Caring Headlines
June 22, 2017

Re-designing the OA role

to focus on customer service and better meet unit-based needs

Lunder 7 operations associate, soon to be unit coordinator, Luis Goncalves, helps patient, Donald Fantini, familiarize himself with the call system.

Nursing & Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Partners 2.0

working together across institutions to make health care better for all

As we continue to make strides in this important work, I want to keep you updated on Partners 2.0, the multi-year initiative we've embarked on to make systems and processes throughout Partners HealthCare more integrated and efficient. Every Partners institution is engaged in this work, set against the framework of one common opportunity statement (See below). Health care is at a critical juncture; we have an opportunity to bring about meaningful change, reduce costs, and deliver the kind of seamless, coordinated care our patients and families expect and deserve. Never before have Partners institutions been so aligned in our commitment to:

- communicate and collaborate across the continuum
- act in unity, making decisions to innovate, improve, and secure the system's financial health
- re-invent clinical care to ensure better health, simplicity of systems, and lower costs
- increase the diversity of our workforce
- modernize education for the new generation of clinicians, scientists, and leaders
- accelerate science and discovery to gain greater understanding of human disease, clinical care, and wellness

Having completed an exhaustive review and design process, implementation has begun with the launching of 13 workstreams all focusing on different aspects of the project (Nursing, Health Professions, Research, Supplies, etc.) A central structure is in place to ensure workstreams are coordinated and in sync to achieve short-, medium-, and long-term goals. Each goal is tied to quality, efficiency, and financial deliverables to ensure we meet our most *important* goal of improving care and reducing costs for patients and families.

As I've mentioned in previous columns, the Partners Chief Nurse Council has formed several cross-institutional tiger teams to accelerate implementation of some high-priority initiatives. The Agency Tiger Team has been looking at ways to build on the Bulfinch Temp model to create an

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

Partners 2.0 Opportunity Statement

- Health care has become too complicated, fragmented, uncoordinated, and costly. Our patients and families, and those who care for them, want and deserve better
- We are united in our commitment to improve our entire system, to drive better health, and bring more joy to our work by unleashing the potential of our workforce to deliver compassionate, innovative, equitable, high-quality, more affordable care
- We have unprecedented opportunities and challenges right now because of radical changes in technology, transparency, and the economics of health care. Because of that, we are empowered to do things not previously considered possible
- Partners is uniquely positioned to take advantage of these opportunities with some of the most talented and dedicated people in the world coming together to find and implement solutions
- To become the best possible healthcare system for our patients, we will plan and work together, trusting and sharing as never before

Representatives from Nursing & Patient Care Services are integrally involved with all of this work... Right now, we're focusing on the well-being of our workforce; improving efficiency through increased utilization of technology; fostering collaborative decision making and ease of work flow; and monitoring our outcomes to ensure we're achieving our goals.

in-house Partners agency. The first wave of this work rolled out June 12th with more than 20 Partners in-house agency nurses ready and available to serve.

The Patient Observer Tiger Team has been developing a system-wide, electronic, patient-observer program utilizing new technology that allows a single observer to simultaneously monitor up to eight patients. This technology is now being used at MGH with great success.

The Required Training Tiger Team is looking at ways to standardize and streamline required training across all Partners institutions, focusing primarily on emergency-response programs such as ACLS, PALS, CPR, and BLS.

The Workforce Injury-Reduction Tiger Team is looking at ways to reduce employee injuries and share best practices related to employees returning to work post-injury. The team is also exploring some innovative employee wellness programs.

The Staffing Standards Tiger Team is working to improve the consistency and reliability of productivity metrics, ensuring that all Partners entities use the same categories and sources for data-collection. The team is recommending a Partners-wide conversion to AcuityPlus 2.1.

The Clinical Advisory Tiger Team is working to standardize systems for acquiring clinical supplies and patient-safety technologies, primarily in the inpatient setting.

The Procedural Areas Productivity Model Development Tiger Team is looking at ways to incorporate a productivity model into procedural areas (Perioperative Services, Endoscopy, Cardiology, and Radiology) throughout Partners to standardize productivity targets.

Representatives from Nursing & Patient Care Services are integrally involved with all of this work that will result in higher-quality, more affordable, coordinated care. Right now, we're focusing on the well-being of our workforce; improving efficiency through increased utilization of technology; fostering collaborative decision making and ease of work flow; and monitoring our outcomes to ensure we're achieving our goals. And we'll be refining our Patient Care Delivery Model to ensure it aligns with this new work.

I look forward to a time in the not-too-distant future when all Partners institutions will be working together to provide seamless, coordinated, high-quality care to all our patients and families.

