

# Caring

Headlines

September 15, 2016

## Fall-prevention



Lunder 9 oncology staff nurse, Kayla Baldwin, RN (left) and physical therapist, Kelly Nickerson, PT, work with patient, 'Chico', on balance and stabilization following a right-extremity amputation.

Preventing falls is everyone's responsibility. Are you using the LEAF Bundle?

- Fall risk assessment
- Interventions based on type of risk
- Communicating risk to the care team
- Patient-education
- Fall-prevention equipment

*(See articles on pages 4 and 5)*

# Capacity-management and patient throughput

This week's column is provided by guest editors, Kevin Whitney, RN, associate chief nurse, and Marianne Ditomassi, RN, executive director for PCS Operations, co-leaders of the PCS Strategic Goal on Capacity-Management

Unfortunately, increasing the number of beds and care providers does not solve our capacity and throughput challenges. We need to identify ways to be more efficient and remove non-value-added steps from the system.

Capacity-management and efficient patient throughput are high priorities for MGH and Patient Care Services. Effectively managing capacity and throughput is in alignment with the Six Quality Aims of the Institute of Medicine, specifically providing care that's patient-centered, equitable, efficient, and timely. Research shows that designing care with these aims in mind ensures that patients and families receive the safest, highest-quality care and are more satisfied with their overall healthcare experience.

Since 2011, the volume in our Emergency Department (ED) has increased from 74,891 visits for the months of October to July, to 92,354 visits for the same time period in 2016 (see graph on opposite page). With two months remaining in FY16, we're on track to reach more than 110,000 visits this year—that translates to an average of more than 300 patients per day; 23% of whom require inpatient level of care. As our ED volume continues to grow, our inpatient capacity also remains high with an average occupancy approaching 99–100%.

Length of stay is a major factor in our inpatient capacity challenge. Inpatients are staying longer, in part due to higher acuity and complexity of care. When inpatient beds are full, the ED becomes responsible for providing inpatient-level care to patients awaiting admission; surgical inpatients remain in the PACU overnight; and our ability to accommodate new patients is severely limited.

Capacity-management and patient throughput have been the focus of much work over the past



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

several years. Since 2011, we've increased the number of inpatient beds with the creation of the Blake 12 ICU and the Ellison 12 and Bigelow 9 medical units; we've added a second ED Observation Unit; and we expanded the physical space of the Emergency Department into the Lunder Building. We've increased the number of direct-care and support staff in these areas as well as in the PACU, which has enhanced our ability to care for RPPR surgical patients after surgery and overnight until they're ready for discharge.

Unfortunately, increasing the number of beds and care providers does not solve our capacity and throughput challenges. We need to be more innovative and flexible to further improve throughput in the ED, in procedural areas, and in the inpatient environment. We need to identify ways to be more efficient and remove non-value-added steps from the system.

One of the 2016 PCS Strategic Goals is: "Increasing Capacity through Ensuring Patients are in the Right Bed at the Right Time." This goal in-

*continued on next page*

This past month, we met with attending nurses and nursing directors to review the goal and ask for their input. Discussions were highly productive, and as a result, several themes and best practices emerged. We want to share them with you and ask for your support in making capacity-management and patient throughput a top priority.

cludes several tactics aimed at capacity-management and throughput, and is aligned with the work of the MGH Capacity Committee led by MGH president, Peter Slavin, MD. This past month, we met with attending nurses and nursing directors to review the goal and ask for their input. Discussions were highly productive, and as a result, several themes and best practices emerged. We want to share them with you and ask for your support in making capacity-management and patient throughput a top priority.

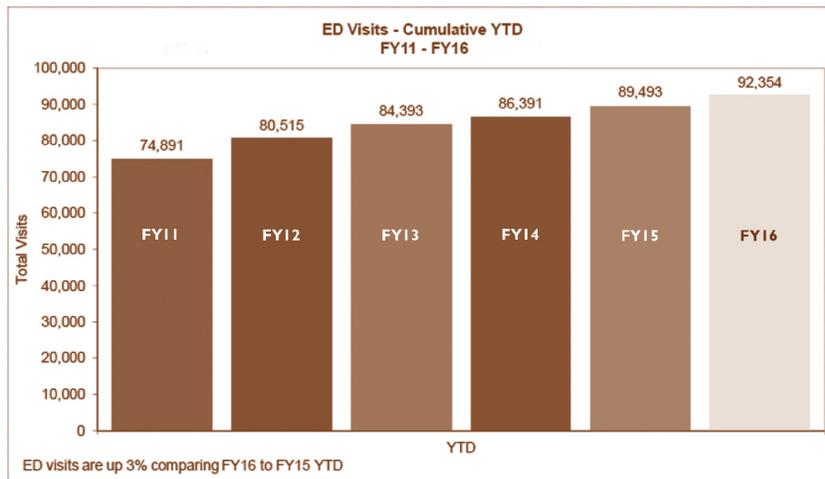
*Best practices:*

- Continue to refine the inter-disciplinary rounding process by ensuring all disciplines are actively engaged and roles are clear. This helps ensure that the entire team understands the plan of care, has identified the expected date of discharge (EDD), and has proactively completed interventions and resolved any barriers to a timely transition to the next phase of care (home, home with home-care services, or post-acute care). This includes involving patients and families in the process to ensure they have a voice in the decision-making and can assist with the most efficient transition to the next phase of

care (e.g., family needs to arrive early in the morning to transport patient ready for discharge)

