

# Caring

Headlines

April 6, 2017

## Speak up for Safety

*N&PCS celebrates National Patient Safety Week*

(see story on page 4)



Speaking up for safety, are (top row, l-r): Karen Miguel, RN, staff specialist; Judi Carr, RN, staff specialist; Dena Alioto, senior director of Pharmacy; Jen Albert, RN, clinical educator; Ruth Bryan, RN, patient safety staff specialist; and Colleen Snyder, RN, director, Nursing & Patient Care Services Office of Quality & Safety. Above: nursing director; Vivien Donahue, RN; and staff nurses, Susan Gordon, RN; and Carolyn Rebholtz, RN. At left: National Patient Safety Week event, Speak up for Safety, in O'Keefe Auditorium.

# The Clinical Recognition Program Survey

*ensuring the process is meaningful  
and accessible to staff*

Staff told us  
that the Clinical  
Recognition  
Program allowed  
them to reflect  
on their practice,  
validated their  
accomplishments,  
and encouraged  
them to seek  
opportunities  
for professional  
growth.

**T**he Clinical Recognition Program (CRP) was created in 2002 as a way to formally recognize professional clinical staff for their expertise. As part of the program, clinical staff from Nursing, Occupational Therapy, Physical Therapy, Respiratory Care, Social Work, and Speech-Language Pathology analyze their practice and seek formal recognition for the level of practice they've achieved.

Over the years, we've employed a number of methods to ascertain staff's perceptions of the Clinical Recognition Program to ensure that the process is meaningful and accessible. Last year, surveys were sent to more than 3,800 clinical staff in the disciplines listed above to get their feedback on the program. More than 1,100 clinicians (29.5%) responded.

The results of the Clinical Recognition Program Survey have been shared at numerous meetings and forums throughout Nursing & Patient Care Services by Gaurdia Banister, RN, executive director for The Institute for Patient Care. Staff told us that the Clinical Recognition Program allowed them to reflect on their practice, validated their accomplishments, and encouraged them to seek opportunities for professional growth. Respondents spoke of managers, supervisors, and colleagues who guided and encouraged them through the process. They expressed appreciation for resources avail-



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

able at the unit and department level as well as on the CRP website.

It was interesting to see that there are a number of misconceptions about the program, so I want to address some of those here. For instance, some respondents spoke of trepidation about the interview process, thinking it was some sort of stressful examination. When in fact, the vast majority of respondents who participated in interviews found it more of an informal conversation, describing members of the Review Board as warm and welcoming.

When we originally developed the Clinical Recognition Program, we knew that some clinicians would be more comfortable writing about their practice while others would be more comfortable talking about it. That's why the application process is comprised of a written portfolio as well as an interview—so clinicians can share their practice in the way that's most natural for them.

*continued on next page*

If the Clinical  
Recognition  
Program has  
shown us anything,  
it's that valuable  
contributions  
are made by  
staff at all levels  
of practice. And  
after 15 years,  
we continue to  
celebrate those  
contributions  
throughout  
Nursing &  
Patient Care  
Services.

Many people find that participating in a mock interview prior to meeting with the Review Board can help them feel more confident. Your manager or supervisor can help you arrange one. It can be especially helpful to do a mock interview with someone outside your discipline who'll be more curious about your work and your practice.

Some survey respondents wondered why members of the interview team were from outside their own discipline; wondering whether they were equipped to evaluate their practice. The Clinical Recognition Program is a multi-disciplinary program that reflects how clinicians throughout Patient Care Services care for patients as a team. All lead interviewers are members of the applicant's discipline, and any discipline-specific questions are deferred to Review-Board members of that same discipline.

There were a number of questions and comments about the salary increase associated with recognition. Many thought it was too small to make a difference. But that's very short-term thinking. A 3% or 6% increase in base salary grows as you receive additional salary increases throughout your career. Just like money you put into retirement accounts, it grows proportionally over the years. I don't know about you, but any opportunity to increase my earnings seems like a good idea; especially when it's combined with recognition of excellent practice.

The survey also revealed some mis-perceptions about the number of clinicians who aren't recognized. In the past two years, 120 clinicians applied for clinical recognition, and only six were denied. Of those six, two have since re-applied and been recognized. I know it can be disheartening to submit a portfolio and not be recognized, but it's important to remember that the Clinical Recognition Program is based on reflection and professional development. Anyone who isn't recognized (and that number is very small) should speak with the lead interviewer to understand why they weren't recognized and to ensure they'll be successful next time.

All applicants have an opportunity to have their portfolios evaluated in a blind 'pre-review' process. This allows clinicians to get feedback on their portfolios from former Review-Board members before actually submitting it for consideration. Directors, clinical specialists, nurse practice specialists, and clinical scholars are invited to observe these pre-reviews to better understand the criteria and process.

If the Clinical Recognition Program has shown us anything, it's that valuable contributions are made by staff at all levels of practice. And after 15 years, we continue to celebrate those contributions throughout Nursing & Patient Care Services. For more information about the Clinical Recognition Program Survey, contact Gaurdia Banister at 617-724-1266.

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(Cover photos by Paul Batista)



# Speak up for Safety

## N&PCS celebrates National Patient Safety Week

—by staff specialists, Karen Miguel, RN, and Judi Carr, RN

High-reliability organizations are obsessed with talking about errors, learning from them, and discovering ways to improve the systems that support the way we work and live every day.

**T**his year, for National Patient Safety Awareness Week, March 13-17th, the Nursing & Patient Care Services Office of Quality & Safety in an inter-disciplinary collaboration, high-lighted the complexities of safety events in the March 15th session, “Speak up for Safety: Anatomy of a Safety Event.”

