Award from the Internal Medicine Residency Program, June 9, 2016.

## Elie a panelist

Sandra Elie, domestic violence advocate, served as a panelist discussing "The Role of a Hospital DV Advocate" at the Health Care Learning Forum at the Training Institute of the Massachusetts Medical Society in Waltham, June 3, 2016.

## Keeney appointed

Tamra Keeney, PT, physical therapist, was appointed item writer, SACE (Specialization Academy of Content Experts), for the Cardiovascular and Pulmonary Section of the American Board of Physical Therapy Specialties.

## Arnstein appointed

Paul Arnstein, RN, clinical nurse specialist, was appointed a member of the Technical Advisory Panel of The Joint Commission on June 29, 2016.

## Keegan Argyropoulos presents

Sarah Keegan Argyropoulos, RN, presented, "Improving the Quality of Inpatient Bowel Preparation for Colonoscopies with Active Nursing Facilitation," at the annual course of the Society of Gastroenterology Nurses and Associates, in Seattle, Washington, May 23, 2016.

## Penzias presents poster

Alexandra Penzias, RN, presented her poster, "Perception of Nursing Presence in Patients Experiencing MRI-Guided Breast Biopsy," at the annual conference of the International Association of Human Caring, in Boston, June 8-10, 2016.

## Scott presents

Katrina Scott, staff chaplain, presented the, "End-of-Life Issues Seminar," at the Summer Institute in Bioethics at Yale University, June 16, 2016.

Scott also presented, "Who Are You? A Dignity Therapy Primer," at the annual conference of the Association of Professional Chaplains in Orlando, Florida, June 24, 2016.

## Peterson re-elected

Gayle Peterson, RN, staff nurse, was re-elected to the staff nurse position of the Board of Directors of the American Nurses Association, in June, 2016.

## Siwy presents poster

Katherine Siwy, OTR/L, occupational therapist, presented her poster, "Fractionated CO<sub>2</sub> Laser and Burn Scar Contractures: Evaluation of Post-Treatment Scar Function and Appearance: a Year Review," at the annual meeting of the American Burn Association, in Las Vegas, May 4, 2016.

## Siwy appointed

Katherine Siwy, OTR/L, occupational therapist, was appointed co-chair of the Rehabilitation Committee for the American Burn Association, in July, 2016.

## Brooks certified

Sarah Brooks, RN, staff nurse, became certified as a medical-surgical nurse by the American Nurses Credentialing Center, in July, 2016.

## Nurses publish

Virginia Capasso, RN, and Alicia Wierenga, RN, authored the chapter, "Carotid Stenosis," in *Primary Care: a Collaborative Practice*, in June, 2016.

## Hebert certified

Jason Hebert, RN, staff nurse, became certified as a critical care nurse by the American Association of Critical Care Nurses Certification Corporation, in July, 2016.

## Inter-disciplinary team publishes

Chantal Ferguson; Cheryl Brunelle, PT; Meyha Swaroop; Nora Horick; Melissa Skolny; Cynthia Miller; Lauren Jammallo; Jean O'Toole, PT; Laura Salama, MD; Michelle Specht, MD; and Alphonse Taghian, MD, authored the article, "Impact of Ipsilateral Blood Draws, Injections, Blood-Pressure Movements, and Air Travel on the Risk of Lymphedema for Patients Treated for Breast Cancer," in the March, 2016, *Journal of Clinical Oncology*.

## Hunter honored

Oncology nurse, Sara Hunter, RN, received a 2016 Massachusetts Care Award from Labouré College on June 9, 2016.

## Kane certified

Amanda Kane, RN, staff nurse, MICU, became certified as a critical care nurse by the American Association of Critical Care Nurses Certification Corporation, in July, 2016.

## Nurses publish

Kevin Mary Callans, RN; Carolyn Bleiler, RN; Jane Flanagan, RN; and Diane Carroll, RN, authored the article, "The Transitional Experience of Family Caring for their Child with a Tracheostomy," in the July-August, 2016, *Journal of Pediatric Nursing*.

## McDonald certified

Carolyn McDonald, RN, staff nurse, became certified as a neuroscience nurse by the American Board of Neuroscience Nursing, in July, 2016.

## MacKenzie presents

Carole MacKenzie, RN, professional development specialist, Lunder-Dineen Health Education Alliance of Maine, presented, "Best Practices in Developing a Statewide Collaborative Practice Model to Advance Nursing Preceptor Education," at the Maine Preceptor Education Program, in Pittsburgh, July 20, 2016.

## Levin-Russman presents

Elyse Levin-Russman, LICSW, social worker, presented, "Developing and Sustaining a Family Advisory Committee in Pediatrics over Many Years," at the annual Patient and Family Advisory Council Conference, in Norwood, June 23, 2016.

## Inter-disciplinary team publishes

Christopher Herndon; Paul Arnstein, RN; Beth Darnall; Craig Hartrick, MD; Keith Hecht; Mary Lyons, RN; Jahangir Maleki, MD; Renee Manworren, RN; Christine Miaszkowski, RN; and Nalini Sehgal, MD, co-edited the 7th edition of *Principles of Analgesic Use*, in July, 2016.

## Nurses present poster

Sheila Golden-Baker, RN, professional development specialist, and Mary McAdams, RN, clinical educator, presented their poster, "Applying Nursing Peer Review to the Nursing Professional Development Role: Challenges and Opportunities," at the annual conference of the Association of Nursing Professional Development, in Pittsburgh, July 20-21, 2016.

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For more information, call: 617-724-1746

### Next Publication

September 15, 2016

# Inpatient HCAHPS

## Current data

HCAHPS Measure	CY 2015	CY 2016 Year-to-date (as of 8/16/16)	% Point Change
Nurse Communication Composite	83.0%	82.6%	↓ -0.4%
Doctor Communication Composite	83.5%	82.7%	↓ -0.8%
Room Clean	72.9%	70.6%	↓ -2.3%
Quiet at Night	50.8%	49.9%	↓ -0.9%
Cleanliness/Quiet Composite	61.8%	60.2%	↓ -1.6%
Staff Responsiveness Composite	65.8%	64.4%	↓ -1.4%
Pain Management Composite	73.1%	72.6%	↓ -0.5%
Communication about Meds Composite	66.6%	66.0%	↓ -0.6%
Care Transitions	62.4%	60.0%	↓ -2.4%
Discharge Information Composite	91.1%	91.0%	↓ -0.1%
Overall Hospital Rating	81.2%	81.3%	↑ 0.1%
Likelihood to Recommend Hospital	90.9%	88.9%	↓ -2.0%

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

The data is complete through June, 2016. We have partial data through August. MGH is performing well in our Overall Hospital Rating category.



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