- Be sure the team, at least daily, enters and reviews the EDD, the expected discharge location, and any barriers to discharge that require resolution using the eCare Huddle Report. The Huddle Report replaced the former EDD tool and

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# ‘Ready, Steady, Balance: Preventing Falls in 2016’

—by Patti Shanteler, RN, staff specialist PCS Office of Quality & Safety

Members of our quality and safety community, including champions from the PCS Quality & Patient Safety Committee, will sponsor an informational table in the White Lobby, September 22nd.

The first day of fall is the perfect time to raise awareness about another kind of fall that can have serious consequences for patients and families. On September 22, 2016, national attention will be focused on reducing falls in the community and in hospital settings across the country. Every year at this time, healthcare providers and advocates for the elderly speak up for safety and fall-prevention. This year’s theme, ‘Ready, Steady, Balance: Prevent Falls in 2016,’ is sponsored by the National Council on Aging.

Every year in Massachusetts, one out of every three people, age 65 and older, experiences a fall. Within one year, approximately one in four com-

munity-dwelling older adults will fall, and of those who fall, more than a third will be injured. This year, to help raise awareness of this public-health issue, the Massachusetts Coalition of Falls Prevention ([ma-coalition.org](http://ma-coalition.org)) is sponsoring an event on September 26th at the State House. The event will bring healthcare and

## According to the Joint Commission:

- Hundreds of thousands of patients fall in hospitals in the United States every year with 30-50% resulting in injury
- Injured patients require additional treatment and sometimes prolonged hospital stays. In one study, falls with injury added 6.3 days to the hospital stay
- The average cost for a fall with injury is approximately \$14,000

community leaders together to share best practices around fall-prevention.

Here at MGH, members of our quality and safety community, including champions from the PCS Quality & Patient Safety Committee, will sponsor an informational table in the White Lobby, September 22nd. The goal is to raise awareness about the risks of falling both in the hospital setting and at home. Fall-prevention materials will be available, and MGH staff will be on hand to answer questions about fall-prevention efforts at MGH.

For more information about preventing falls at MGH, visit the PCS Falls portal page at [http://www.mghpcs.org/eed\\_portal/EED\\_fallprevention.asp](http://www.mghpcs.org/eed_portal/EED_fallprevention.asp). To share a best practice or strategies you’ve used to partner with patients to improve safety, contact Colleen Snyderman, RN, director of the PCS Office of Quality & Safety, at 617-643-0435.

## Falls Prevention Awareness Day

SEPTEMBER 22, 2016

Ready, Steady, Balance:  
Prevent Falls in 2016



# LEAF: Let's Eliminate All Falls

## *one fall at a time*

—submitted by the PCS Quality & Patient Safety Committee

**W**hen someone asks you about the MGH LEAF program, what do you tell them? LEAF is a bundle of strategies that when used together reduces the risk of patient falls. Fall-prevention requires honing your assessment skills, employing targeted interventions, and often relying on the 'power of persuasion' to keep patients safe. In recent years, the literature has focused on a group of strategies that has proven effective in reducing falls in hospitals. Organizations successful in reducing and preventing falls use these strategies consistently with patients at

### Interventions

Interventions should be tied to the type of risk. For example, if the patient has a history of falls there's a strong chance he/she could fall again in the hospital. Consider a bed/chair alarm and increased rounding throughout the patient's stay.

### Fall Risk Assessment

Assessing patients initially upon admission and then regularly for type(s) and level of risk can assist the care team in staying alert to changes in the patient's status that may warrant additional strategies to keep them safe.

### Team Communication

Share assessment findings and strategies that have worked for you during your shift. Alert colleagues to patients identified to be at high risk. Ask your team when you come on duty if there has been any recent fall activity or changes in the fall-risk plan.

risk for falling. Key to successful implementation is keeping the risk-assessment findings for each patient front-and-center and choosing the right strategies for the right type of risk. This is important even when the patient is currently participating in the fall-risk plan. Ask yourself if the risk factors are still present. Patient behavior alone should not be considered the indicator of fall risk; clinical status can change in an instant.

The graphic on this page shows the prevention strategies developed to help keep patients safe from falls. Used together they're a powerful tool in our efforts to promote and foster fall-prevention.

### Patient-Education

Letting patients and families know that we constantly assess for risk and why we do it may assist you in developing a plan. Many patients are younger and underestimate their risk because they don't understand what has put them at risk.

### Fall-Prevention Equipment

Low beds, floor mats, alarms, protective foot coverings, and visual cues, such as signs, can be key to protecting patients from a fall, or if a fall cannot be prevented, fall-prevention equipment can help protect against injury.