The session began with the new *Speak Up For Safety* video sponsored by the N&PCS Quality & Safety Committee. Following the video, a panel of nurses, content experts, Quality & Safety leaders, and a pharmacist shared stories illustrating how one voice can impact the care of a single patient and/or systems throughout the entire Partners’ enterprise.

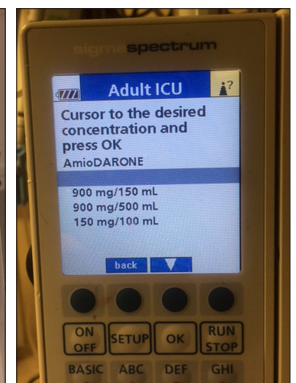
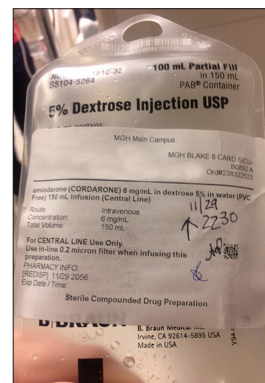
In her remarks, director of the N&PCS Office of Quality & Safety, Colleen Snyderman, RN, noted, “Culture is local. How we think and collaborate at the unit level is the norm for the way we do things around here.” Snyderman shared the key components of a high-reliability organization. High-reliability organizations are preoccupied with failure, embracing the belief that errors may never be completely eliminated. High-reliability organizations are obsessed with talking about errors, learning from them, and discovering ways to improve the systems that support the way we work and live every day.

Snyderman shared that N&PCS staff were responsible for more than 2/3 of the 21,000 MGH safety reports filed in 2016. The highest areas of focus were medication and IV safety, care service coordination, and skin/tissue issues.

Two staff nurses on the panel recounted their experience with a near-miss involving a medication label. Shortly after the October eCare upgrade, two staff nurses on two different units, Susan Gordon, RN, Ellison 9, and Carolyn Rebholtz, RN, Blake 8, realized that pharmacy labels on continuous medication infusions were no longer displaying the total drug amount. That meant that nurses had to calculate dosing in order to program large-volume pumps.

Said Gordon, “I was taking care of a pretty sick patient on high-dose levo that day. Two other seasoned nurses were with me at the large-volume

*continued on next page*



Opportunities to enhance safety can only be acted upon when every member of the workforce is willing to 'speak up' about the risks they encounter and share that information broadly. Every employee has the power to make care safer for patients and families, sometimes by simply asking the question, 'Does this make sense?'

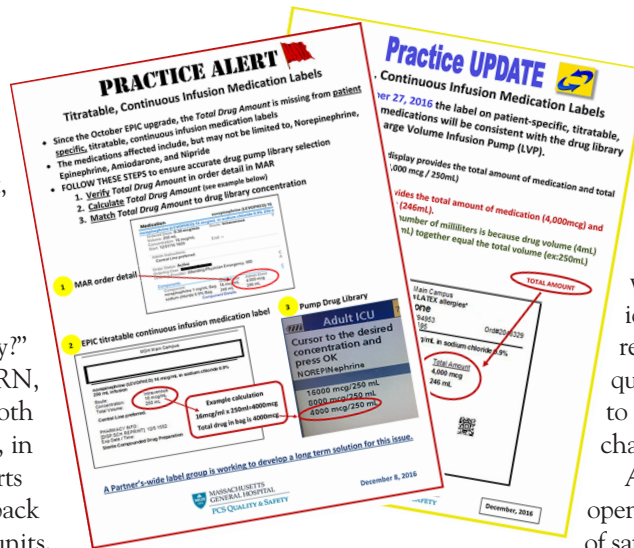
infusion pump. We were using a calculator to figure out the dosing, and I thought, there's something wrong with this—three veteran nurses and a calculator, and we're having difficulty?"

Vivian Donahue, RN, nursing director for both Ellison 9 and Blake 8, in reviewing safety reports and listening to feedback from nurses on both units, began to 'connect the dots.' She realized this wasn't an isolated case. She immediately brought the issue to both the N&PCS Office of Quality & Safety and the MGH Center for Quality & Safety to ensure the issue was communicated throughout the organization as quickly as possible.

Ruth Bryan, RN, staff specialist, in the Center for Quality & Safety, convened representatives from Nursing, Pharmacy, Nursing Informatics, Quality & Safety, and hospital leadership to debrief.

Said Jennifer Albert, RN, staff nurse and infusion pump specialist, "As soon as I saw the pictures, I knew right away what the problem was."

The meeting resulted in short- and long-term actions. The group outlined concerns and accelerated a request for revisions to the labels on all medications involved. A Practice Alert was circulated to raise awareness among staff; the Practice