In this Issue

(Photo on page 8 by Paul Batista)

Re-designing the OA role to better meet unit-based needs

—by Mandi Coakley, RN, staff specialist

With implementation of Partners *e*Care in April, 2016, operations associates (OAs) experienced a significant change in their work flow as it was no longer necessary for them to transcribe physician's orders—previously a significant part of their job. This presented a great opportunity for operations associates to take on new work and contribute to the smooth operation of the unit in other ways.

In order to re-design the OA role, a group of nurse leaders came together and conducted focus groups with OAs in the summer of 2016. They looked at a pilot program conducted by nursing director, Suzanne Algeri, RN, on Lunder 7, where OAs had taken the lead on customer service, greeting patients and families as they arrived on the unit. Kapre Jones, Lunder 7 operations associate, explains that OAs walk around the unit, introduce themselves to patients and families, and answer any logistical questions they may have.

Jen Brooks, operations associate on Phillips 22 also rounds every day. Says Brooks, "It gives me an opportunity to get to know patients and family members and make them feel welcome."

Many OAs had expressed an interest in having a greater role in customer service, but it was challenging when so much of their time was spent transcribing physician's orders.

During focus group meetings, OAs shared their thoughts on how they'd like their role to change in a post-*e*Care world. And they suggested changing the job title to better reflect the work they'd be doing. Recommendations that emerged from focus groups included:

- revising the job description to better reflect the work of this role group
- changing the job title to unit coordinator
- adjusting staffing patterns to meet workload needs post-*e*Care implementation
- focusing on enhancing the customer-service aspect of the position

(Photos by Sam Riley)

Below (l-r): operations associates, soon to be unit coordinators, Kapre Jones, Luis Goncalves, and Lina Poum, of Lunder 7. Above, Phillips 22 operations associate, Jen Brooks.

Beginning in July, 2017, unit coordinators (formerly operations associates) will assume a greater customer-service function, greeting people as they enter the unit, helping patients get to their rooms, showing them how the call system works, and circulating throughout the unit to check on patients' needs.

Leaders of the OA group are still actively working to refine the responsibilities of the new role. For more information, contact Mandi Coakley, RN, staff specialist, at 617-726-5334.

Using customized videos to reinforce patient education

—by Chrisanne Sikora, senior project manager, MGPO

A relatively new technology, 'vidscrips' enable caregivers to create customized videos tailored to the needs of their patients. Short videos made by caregivers contain information available for patients to watch at home at their convenience as often as they want.

It has been shown that patients who are more engaged with their care have better outcomes and lower healthcare costs. But more and more, providers are experiencing greater demands on their time, which can limit the amount of time they're able to spend with patients. This can affect the quality and effectiveness of patient-education. In addition to limited face time with providers, many situations call for complex instructions, much of which is forgotten by patients by the time they get home. As a result, they turn to alternative, sometimes less reliable sources of health information.

One solution is to provide clinicians with effective tools for disseminating health information in a way that patients will understand and retain. A relatively new technology, 'vidscrips' enable caregivers to create customized videos tailored to the needs of their patients.

Vidscrips are short videos, made by providers to capture the information they provide in the care settings that patients can then watch at home. They're created using a simple app on your cell phone or other portable device. Vidscrips allow clinicians to convey important, accurate information about frequently discussed topics, and patients have a tangible version of their providers' instructions that they can access at their convenience and view as many times as they want. Content of vidscrips can range from clinical conditions and treatment options (especially high frequency/low variation conditions) to introducing patients to members of their care team.

Videos can be 'prescribed' to patients before, during, or after a clinic visit or inpatient stay. Prescribing a video is as simple as sharing a link to the video via e-mail or text message. In collaboration with the Blum Patient & Family Learning Center, vidscrips can be added to the MGH Patient Education TV Library, offering additional opportunities to provide information to patients in the inpatient setting.

Any member of the care team can make a vidscrip at no cost. The Department of Surgery recently utilized vidscrips to create a colorectal surgery 'video bundle' with instructions on preparing for surgery and post-surgical ileostomy care. The hope is that these videos will improve adherence to post-surgical instructions and reduce surgical-site infections. The ileostomy care videos were among the first vidscrips added to the inpatient TV library.

For more information or to view the catalogue of videos made at MGH, go to vidscrip.com/massgeneral. For information on how to create your own videos, contact Chrisanne Sikora, senior project manager, MGPO, at 617-643-0170.

The Professional Learning Environment surveys

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

Staff of the Knight Nursing Center have begun forming educational planning committees to address the learning needs identified in the survey.