### MGH LEAF Bundle

- Fall risk assessment
- Interventions based on type of risk
- Communication of risk to the care team
- Patient-education
- Fall-prevention equipment

# Educating nurses on substance use disorder

—by Pamela Quinn, RN, professional development specialist

Substance use disorder (SUD) is an increasingly troubling health concern at the local, state, and national levels. In 2015, Governor Baker asked healthcare providers to explore new ways of treating addiction. Based on the evidence, we know that patients with SUD are generally admitted with complex co-morbidities requiring intensive nursing care. As a result, every unit and setting has the potential to care for this complex patient population. The 2015 Professional Learning Environment for Nurses survey revealed that 63% of respondents reported feeling “not prepared” or only “somewhat prepared” to care for patients with SUD.

To address this learning need, a group of nursing experts from the ED, the Knight Nursing Center, inpatient units, and the Addiction Consult Team developed a pilot study to examine the knowledge level of nurses caring for patients with SUD.



Wong



Foshey



McCleary

(Photos by Michelle Rose and Paul Batista)

As part of the study, the team developed educational programs open to the entire hospital community.

On July 26, 2016, Leslie Kerzner, MD, and Brianne Fitzgerald, RN, presented, “SUD in the Setting of Pregnancy and Early Life Span.” Feedback from nurse attendees confirmed the importance of education on this topic. “I’ll work harder to help mothers of neonatal-abstinence-syndrome babies to breast-feed,” said one nurse. “I’ll teach pregnant women with opioid use disorder about the physical, hormonal, and emotional changes that can trigger relapse,” said another. “I’ll be mindful of trauma-informed care with pregnant women, in particular, as this population is at increased risk for trauma-related issues.”

On August 8th, “Marijuana, Tobacco, and Treatment Options for All Addictions,” was presented by Shucheng Wong, MD; Nancy McCleary, RN; Christopher Shaw, RN; and Clare Foshey, RN, from Signature Healthcare Brockton Hospital. Attendees reported feeling better informed and more aware of their role in the care of patients with SUD. Comments included: “I’ll have more patience when dealing with patients who have addictions”; and “It’s easy to become frustrated and burned out with chronic substance-abusers. I hope to be more patient and understanding.”



L-r): Sara Fisher, RN; Brianne Fitzgerald, RN; Dawn Williamson, RN; Christopher Shaw, RN; Leslie Kerzner, MD; Joanne Parhiala, RN; Pamela Quinn, RN; and Virginia Capasso, RN. (Not pictured: Mary McAdams, RN; and Sara Macchiano, RN.)

The pilot study was the recipient of a 2016 Yvonne Munn Nursing Research Award. Given the tremendous support and favorable response to this educational program, the team is excited to continue the initiative after the study concludes. For more information, contact Joanne Parhiala, RN, at 617-724-9110.

# Preparing for emergencies at work and at home

—by Monica Staples, RN, and Jacky Nally, RN, Center for Disaster Medicine

September is National Preparedness Month. Do you know what to do in case of an emergency or local disaster? MGH is always open. Being ready to respond to emergencies is a critical part of ensuring the safety of patients, staff, and all who walk through our doors.

Every MGH employee is *essential staff*; everyone plays a role in the effective management of emergencies. If a *code disaster* is declared while you're at work, our response as a hospital relies on every employee following certain steps:

- Report immediately to your manager or supervisor and stay on site until you're told it's okay to leave. There may be ways you can contribute that you're not aware of; stay alert and available
- Remain calm and be flexible; you may be asked to perform a task or tasks that aren't normally part of your job description

Both at work and at home, these steps can ensure you're prepared in the event of an emergency:



## At work:

- Have a back-up plan for traveling between work and home and other locations that are part of your daily routine (such as schools or day care)
- Include alternate routes and methods of transportation (car, public transportation, etc.); keep a copy in your wallet or other safe place



- Pack an overnight bag if there's a chance the weather may impact your ability to get home from work. Safety is our primary concern—the hospital may set up sleep areas for staff who need to stay overnight

## At home:

Knowing your home and family are prepared gives you peace of mind, even if you're at work when the emergency occurs.

- Put together an emergency kit at home
  - Include any special considerations for children, the elderly, and pets
  - See a recommended supply list at [ready.gov/kit](http://ready.gov/kit)
- Prepare your car for winter weather
  - Always keep your gas tank at least half full
  - Keep an emergency kit and shovel in the trunk just in case
- Make a communications plan
  - Identify key individuals and emergency contacts (someone who can care for your children, pets, home, etc.)
  - Make sure they know you've chosen them as emergency contacts
  - Print out key contact information and keep it with you

For more information about the MGH Emergency Preparedness Program, or to contact the MGH Center for Disaster Medicine, go to: [www.massgeneral.org/disaster-medicine](http://www.massgeneral.org/disaster-medicine).

# Providing end-of life spiritual care in the oncology setting



Katrina Scott, oncology chaplain

'Rita' was first diagnosed after a colonoscopy when the biopsy of a rectal mass showed invasive adenocarcinoma. During the year and a half that Rita received care at MGH, she sought out every support offered by the Cancer Center.