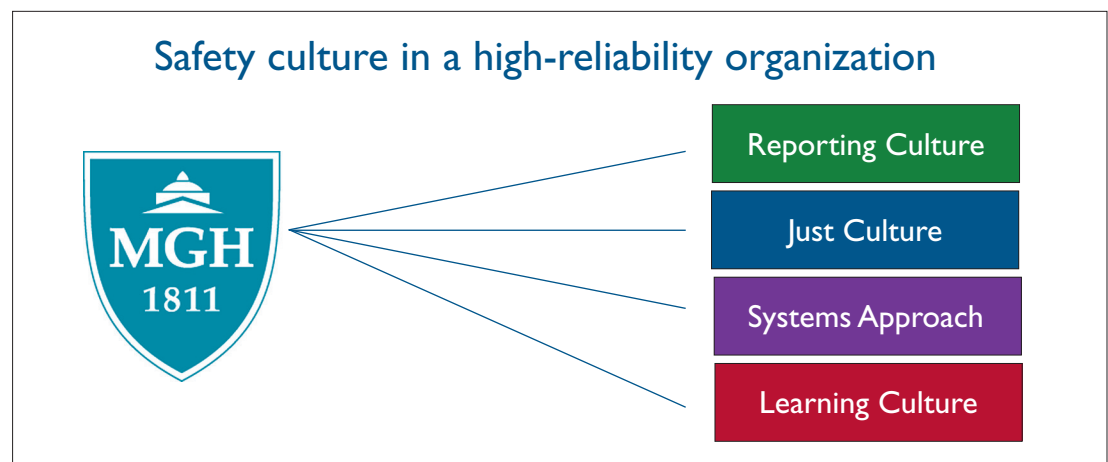
Alert was followed soon after by a Practice Update outlining the changes that had been made to medication labels. These corrections were possible because staff identified a risk, and the responding group worked quickly and collaboratively to make the necessary changes.

A strong safety culture openly embraces the reporting of safety concerns, a non-punitive response to errors, and a focus on systems improvement. In health care, 'close calls' are 30 to 300 times more frequent than events that result in actual harm or those in which patients experience an adverse outcome.

Opportunities to enhance safety can only be acted upon when every member of the workforce is willing to 'speak up' about the risks they encounter and share that information broadly.

Every employee has the power to make care safer for patients and families, sometimes by simply asking the question, 'Does this make sense?' If/when you encounter a scenario that concerns you, file a safety report.

For more information, contact Karen Miguel, RN, staff specialist, at 617-726-2657. The *Speak up for Safety* video can be accessed at: <https://www.dropbox.com/s/6z99xn79dm8z5fo/SafetyMASTERfin.mp4?dl=0>.



# MGH nurses volunteer to serve in First World War

—submitted by the MGH Nursing History Committee

Anticipating US entry into the war, hospital leadership established 'Red Cross Base Hospital No.6, the Massachusetts General Hospital Unit.'

Telegram from Clara Noyes, head of Nursing at the American Red Cross directing Sara Parsons to activate MGH Base Hospital No. 6 Unit.

In 1916, what would come to be known as, 'The Great War,' had been roiling throughout Europe for more than two years. The United States had not yet entered the conflict, but Massachusetts General Hospital was in the process of increasing capacity with construction of the Moseley Memorial Building, converting part of the Bulfinch Building to a patient care area, and preparing to open the Phillips House a year later. As patient admissions increased, the MGH School of Nursing expanded to be able to provide additional 'pupil nurses' to staff the new wards. Prior to 1925, the nursing staff at MGH consisted almost entirely of students, and head nurses were typically graduates of the MGH School of Nursing.

Anticipating US entry into the war, hospital leadership established 'Red Cross Base Hospital No.6, the Massachusetts General Hospital Unit.' Sara E. Parsons, an 1893 graduate of the MGH Training School for Nurses, was well equipped to serve as chief nurse having interrupted her career in mental health nursing in 1898 to work with MGH director, Dr. Frederic Washburn, and Dr. Richard Cabot of the department of Medicine, to care for soldiers during the Spanish-American War. By 1917, 53-year-old Parsons was a seasoned leader at MGH, she was president of the National League for Nursing Education, and had served as president of the Massachusetts

State Nurses Association. She transferred her MGH responsibilities to her assistant, Helen Woods, then took on her new duties as chief nurse for MGH Base Hospital No. 6.

Parsons enrolled nurses who fulfilled specific requirements: registered nurses at least 25 years of age; unmarried; graduates of a three-year, accredited, nurses training program; and members of their alumni associations. Parsons had been active in an effort to gain control over who could be considered a trained nurse. Massachusetts law requiring nurses to be registered had only recently been passed (1910), and in the months leading up to the war, there was a movement to loosen those requirements to use nurses' aides. Parsons would have none of it.

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Form 1201

CLASS OF SERVICE	SYMBOL
Day Message	Blue
Day Letter	Blue
Night Message	Blue
Night Letter	Blue

WESTERN UNION  
TELEGRAM

NEWCOMB CARLTON, PRESIDENT      GEORGE W. E. ATKINS, FIRST VICE-PRESIDENT

RECEIVED AT 169 CONGRESS STREET, BOSTON  
11WM9 119 NL

WASHINGTON DC MAY 19 1917

MISS SARA E PARSON      766

MASS GENERAL HOSPITAL BOSTON MASS

THE BRITISH GOVERNMENT REQUESTS US TO SUPPLY TWO HUNDRED NURSES  
JUNE JULY AUGUST WILL YOU APPOINT A MATURE GRADUATE YOUR SCHOOL OF  
GOOD JUDGMENT AS HEAD NURSE OF DETACHMENT TO BE ORGANIZED BY YOU  
CONTAINING FIVE TO TEN MEMBERS YOUR RECENT GRADUATES IF NOT EN-  
ROLLED THESE MUST BE ELIGIBLE BUT SHOULD NOT BE CONNECTED WITH ANY  
OTHER UNIT COMPLETE INFORMATION CONCERNING DETACHMENTS FOLLOWS  
WITH ENROLLMENT PHYSICAL AND IMMUNITY BLANKS VERY DESIRABLE SUCH  
UNITS TO BE READY PAPERS ON FILE IN THIS OFFICE NOT LATER THAN JUNE  
TENTH ALL PAPERS SENT TO THIS OFFICE FOR THIS SERVICE SHOULD BE  
MARKED "ED FOREIGN SERVICE" MINIMUM AGE FOR NURSE TWENTY FIVE  
SHOULD HOLD POSITIONS UNTIL ORDERED FOR DUTY PLEASE WIRE REPLY  
CLARA A NOYES 1229A



On November 11, 1918, as the Armistice was being signed, Base Hospital No. 6 was actively caring for 4,319 wounded and/or influenza-stricken patients.