The Professional Learning Environment for Nurses (PLEN) survey is a tool designed in 2010 by The Norman Knight Nursing Center for Clinical & Professional Development and the Continuing Education Redesign Task Force. PLEN was designed to assess the learning needs of all nurses (including patient care associates) at all levels throughout the organization. Since 2010, the survey has undergone modifications, including reducing the amount of time required to complete the survey, revising or eliminating items to be more representative of the environment, and trying to ask consistent questions across nursing, advanced practice nursing, and patient care associate role groups while respecting the uniqueness of each group.

Many of the items from the 2015 PLEN survey, such as peer feedback, professional-development planning, testing skills for certification exams, compassion fatigue, components of a good handover (I-PASS), alarm response, and substance use disorders have not changed. This consistency allows for a valid comparison between 2015 and 2017 surveys. The 2017 survey also included new questions on preferred learning methods, diversity and inclusion, and caring for patients with sepsis.

All surveys were conducted on-line. Participants were informed that the survey was confidential, and that only aggregate data would be reported. The survey utilized a 5-point Likert scale to rate how prepared respondents felt about a particular subject/topic (or in the case of advanced practice nurses, how important the topic was to individual

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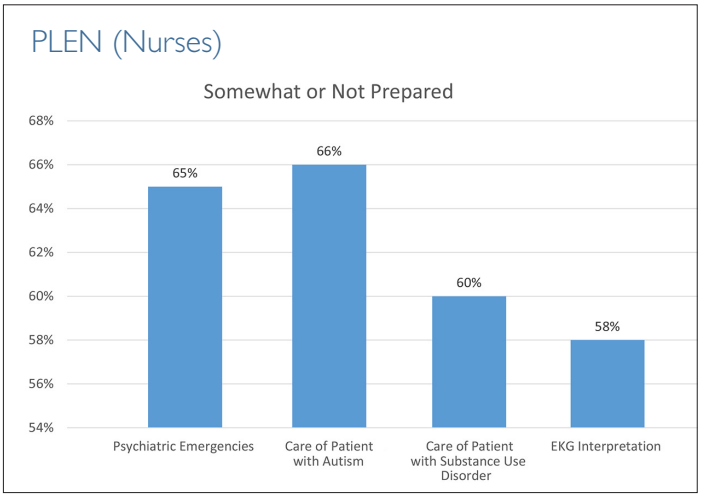
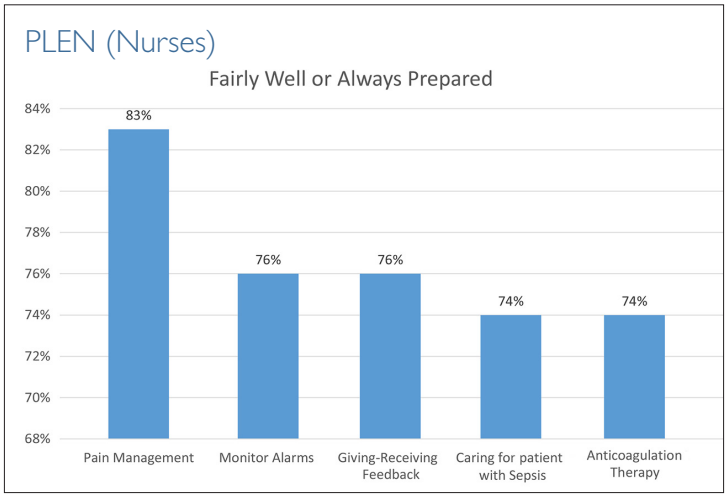




professional-development plans). Diversity and inclusion questions used a 5-point Likert scale to indicate strongly disagree to strongly agree.

The surveys were intended to:

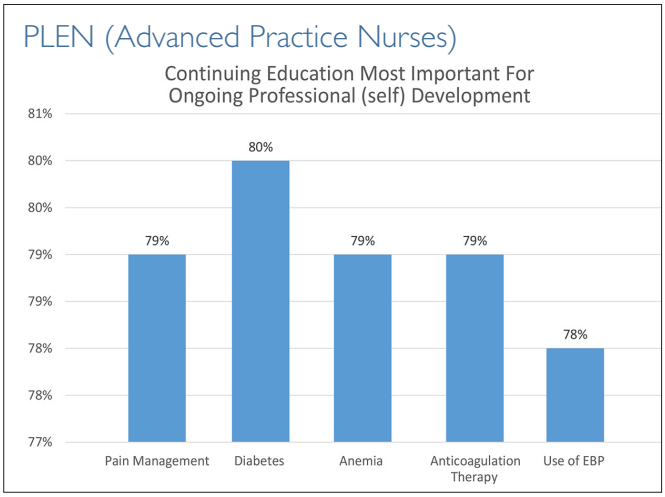
- determine the perceived learning needs of participants
- identify the best methods of meeting the knowledge, skill, and practice gaps of participants