**M**y name is Katrina Scott, and I am the oncology chaplain. When a new oncology patient or family arrives at the MGH Cancer Center, they're informed of all the patient-centered support services we offer. As a member of the multi-disciplinary healthcare team, I adhere to a long-care relational model. I enter into sustained relationships from initial diagnosis, throughout treatment, and I maintain relationships with patients who may return with recurring cancer.

While the medical team focuses primarily on cure and/or symptom-management, my role as a spiritual caregiver focuses on healing and reintegration. Offering a 'ministry of presence,' MGH chaplains are clinically trained to accompany patients and families wherever they are on their spiritual life-journey and be a witness to them. The following case represents the essence of my practice as a member of the inter-disciplinary team providing care to a patient and her family from her first round of treatment at MGH to her final days.

'Rita' was first diagnosed after a colonoscopy when the biopsy of a rectal mass showed invasive adenocarcinoma. During the year and a half that

Rita received care at MGH, she sought out every support offered by the Cancer Center: art therapy, music therapy, massage therapy, social work, and chaplaincy. She first contacted me by phone, and we arranged to meet before her next radiation treatment in the very public outpatient waiting area.

Open and talkative, Rita shared her story in what I often call our 'get to know me conversation.' She touched on all aspects of her life before and after her diagnosis, and she acknowledged that she was having, "difficulty coping with cancer."

This was the beginning of my 'dance' with Rita and her family. A practicing Catholic, she and her husband had just celebrated their 30th wedding anniversary. Over the next 14 months, I saw Rita weekly during her chemo and radiation treatments, and then during her inpatient stays. Rita was never alone—a family member, her husband, son, or daughter, was always with her. An anxious person

*continued on next page*

We spoke of her life as a devoted wife and mother. We talked about how she could still comfort her family as well as teach them through her dying process. By letting them know that dying is part of life, something we all must face, she could reinforce their belief (and her own) that they'd be okay without her.

by nature, Rita presented with what is clinically referred to as 'total pain,' encompassing physical, emotional, psychological, and spiritual distress. A former nurse and loyal daughter, she had been the primary caregiver to her 90-year-old mother who died the year before. She had also cared for her dying brother.

Rita's spiritual distress was based on 'why me?' questions and issues around her relationship with God. A very religious woman with a deep faith in God's ability to cure, she regularly attended healing masses and charismatic church services. We spoke at length about re-framing the concept of a 'pain-giving God who allows cancer' to a 'pain-sharing God who suffers with her.' Our visits often included mindful breathing, prayers of healing and gratitude for family love, and most of all, providing a listening and supportive presence.

Rita underwent surgery, chemo, radiation, and more chemo. When she responded well to these interventions, the family decided to go on a cruise to celebrate Rita's return to good health. This caused one family member to comment, "No one loves life as much as she does."

Three months later, Rita and her close-knit family were devastated to learn that the cancer had returned and was now in her liver and lungs and spreading to her bones. Rita remained very hopeful as each new cancer was treated with a different line of chemotherapy. Palliative Care became involved for symptom-management and support.

During this time, Rita and her family found goals-of-care conversations very upsetting and quickly deferred. Rita required lengthy and frequent hospital admissions, but she still held out hope for a longer life through continued treatment. She would return home only to be re-admitted a few days later in distress, and this pattern continued even as she refused to transition to hospice care.

During her last admission and facing increasing pain, Rita confided that she could no longer go on.

"I'm suffering," she said. "I can't do this anymore. But what about my family?" she asked.

We spoke of her life as a devoted wife and mother. We talked about how she could still comfort her family as well as teach them through her dying process. By letting them know that dying is part of life, something we all must face, she could reinforce their belief (and her own) that they'd be okay without her.

"I'll watch over them from heaven," she said.

Rita's condition continued to deteriorate. Bed-bound and on full flow oxygen, the decision was made to transfer her to inpatient hospice to be able to manage her complicated care. Until the day she died, Rita's devoted son and daughter took turns being with her during the day, and her husband stayed with her at night.

I checked in with them in the morning and before going home. Her children always discreetly left the room when I arrived to "give me some time with their mom." I would stroke Rita's hair as I re-affirmed how special she and her family were and how much love they had for one another. Our visits always ended with Rita's favorite prayer, the Hail Mary. "Because Mary and I are both mothers," she explained.

Rita died one Tuesday morning in comfort, with her husband by her side, holding his hand.

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

As caregivers, we know we might not be able to change the outcome, but we *can* influence the process. Katrina met Rita where she was in her journey and stayed with her as she came to terms with her mortality. Caring for patients at the end of life is a privilege; one that reminds us of the profound nature and responsibility of our work. Rita was fortunate to have such an experienced and compassionate spiritual guide as Katrina accompany on her on way.

Thank-you, Katrina.

*Chaplains provide spiritual support to patients and families of all traditions, cultures, and beliefs. To contact a chaplain, ask a member of your healthcare team to make a referral, or call the Chaplaincy at 617-726-2220. Chaplains are on-site 24 hours a day, seven days a week, including holidays. MGH chaplains are accessible on all patient care units, including the Emergency Department and many outpatient areas.*

# October is National Health Literacy Month

—submitted by the PCS Patient Education Committee

Stop by the booth in the Main Corridor, between 11:00am and 2:00pm, Friday, October 7th, for tips on how to get the most out of your patient-education encounters.