The Bordeaux Belles returned to Base Hospital No. 6. And when it closed two months later, the teams had cared for 24,122 patients.

In April, 1917, the United States officially entered the war, and a month later, Parsons received a telegram from Clara A. Noyes, head of Nursing at the American Red Cross. She directed Parsons to activate the unit and ensure that all nurses had the appropriate vaccinations and could meet the physical requirements set by the government. Of the 64 nurses activated, 55 were MGH graduates; three were graduates of the Massachusetts Homeopathic Hospital School of Nursing, chosen for their advanced training in infectious diseases; and four were graduates of Children's Hospital School of Nursing. Most had graduated within the previous five to ten years; 38 had held positions as head nurse, supervisor, superintendent or director. These nurses would be working together for the first time as part of an all-RN nursing staff directly at the patients' bedside.

On June 29, 1917, the nurses of Base Hospital No. 6 left Boston for New York. On July 11th, they boarded the RMS Aurania, which took them safely around the coast of Ireland, an area that Winston Churchill had dubbed, "the cemetery of British

shipping." It was here that the HMS Lusitania was torpedoed two years before and the Aurania itself would be torpedoed seven months later. The MGH nurses arrived safely in Le Havre and Talence, France, where for the next 19 months they cared for soldiers brought in convoys from the front lines. Some of the Bordeaux Belles (as they called themselves) were dispatched to care for patients on hospital trains; others joined mobile surgical teams; while others set up public health units to care for refugees of war.

On November 11, 1918, as the Armistice was being signed, Base Hospital No. 6 was actively caring for 4,319 wounded and/or influenza-stricken patients. The Bordeaux Belles returned to Base Hospital No. 6, and when it closed two months later, the teams had cared for 24,122 patients.

This story coincides with the 100th anniversary of the United States entering World War I. Look for other installments from the MGH Nursing History Committee in future issues of *Caring Headlines*. For more information, contact Georgia Peirce, special projects manager, at 617-724-9865.



The nurses of Base Hospital No. 6

(Photos provided by the MGH Nursing History Committee)

# Therapist tailors treatment to help patient overcome pulmonary limitations

'Lucy' was a 72-year-old writer and artist referred to MGH Physical Therapy for pulmonary rehab for breathlessness related to sarcoidosis and pulmonary hypertension, both known to impact lung capacity and oxygenation.

My name is Jessica Riggs Garton, and I am a staff physical therapist. 'Lucy' was a 72-year-old writer and artist referred to MGH Physical Therapy for pulmonary rehab for breathlessness related to sarcoidosis, a progressive, restrictive lung disease, and pulmonary hypertension, both known to impact lung capacity and oxygenation. Six years ago, Lucy had been able to make the four-flight climb to her artist studio with no difficulty. Despite interval CT and spirometric evidence of disease progression, it wasn't until this year that she began to notice a change in her quality of life.

When I met Lucy in the reception area, she was hunched over in a wheelchair with supplemental oxygen. During her examination, I asked about her functional limitations related to her breathing and found she'd been slowly decreasing activity over the last eight months. She was now mostly homebound, leaving home only for medical appointments and with assistance. As I listened to her story, Lucy continuously cleared her throat and occasionally took gasping breaths. I placed the pulse oximeter on her finger to assess her oxygen levels and found that her levels were stable. She expressed worry over her declining function, which appeared to precipitate or exacerbate the gasping episodes.

Based on my evaluation, and especially her gasping breaths and significant worry over her functional limitations, I wondered if Lucy's anxiety was playing a prominent role in her dyspnea (uncomfortable



Jessica Riggs Garton, PT, staff physical therapist

breathing). Often, patients receiving pulmonary rehab fall victim to 'the dyspnea cycle.' They become short of breath with activity, then limit those activities because of fear or anxiety around expected breathlessness. This, in turn, causes progressively more shortness of breath with progressively less activity. The result is a downward spiral of functional loss, and I suspected Lucy may already have begun this decline. While some degree of anxiety is to be expected in patients with multiple pulmonary diseases, Lucy's level of anxiety was a significant prognosticator of her rehab potential.

Based on my concerns, I consulted a senior physical therapist colleague and Lucy's referring pulmonologist to develop a plan of care. I learned from her pulmonologist that Lucy's anxiety and depression were being monitored and managed by another healthcare professional. I was going to have to take a more gradual approach to her rehabilitation so as not to overwhelm her and add to her anxiety. In contrast with the typical pulmonary rehab course of two or three visits a week for 12 weeks in a group setting, I felt Lucy would benefit from less frequent, individual sessions so as not

*continued on next page*



She's no longer  
slouched in a  
wheelchair; she  
sits upright in  
a regular chair,  
eagerly awaiting  
her appointment  
to which she  
walks without  
assistance. More  
importantly, Lucy  
is now able to go  
grocery shopping  
for the first time  
in two years and  
is taking small  
walks in her  
neighborhood.

to overwhelm her at the start. In her case, less frequent visits would mean improvement wouldn't be expected initially, but I felt it was a necessary precursor to build her confidence to be able to tolerate effective exercise sessions. On her first follow-up visit, we spent more than half the session on relaxation techniques specifically related to shortness of breath associated with anxiety. I added low-level aerobic exercise on the recumbent stepping machine. Lucy was only able to do two repetitions of three-minute intervals and was initially upset with her seemingly limited performance. But I reminded her this was more activity than she'd had in eight months. Recovering function was taking more time than she expected, and she needed to be patient. I instructed her in some strengthening exercises for her legs that she could do at home until our next session, which was scheduled for the following week. I knew including pictures of the exercises would enhance her ability to do them correctly and reassure her that she was on track.

I returned from an unexpected leave of absence to find that Lucy had not returned for any of her physical-therapy appointments. In following up with her, I learned that she'd been admitted to MGH via the Emergency Department due to continued issues with throat clearing and gasping for air. The team had decided to pursue a more aggressive approach to manage her stress and anxiety.

Lucy came back to see me four months after her initial evaluation to resume pulmonary rehab while on new medications to control her anxiety. Based on my re-evaluation, we proceeded with our initial plan of care as she hadn't demonstrated any decrease in her aerobic capacity, and she'd continued her breathing and strengthening exercises in my absence. She showed some initial strength gains and other signs that she was better able to participate in her care. I was surprised and excited to see she'd been so persistent despite the factors stacked against her. This told me that Lucy was capable of partnering in her rehab, and I became more hopeful for her success.

We continued with gradual aerobic exercise, but Lucy wasn't able to come to her appointments at the prescribed frequency of twice a week. She was seen in the clinic an average of two or three times a month throughout the summer. When she expressed dismay at her lack of progress after six weeks, I had a long talk with her about how she needed to be consistent with physical therapy twice a week to achieve the

changes necessary to improve her function. She was hesitant at first—it meant she'd have to drive herself to these appointments without her husband who'd accompanied her to all her appointments so far. We brainstormed ways to make it easier for her, including using valet parking to limit the walking she'd have to do. She agreed to try it for a few weeks.

Lucy came to therapy consistently for the next two months, progressing to 20 minutes of continuous exercise on the seated stepper, and she began interval walking on the treadmill. Greeting Lucy in the reception area is now a different experience. She's no longer slouched in a wheelchair; she sits upright in a regular chair, eagerly awaiting her appointment to which she walks without assistance. More importantly, Lucy is now able to go grocery shopping for the first time in two years and is taking small walks in her neighborhood. While her pulmonary rehab has been longer than anticipated with some setbacks, Lucy's determination and perseverance have paid off.

Lucy's heightened anxiety had a greater impact on her function and progress than is typical; however, anxiety and depression frequently accompany chronic lung disease. It's incumbent on physical therapists to recognize when emotional health may be impacting function or patients' ability to care for themselves. In the past year, Physical Therapy has worked closely with Social Work to determine the best screening tools and educational strategies to identify and address anxiety and depression in pulmonary-rehabilitation patients. Working with Lucy reinforced the importance of recognizing emotional barriers and getting support as early as possible.

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

This narrative is a wonderful glimpse into the delicate balance between challenging patients so they can achieve their highest level of recovery and recognizing when competing factors may impact their progress. Jessica masterfully helped Lucy move beyond fear and anxiety to achieve her optimal level of function. And working with Social Work to develop better screening and educational tools is an extension of her commitment to care for this patient population.

Thank-you, Jessica.

# Future nurse learns about humility and engagement

*In the Maternal Child Health course taught by Mimi Pomerleau, RN, and Kristine Ruggiero, RN, at the MGH Institute of Health Professions, students were asked to reflect on how they link nursing theory to nursing practice and about the core virtues they're developing as a result of their clinical experiences.*

*The following reflection was written by student, Amy Smith.*

I could feel the excitement as I entered the room. The couple was receptive to my questions and suggestions, and the patient was more than happy to involve me in her care. I tried to build a rapport, even though I was nervous in my role as a nursing student. This was the first time I'd assisted with a woman in labor, and after her membranes had been artificially ruptured, her contractions started to come relatively quickly—now about two minutes apart. At one point, I was stroking the patient's back, and her husband discreetly motioned for me to stop. It was a great moment of connection between me and the support person. I remained quiet during the patient's contractions then asked if she wanted me to breathe with her, but she said she had it under control.

I thought back to my own labor experiences and what I might have wanted from support people. I asked if she'd like some lower-back counter-pressure, but again, she said she was okay. The couple had not taken any childbirth preparation classes, so I assumed their skill at working through labor was limited. But they did have some tools: prenatal yoga practice and music they'd brought from home helped her remain calm and focused during contractions.

Reflecting on this experience, I believe the virtues I used were humility and engagement. Humility, in that I had to understand that I didn't know what was best for this particular family. I thought they might want or need what I needed during childbirth. I thought they might benefit from some of



Amy Smith, nursing student

the comfort measures I'd learned prior to this clinical experience. But the patient knew what she wanted and needed, and I was there to support her.

I was lucky that she was a great communicator and her partner's demeanor had a very calming influence. Respecting their wishes made it possible to engage more fully with this family.

Before I left, they told me, "We feel like we had our own doula" [a woman trained to assist and support another woman during childbirth].

It was a pleasure to engage with this couple, help meet their needs, and feel empowered through my nursing education to offer suggestions. Unfortunately, I had to leave before the baby was born, but never before had I wanted to stay at a clinical so much. I'll always remember the three of them.

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## Next Publication

April 20, 2017

# Celebrating one year of eCare

*entering the optimization phase; reviewing and prioritizing potential improvements*

A patient can be seen by her primary care provider, go to the Emergency Department, have surgery, recover on an inpatient unit, and return to her primary care provider after discharge. All those interactions, orders, reports, notes, etc. reside in one electronic record with shared documentation and access by caregivers.

*Question:* How would you describe our first year with eCare?