The PCS Patient Education Committee will celebrate National Health Literacy Month with an informational table in the Main Corridor from 11:00am–2:00pm, Friday, October 7, 2016. Stop by to learn techniques on how to optimize communication and get the most out of your healthcare encounters. Using these proven strategies can enhance your patient-provider partnerships.

#### *Healthcare providers:*

According to the Agency for Healthcare Research and Quality, more than half the information patients are given by their healthcare providers is quickly forgotten. To ensure an effective teaching session with your patients:

- Use the teach-back approach; it's one of the most effective ways to ensure patients understand instructions. It can help clear up misunderstandings, answer questions, improve patient-satisfaction, and decrease call-backs
- Avoid asking, "Do you understand?" Instead, say something like, "I want to be sure my directions were clear. Can you show me how you're going to give yourself the injection when you get home?"
- Encourage patient to ask questions. Patients might feel nervous or not realize it's okay to ask questions. Say something like, "Most patients have questions about what we've talked about. Do you have any questions for me?"
- Use simple words and short, concise sentences. Separate important information into relevant steps. Avoid medical terms and abbreviations when possible
- Reinforce your instructions with handouts, resources, or other materials. This gives your patients information they can review at home

#### *Patients:*

It's easy to forget information shared during visits with caregivers. This is normal. These tips can help you get the most out of your healthcare visits:

- Write down instructions in a notebook or enter them into an electronic device (such as a phone or iPad). That way, you can have the instructions with you at home and follow them the same way you did in your provider's office
- Ask your provider to repeat anything you don't understand. It's in everyone's best interest to ensure you understand the directions. Say something like, "Can you show me that again? I want to make sure I got it right."
- Ask questions even if it may take a few more minutes. It's better to leave your provider's office informed and confident than confused or with unanswered questions. It's important to you *and* your provider that you understand completely
- Ask for handouts and other resources you can use at home
- Speak up if you don't feel comfortable with any of the steps. This gives your provider an opportunity to come up with alternate ways of helping you feel more comfortable and in control

National Health Literacy Month is the perfect time to reflect on your practice and explore ways to improve your communication skills. Stop by the PCS Patient Education Committee's informational booth on October 7th to learn more about techniques to improve patient-education encounters.

For more information, call The Blum Patient & Family Learning Center at 617-724-7352.

# A Day in Proton Beam

an age-appropriate guide to proton-beam therapy  
for pediatric patients

—by Elizabeth Ryan, pediatric social worker

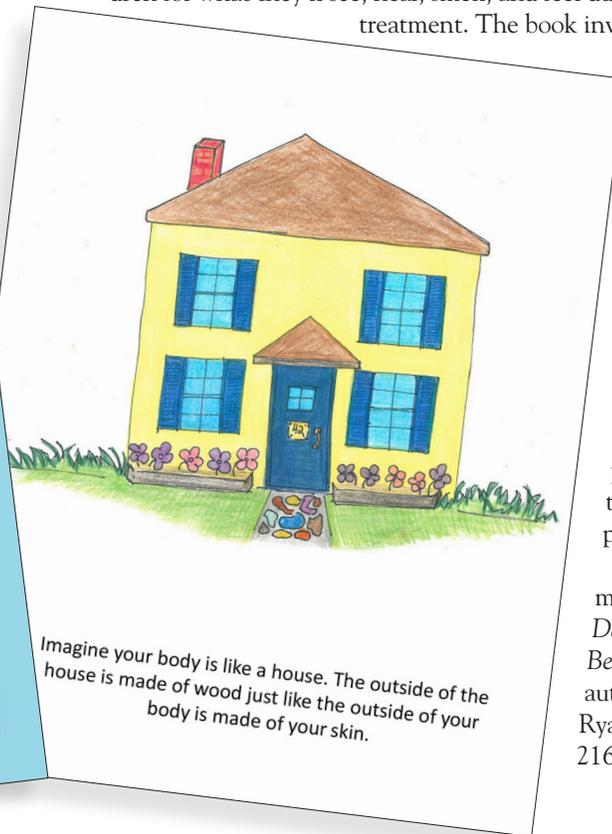
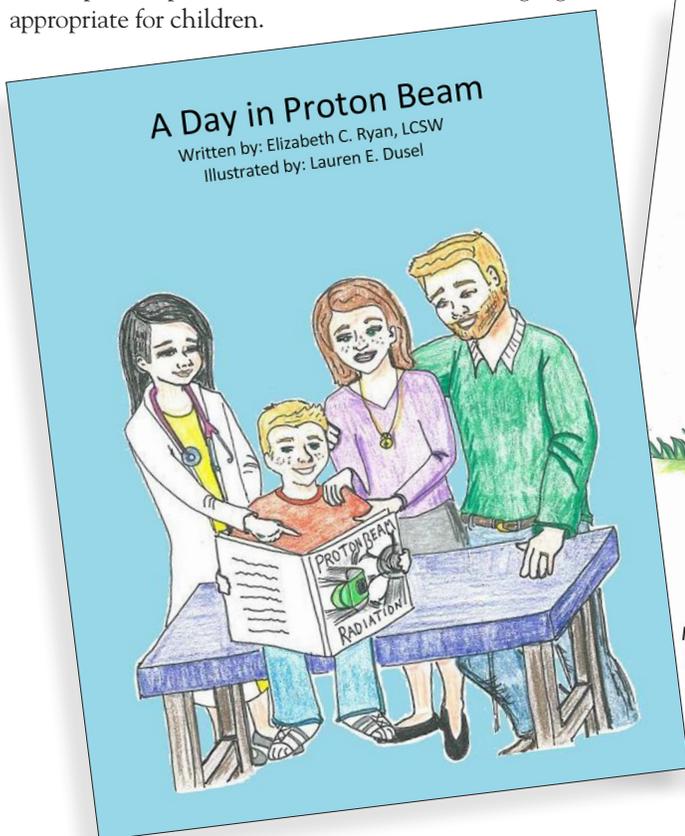
The MGH Francis H. Burr Proton Therapy Center treats a number of pediatric patients each year. Proton therapy often requires six to eight weeks of daily treatments using specialized equipment to combat a variety of benign and malignant tumors. During the two years that Elizabeth Ryan, LCSW, pediatric social worker, worked in the Proton Therapy Center, she identified a need for additional educational resources to better serve the pediatric population. There were no written materials that explained proton-radiation treatment in language appropriate for children.