*Jeanette:* It's hard to believe it's been a whole year since we went live with Partners eCare. I'd say the initial implementation phase was characterized by rapid change and hard work as challenges were addressed and overcome. As we moved into the stabilization phase, there were fewer issues, and they were less disruptive. Now, at our one-year anniversary, we're entering the optimization phase. We'll continue to make improvements to the system and strive to improve clinician efficiency.

*Question:* What will optimization look like?

*Jeanette:* Now that we've had time to work with the system, several groups are meeting to review and prioritize changes to improve how eCare functions. Nursing & Patient Care Services participates in these hospital review sessions, and the inter-disciplinary N&PCS Informatics Committee and super-users continue to meet regularly to exchange ideas and information. We'll soon be piloting a program pairing informatics nurses with members of the Service Now team to round on units and talk with staff about their experience with eCare. We're hoping this program will help identify opportunities for change and improve satisfaction with the system.

*Question:* How is inter-disciplinary care and collaboration documented in eCare?

*Jeanette:* With eCare, the electronic health record (EHR) truly belongs to the patient, with all disciplines having access. Each discipline's work is visible to all members of the team, and having a single electronic record enhances continuity and patient safety. A patient can be seen by her primary care provider, go to the Emergency Department, have surgery, recover on an inpatient unit, and return to her primary care provider after discharge. All those interactions, orders, reports, notes, etc. reside in one electronic record with shared documentation and access by caregivers. The Patient Story report pulls together plan of care issues, medications, nursing progress notes, and vital signs, and the Huddle Tool pulls together aspects of discharge-planning among providers, nursing, and health professionals.

The system doesn't eliminate the need for clinicians to communicate with each other or with patients and families, but it is an incredible tool for recording and sharing information.

*Question:* How can staff communicate feedback and ideas for optimization?

*Jeanette:* Several mechanisms are in place for staff to provide feedback and suggestions. Service Now tickets can be entered at any time to be reviewed by the MGH eCare support team. Staff can reach out to their N&PCS Informatics Committee representatives or call N&PCS Informatics at 617-724-3561.



# Certified Nurse Day

## *and the inaugural Jean Ridgway Tienken Certification Scholarship*

—by Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development

On Thursday, March 16, 2017, Nursing & Patient Care Services celebrated national Certified Nurses Day with a special Nursing Grand Rounds. Diane Hanley, RN, president-elect of the American Nurses Association of Massachusetts, spoke on the theoretical and practical perspectives of professionalism and advocacy as outlined in the nursing Code of Ethics, the Nurse of the Future Nursing Core Competencies, and the Magnet Recognition Program. Hanley discussed the importance of nurses mentoring both new and experienced nurses; the role of professional associations in promoting safe, high-quality care; and the need to be informed about health policy. She reviewed several pending bills that will have direct impact on the practice of nursing here in Massachusetts.

Gaurdia Banister, RN, executive director of The Institute for Patient Care, used the occasion to present the inaugural Jean Ridgway Tienken MGH School of Nursing Class of 1945 Certification Scholarship. This new scholarship was created by the Tienken family as a tribute to their late mother. The scholarship will support several nurses each year to be

able to attend certification review courses in their specialty areas in preparation for their certification exams. The inaugural recipients were: Natalia DeMatteo, RN; Brittany Durgin, RN; Jillian Hegarty, RN; Christine Marmen, RN; and Danielle Theriault, RN.

Scholarship criteria center on four qualities that defined Ridgway Tienken's professional life: a commitment to providing extraordinary patient- and family-centered care; a commitment to extraordinary service; caring and compassion; and a well designed plan for self-development.

The Jean Ridgway Tienken MGH School of Nursing Class of 1945 Certification Scholarship will be awarded annually as part of the N&PCS celebration of Certified Nurse Day. The next call for applicants will go out in early December. For more information on certification, go to the professional development page of the Excellence Every Day portal at [http://www.mghpcs.org/eed\\_portal](http://www.mghpcs.org/eed_portal).



Top photo: Diane Hanley, RN, president-elect of the American Nurses Association of Massachusetts, and above: Chisari (right) with scholarship recipients and donor family members.

(Photos by Michelle Rose)

# GI Nurses and Associates Week

—by June Guarente, RN, endoscopy nursing practice specialist, and Janet King, RN, endoscopy staff nurse

Every March, the Society of Gastroenterology Nurses and Associates (SGNA) celebrates GI Nurses and Associates Week. This year, on March 21st, staff in the Endoscopy Unit celebrated with an informational table outside of Eat Street Café.

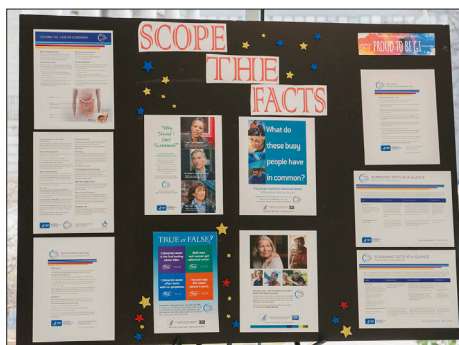
Since March is also Colon Cancer Awareness Month, the Planning Committee chose to focus on this important aspect of GI care with educational materials and posters containing information on colon-cancer screenings and colonos-

copies. Posters displayed pictures of staff in each of the Endoscopy Units: Blake 4; the Charles River Endoscopy Unit; and the Pediatric Endoscopy Suite on Gray 4. An informational video showed a mock endoscopy visit, following a fictional patient from arrival, through the procedure, to discharge.

The Planning Committee was comprised of: Janet King, RN; Deborah Meade, RN; Tiffany Torres, ST; Stephanie Tsacogianis, ST; Ellen Fern, RN; Debbie Shahidi, RN; Alice Sickey, ST; Lori Allen, GIT; and June Guarente, RN.

For more information, call 617-726-3732.

Below (l-r): June Guarente, RN; Heidi Pfeifer, RN; and Tiffany Torres, ST, staff informational booth in the Main Corridor during GI Nurses and Associates Week. Below right: Pfeifer and Torres show their Endoscopy 'pride.'



(Photos by Jeffrey Andree)

# Professional Achievements

## Appointments

### Zary Amirhosseini

Member, Technical Working Group  
Department of Labor  
Washington, DC  
December 15, 2016

### Sarah Keegan Argyropoulos, RN

Board of Directors, Division of  
Gastroenterology  
New England Society of  
Gastroenterology Nurses and  
Associates  
January, 2017

### Ellen Fern, RN

President  
New England Society of  
Gastroenterology Nurses and  
Associates  
January, 2017

### June Guarente, RN

Board of Directors  
New England Regional Society  
of Gastrointestinal Nurses and  
Associates  
January, 2017

### Catherine Holley, RN

Co-Chair, Massachusetts Chapter of  
Lymphatic Education and Research  
Network  
February, 2017

### Linda Kelly, RN

Member, Commonwealth of  
Massachusetts Board of Registration  
in Nursing, Office of the Secretary  
of the Commonwealth  
January, 2017

### Barbara E. Moscovitz, LICSW

Acute Care Advisory Committee,  
Massachusetts Department of  
Public Health, Alzheimer's and  
Related Dementias

### Lynn B. Oertel, RN

Nurse representative for the  
Initiation of Therapy Workgroup  
on Anticoagulation, Task Force  
on Health Policy Statements and  
Systems of Care, American College  
of Cardiology

### Margaret Doyle Settle, RN,

Advisor, Moral Resilience  
Professional Issues Committee  
American Nurses Association  
January, 2017

## Poster Presentations

### Maureen Hemingway, RN

"A Pilot Study to Assess Nurses'  
Attitudes toward Multidisciplinary  
Team Training"  
International Meeting on Simulation  
in Healthcare  
Orlando, Florida

### Leslie Milne, MD

Dawn Williamson, RN  
Rebecca Klug, RN  
Ines Luciani-McGillivray, RN  
Kim Cosetti, RN  
Jane Reardon, RN  
Patricia Mian, RN  
Curtis Wittmann, MD  
William McLaughlin  
Samantha Stoll, MD  
David Peak, MD  
Jason Parente, PA  
Steve McHugh  
Theodore Benzer, MD  
Mary Fran Hughes, RN  
Laura Prager, MD  
"Improved Care of the Impaired  
Patient"  
National Emergency Nurses  
Association  
Los Angeles, September, 2016

## Presentations

### Linda Kane, LCSW

"The Role of Advocate in the  
Emergency Department"  
National Patient Advocacy  
Conference  
Las Vegas,  
December, 2016

### Denise Flaherty, RN

"The Role of Advocate as Human  
Rights Officer"  
National Patient Advocacy  
Conference  
Las Vegas,  
December, 2016

### Daniel D. Yeh, MD

Ellen Robinson, RN  
Brittney Grazio, RN  
Caitlin Laidlaw, LICSW  
Benjamin Hollingsworth, RN  
Kathleen Buckley, RN  
"Challenging Care: Facilitation and  
Expectations of the Family Meeting"  
Second Annual Geritrauma Nursing  
Conference, MGH,  
October, 2016.

### Jessica Driscoll, RN

"Coping with Moderate and Severe  
Chronic Graft-Versus-Host Disease:  
a Qualitative Study"  
American Society for Blood and  
Marrow Transplant Tandem Meetings  
Orlando, Florida,  
February 2017

### Catherine Holley, RN

"Living With Lymphedema: One  
Nurse's Journey as Patient and  
Advocate"  
Lymphatic Education and Research  
Network  
Live Webinar: Symposium Series  
January, 2017

### Catherine Holley, RN

"Lymphedema: My Story"  
Nurse and Medical Professional  
Lymphedema Conference  
Lighthouse Lymphedema Network  
Atlanta, Georgia,  
March, 2017

## Publications

### Cheryl Cirillo, RN

Kim Francis, RN  
"Does Breast Milk Affect Neonatal  
Abstinence Syndrome Severity, the  
Need for Pharmacologic Therapy,  
and Length of Stay for Infants of  
Mothers on Opioid Maintenance  
Therapy During Pregnancy"  
*Advances in Neonatal Care*  
October, 2016

### Paul Arnstein, RN

"Keeping Pain a Priority"  
*Clinician Reviews*  
January, 2017

### Margaret Doyle Settle, RN

Amanda Bulette Coakley, RN  
Christine Donahue Annese, RN  
"Human Milk Management  
Redesign: Improving Quality and  
Safety and Reducing Neonatal  
Intensive Care Nurse Stress"  
*Creating Nursing*, 2017

## Certification

### Marjorie Voltero, RN

GI Endoscopy  
Informatics Nursing  
November, 2016

### Kate Dalzell, RN.

General Medicine  
Addictions Nursing  
October, 2016

### James Ehrlich, RN

Burns & Plastics Unit  
Critical Care Nursing  
February, 2017

### M. Ellen Kinnealey, RN

Perioperative Nursing Informatics  
Informatics  
February, 2017

Ellison 17 nurses:

Elise Burge, RN  
Alyssa Hurley, RN  
Jordan Mikula, RN  
Allison Morris, RN  
Becca Muise, RN  
Erin Tancreti, RN  
Kim Waugh, RN  
Pediatric Nursing

Ellison 18 nurses:

Emily Bombadeiri, RN  
Elizabeth Corrieri, RN  
Joanne Depalma, RN  
Anne Fonseca, RN  
Vira Kou, RN  
Joanne Prendergast, RN  
Pediatric Nursing

(Submit professional achievements to Georgia Peirce at [gwpeirce@partners.org](mailto:gwpeirce@partners.org))



# Announcements

## Blum Center Events

"Skin Cancer and Sun Safety"  
Friday, April 21, 2017  
12:00–1:00pm

Join Shadi Kourosh, MD, to learn more about current research and recommendations on skin cancer screening and prevention.