Ryan took matters into her own hands and decided to write a book herself, specifically to demystify the proton-radiation experience for young children. After completing the text, Ryan approached her childhood friend, Lauren Dusel, to provide illustrations. The book describes in age-appropriate terms, the overall process of proton-radiation treatment for children. The book, *A Day in Proton Beam*, is the first of its kind and is being distributed free of charge in the Proton Center to children undergoing or about to undergo proton-radiation treatment.

In simple, easy-to-understand terms, the book prepares children for what they'll see, hear, smell, and feel during the course of treatment. The book invites questions

and is meant to be a springboard for conversation. The goal of *A Day in Proton Beam* is to alleviate fear and anxiety and prepare children for treatment by giving them a glimpse into the process before they actually experience it.

For more information about *A Day in Proton Beam*, contact the author, Elizabeth Ryan, at 617-643-2166.



# Medical Interpreter Services

*Question:* Sometimes it's difficult to find an interpreter for less-frequently requested languages. What options do we have?

*Jeanette:* Our medical interpreters can work with you to explore ways to meet patients' language needs. For less-frequently requested languages, and with sufficient notice, they might be able to pre-schedule time with an interpreter. We also retain a back-up telephone service if the language you need isn't available through CyraCom (our primary telephone interpretation service). To access the back-up service during business hours, call the Medical Interpreters Office at 6-6966. During off hours, page the on-call coordinator at 3-0009. If you experience any challenges accessing an interpreter, call 6-6966.

*Question:* Where do I record documentation of interpreter-facilitated communications?

*Jeanette:* Documentation of interpreter-service utilization is important, not only for regulatory compliance, but also to quantify our need for interpreters and track what languages are being requested. The best practice is to record interpreter-assisted communication in your notes. Staff interpreters can be documented by name; remote interpreters can be identified by ID number.

*Question:* How do we handle situations where patients are accompanied by bilingual family members and prefer not to use MGH interpreters?

*Jeanette:* At MGH, we offer professional medical interpreters around the clock, free of charge. Hospital policy strongly discourages using family members as interpreters, but patients do have the right to refuse interpreter services. In those cases, a waiver form must be signed by the patient, the clinician, and the interpreter, and a professional interpreter must interpret the form for the patient.

*Question:* Is it okay to use Google translate to communicate with patients?

*Jeanette:* No, it is not. On-line translation tools are not accurate and should not be used to communicate with patients and families.

*Question:* I was told that MGH interpreters aren't able to interpret for outside agencies such as local law enforcement. Why is that?

*Jeanette:* MGH interpreters are specifically trained in medical interpretation in the healthcare setting. They don't possess the skill set necessary to interpret in the legal environment. Due to liability issues, department policy is not to interpret for any outside agencies. Law enforcement, government, and many private agencies have access to their own specialized interpreters.

*Question:* Whenever I use an IPOP or VPOP to access an outside interpreter, they don't seem as effective as MGH interpreters. Why is that?

*Jeanette:* MGH interpreters are very familiar with our hospital, our providers, and our culture. We're proud of their skill and professionalism. Our vendor, CyraCom, provides interpreters for thousands of patient encounters every month. Their interpreters, although highly skilled and professional, work out of a large call center with no familiarity to MGH. And telephone interpretation is more challenging anyway because there's no opportunity to read visual cues. We work closely with CyraCom to provide feedback and help enhance their services. If you ever encounter a sub-standard interpretation, file a safety report, and Interpreter Services will follow up to help improve the quality of service.

For more information about any services provided by MGH medical interpreters, call 617-726-6966.

# Safe Patient Handling

*Question:* What does ‘safe patient handling’ mean?

*Jeanette:* Safe patient handling refers to the efforts we make to promote the safety of patients and staff. For patients, the goal is two-fold: eliminate friction and shearing injuries that can lead to potential pressure injuries and ensure that patients are re-positioned or moved in the safest manner possible. Friction and shearing can occur when soft tissue is dragged across a surface when patients are ‘boosted up’ in bed.

For staff, the goal is to eliminate preventable back and other injuries that can result when lifting, moving, or re-positioning patients.

The Safe Patient Handling initiative is designed to increase awareness of the risks associated with lifting and moving patients and encourage staff to commit to using safe patient-handling strategies to their fullest.

*Question:* I’m surprised we need this. Do we have a lot of patient and staff injuries?

*Jeanette:* Our overall rate of pressure injuries has decreased, but some patients still develop them. Stage 2 pressure injuries are most common; usually a consequence of repeated friction and shearing. We must do everything in our power to prevent this from occurring.

The number of staff injuries related to lifting and moving patients has not decreased, and many of these injuries are preventable. Most staff injuries are a result of cumulative stress and strain.

*Question:* I was taught good body mechanics when handling patients, so I should be okay, right?

*Jeanette:* According to William Marras, of the Sine Research Institute at Ohio State University, “There is no safe way to do it with body mechanics... You could be doing damage... and never realize it. The event that caused you to feel the problem is just the straw that broke the camel’s back.” He explains that lifting heavy loads causes microscopic tears on the thin films below each disc. Those tears lead to scar tissue that builds up and blocks the flow of nutrients to the disc; eventually the discs start to collapse.

*Question:* I use ceiling lifts to move patients between the bed, the stretcher, and the chair. Is there anything else I should use ceiling lifts for?

*Jeanette:* Ceiling lifts can be used for re-positioning patients in bed (including turning and boosting up), assisting with urinary catheterization, and lifting limbs for wound care.

*Question:* Is there any kind of tutorial available on how to properly use ceiling lifts?

*Jeanette:* A quick guide to ceiling lifts has been developed and will soon be available at every bedside. The guide includes a streamlined list of slings, what each should be used for, the sizes and materials they’re available in, weight limits, and helpful hints to avoid depleted batteries and twisted straps. Three short videos have also been developed to show how the lifts should be used.

It’s helpful to identify patients in advance who might be candidates for ceiling lifts and leave a sling in place on their beds. That way, you avoid the temptation of lifting manually, patients will be more comfortable, and both you and your patient will be safer.

*Question:* Is that the extent of the Safe Patient Handling Initiative?

*Jeanette:* The Safe Patient Handling initiative has several prongs. The quick guide to ceiling lifts will be placed in patients’ rooms this month. *Safe Patient Handling Guidelines* will be available in Ellucid. In addition to general information about how to safely handle patients to prevent injury, the *Safe Patient Handling Guidelines* contain links to the videos I mentioned above. You’ll see posters on units highlighting key points of the initiative, and your nursing directors may share information with you via e-mail. Safe patient handling will also be featured at the up-coming SAFER Fair on October 19th.

For more information about safe patient handling, contact Janet Madden, RN, staff specialist, at 617-726-4996.

# Announcements

## MGH Nurses Alumnae Association fall reunion and educational program

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

Friday, September 23, 2016  
O'Keeffe 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.

## Munn Nursing Research Awards

Staff nurses, consider applying for a Munn Nursing Research Award. Information can be found at [http://www.mghpcs.org/munncenter/Munn\\_Research\\_Award.asp](http://www.mghpcs.org/munncenter/Munn_Research_Award.asp).

Letters of intent due October 14th; full proposals due December 9th.

For information, contact Mary Larkin at 617-724-8695 or Kim Francis at 617-726-0328.

## SAFER Fair and community outreach

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.

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:

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: [acls@partners.org](mailto:acls@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).

## Mentors make a difference!

The Center for Community Health Improvement is seeking volunteers to mentor students from the Timilty Middle School with their science projects from October through January. No experience necessary. For information, contact Arthur Newbould at 617-724-8326.

## Earn your DNP at the MGH IHP

Have lunch and enjoy a brief informational session about the MGH Institute of Health Professions DNP Programs:

- RN to DNP (hybrid)
- Post-master's DNP (on-line)
- DNP for nurse executives (on-line)

Tuesday, September 13, 2016  
1:00, 1:30, and 2:00pm  
Haber Conference Room.

All sessions will discuss each of the DNP tracks.  
Lunch will be provided.  
RSVP to: [info.mghihp.edu/dnmpmh](mailto:info.mghihp.edu/dnmpmh).