"Sleeping Better: Help for Long-Term Insomnia"  
Thursday, April 27th  
12:00–1:00pm

Join Kathleen Ulman for a presentation and short video on treatments for insomnia and how to get better sleep.

No registration required.  
All sessions held in the Blum Patient & Family Learning Center.  
For more information, call 4-3823.

## Stand Against Racism

"Healing Racism: Skill-Building through Crucial Conversations," a presentation by Teja Arboleda, multi-media diversity specialist, along with interactive exercises to promote discussion and learning.

The event is sponsored by the Nursing & Patient Care Services Diversity Program in collaboration with the Emergency Department Diversity and Inclusion Committee, the Center for Diversity and Inclusion, MGH Psychiatry Center for Diversity, MGH Executive Committee on Diversity, the Center for Community Health Improvement, the Executive Committee on Community Health, and the Disparities Solutions Center at MGH.

Wednesday, April 26, 2017  
2:00–3:00pm  
O'Keefe Auditorium

For more information, call Deborah Washington, RN, director, N&PCS Diversity Program, at 617-724-7469.

## Advance Care Planning Booth

The N&PCS Ethics in Clinical Practice Committee will sponsor its 17th annual Advance Care Planning Booth with information about advance care planning for patients, visitors, and staff.

Tuesday, April 11, 2017  
8:00am–3:00pm  
Main Corridor

The booth coincides with National Healthcare Decisions Day (NHDD) whose theme this year is, "It always seems too early, until it's too late."

NHDD is a national initiative to try to demystify healthcare decision-making, encourage patients to express their wishes about advance care planning, and increase awareness about respecting those wishes. Information packets will be available with copies of the Massachusetts Health Care Proxy Form, a list of helpful websites, and information about the role of the healthcare proxy and the advanced care planning process.

To learn more, about NHDD, go to: [www.nhdd.com](http://www.nhdd.com).

For more information, contact Cindy Lasala, RN, at 617-643-0481.

## ACLS classes

Two-day certification program

Day one:  
June 12, 2017  
8:00am–3:00pm

Day two:  
June 13, 2017  
8:00am–1:00pm

Re-certification (one-day class):  
April 12, 2017  
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).

## AMMP Scholarship

2017 AMMP  
(Association of Multicultural Members of Partners)  
Scholarship Opportunity

Are you an AMMP member?  
Are you currently in school?

The AMMP scholarship was established as part of AMMP's mission to support the educational goals of members and assist in their pursuit of degrees and training at colleges and universities.

Applications are now being accepted for the 2017 AMMP scholarship.

Applications are available at the Employee Access Center in Bulfinch 107 or on the AMMP website at: <http://AMMP.massgeneral.org>

Review application for eligibility.

For more information, go to the AMMP website at <http://AMMP.massgeneral.org>; or call AMMP Scholarship chair, Sandra Thomas, at 617-643-0140.

Application deadline is Wednesday July, 12, 2017.

## 2017 Staff Perceptions of the Professional Practice Environment Survey

The 2017 Staff Perceptions of the Professional Practice Environment Survey (SPPPE) has been e-mailed to staff in Nursing and Patient Care Services. It will remain in the field through the end of April.

The survey takes approximately 45 minutes to complete and provides leadership with an assessment of organizational characteristics influencing staffs' perceptions of and satisfaction with the MGH professional practice environment.

Survey results are examined by leadership across N&PCS, used to guide strategic planning, and help monitor the impact of changes made to improve professional practice across the work environment.

All survey responses are important. Every voice counts.

All answers are confidential; no individual data will be reported unless agreed to by the participant at the start of the survey. Data from the survey are reported at three organizational levels: N&PCS; discipline-specific; and unit-level. Information shared with leadership will also be discussed with staff in unit and department meetings.

For more information, contact Dorothy Jones, RN, director emerita and senior nurse scientist, Yvonne Munn Center for Nursing Research, at 617-724-9340.

# Inpatient HCAHPS

## Current data

HCAHPS Measure	CY 2015	CY 2016 Year-to-date (as of 3/17/17)	% Point Change
Nurse Communication Composite	83.0%	83.0%	→ 0.0%
Doctor Communication Composite	83.5%	82.6%	↓ -0.9%
Room Clean	72.9%	71.2%	↓ -1.7%
Quiet at Night	50.8%	49.9%	↓ -0.9%
Cleanliness/Quiet Composite	61.8%	60.5%	↓ -1.3%
Staff Responsiveness Composite	65.8%	64.9%	↓ -0.9%
Pain Management Composite	73.1%	72.8%	↓ -0.3%
Communication about Meds Composite	66.6%	65.8%	↓ -0.8%
Care Transitions	62.4%	61.0%	↓ -1.4%
Discharge Information Composite	91.1%	91.9%	↑ 0.8%
Overall Hospital Rating	81.2%	81.9%	↑ 0.7%
Likelihood to Recommend Hospital	90.9%	89.8%	↓ -1.1%

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

Data is complete for calendar year, 2016. Scores for Discharge Information and Overall Hospital Rating exceeded targets, and Nurse Communication met target. All other scores were within two percentage points of targets, most within one percentage point.



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