## Blum Center Events focus on Recovery Month

"Beyond Traditional Treatment Options: Innovations to Engage Patients"

Tuesday, September 20th  
1:00–2:00pm

"There is Treatment. Treatment Works"

Thursday, September 29th  
1:00pm–2:00pm

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.

is a way to ensure all members of the team have access to these key discharge-planning items. The information in the Huddle Report flows over to the eCare Patient Story view

- Strengthen our partnership with our provider colleagues by shifting the discharge order and documentation work flow to the night before or as early in the morning after inter-disciplinary rounds as possible. This enables providers to prepare patients and families for discharge earlier in the day (see graph below). Discharging patients earlier and decreasing wait times improves patient satisfaction and helps free up inpatient beds for patients coming from the ED, the PACU, and outside hospitals
- Continue to partner with patients, providers, therapists, and case managers in

considering home care rather than inpatient rehabilitation when appropriate. Home care nurses and therapists provide a wide-range of treatments in the comfortable and familiar surroundings of the patient's home

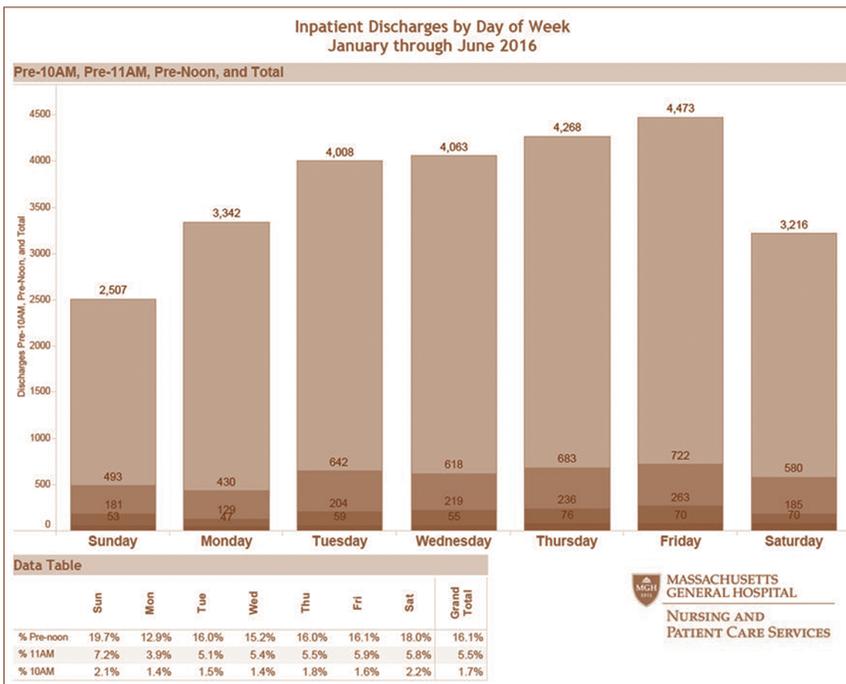
- Notify Admitting as early as possible of anticipated discharges by entering them in eCare. Currently only 60% of daily patient discharges are communicated to Admitting in advance. Improving that number, would significantly enhance our ability to place patients in the most appropriate beds in a timely manner
- Continue to partner with ED providers in considering discharging patients home with home care or home infusion services when appropriate rather than admitting them to an observation unit or inpatient setting. A wide

range of home-infusion services are now available; some infusions previously only administered on an inpatient basis are now routinely and safely administered in the home. Patients don't need to qualify for home-care services in order to receive home-infusion services. For more information, contact the Infusion Referral Center within Case Management

We're asking all team members to closely review these recommendations and continue to work together to ensure that all best practices are implemented consistently.

To learn more about the 2016 PCS Strategic Goals, go to: [www.mghpcs.org/PCS/about/Goals.asp](http://www.mghpcs.org/PCS/about/Goals.asp). Our goal is to provide the highest quality, safest, most efficient and timely care to all patients. With the combined efforts of our entire

workforce, we can achieve that goal while at the same time improving the work environment and providing speedier access to patients in need of our care. We look forward to advancing this work in the coming months and years. For more information, contact Kevin Whitney, RN, associate chief nurse, at 617-724-6317.



**Published by**  
Caring Headlines is published twice each month by the department of Nursing & Patient Care Services at Massachusetts General Hospital

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For more information, call: 617-724-1746

**Next Publication**  
October 6, 2016

# 12th annual Allan Moore Memorial Medical Services Blood Drive

**C**ongratulations to staff of the RACU for winning this year's Allan Moore Memorial Medical Services Blood Drive. With an impressive 95% participation rate, the RACU soundly trounced their competition, with the Bulfinch Medical Group coming in 2nd (with 48% participation rate) followed closely by Bigelow 11 (46.7%) and the MICU (45.3%).

This annual blood drive is more than a friendly rivalry, it's a tribute to former colleague, Allan Moore, MD, who started the

tradition back in 2004, and who sadly passed away before his time in 2008. Moore was passionate about donating blood as a way to demonstrate our advocacy and commitment to patient care; and he led by example, always first in line to donate.

Said Dan Gallagher, RN, staff nurse and co-organizer of the RACU blood donor campaign, "This is such an important initiative. Rachael [Salguero] and I really just got the ball rolling—our incredible staff stepped up, and we had tremendous support from leadership."



RACU staff, including blood drive co-coordinators, Danial Gallagher, RN (back row, second from left) Rachael Salguero, RN (front left), and a team of highly motivated colleagues and blood donors.

(Photo by Jeffrey Andree)



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