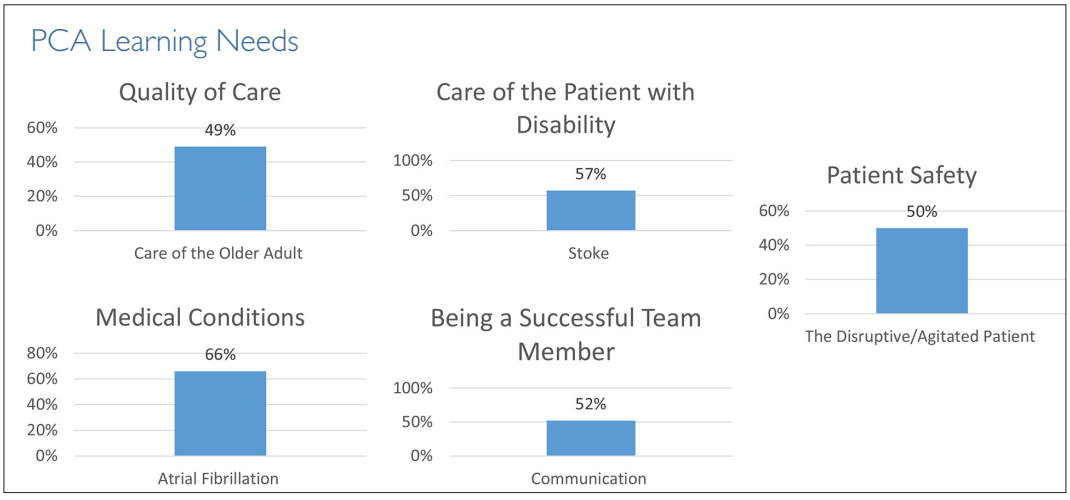
The nurses survey was sent electronically to 4,185 nurses with 1,004 nurses responding, a response rate of 25%. The advanced practice nurses survey was sent to 656 advanced practice nurses, including nurse practitioners, nurse anesthetists, nurse midwives, and psychiatric clinical nurse specialists. 159 advanced practice nurses responded for an overall response rate of 24%. PCA surveys were sent to 640 patient care associates with 239 respondents, a response rate of or 37%. Demographic data from the PCA survey showed that 21.7% of respondents held a bachelor's degree or higher. 9.2% were enrolled in a college or university and 29.7% of those were majoring in Nursing.

The majority of nurses and patient care associates worked on inpatient, general care units, compared to the majority of advanced practice nurses who worked in an outpatient or ambulatory setting. All role groups preferred educational activities between 1-4 hours long using a blended model and offered on Tuesdays, Wednesdays, or Thursdays. Nurses and advanced practice nurses preferred sessions in the morning, while patient care associates preferred afternoon sessions.

In response to the PLEN data, staff of the Knight Nursing Center have begun forming educational planning committees to address the learning needs identified in the survey. The center will reach out to the MGH community for subject matter experts and volunteers representative of the intended audiences to join these committees. The team will identify and design educational offerings using new technology and other innovative methodology while respecting the diversity of preferred learning styles. The Knight Center is currently planning several conference-style, full-day events, interactive workshops, and a revised Skills Day.

For more information go to: www.mghpcs.org/knightcenter. The Knight Nursing Center team would like to thank nurses and patient care associates for their participation in the PLEN survey. For more information about the survey or upcoming educational offerings, call the Knight Center at 617-726-3111.





Graphs represent role-specific data for nurses, advanced practice nurses, and patient care associates from the Professional Learning Environment surveys.

Dialysis patient benefits from the care and expertise of experienced nurse

Mr. P was an 82-year-old man who was about to start hemodialysis for volume-overload that had been unresponsive to diuretics. His renal failure was due to a condition where the filtration components of the kidney are scarred.

My name is Mary Boisse, and I'm a nurse on the Bigelow 10 Hemodialysis Unit. Mr. P was an 82-year-old man who was about to start hemodialysis for volume-overload that had been unresponsive to diuretics. His renal failure was due to focal segmental glomerulosclerosis, a condition where the filtration components of the kidney are scarred. Despite this condition and a history of coronary artery disease, Mr. P led an active life.

On his first visit, Mr. P was accompanied by his wife and children. He told me he was anxious about starting treatment and had put it off as long as he could. It's not unusual for patients to react this way; dialysis makes the diagnosis of renal failure real, and it has a tangible impact on their daily routines. I tried to allay Mr. P's fears by asking him and his family to tell me what they knew about dialysis and what their concerns were. Knowing the patient and family's understanding of the situation allows me to meet them where they are and honestly address their concerns. It's also a good way to build trust.

Mr. P had many concerns. He thought that once he started dialysis he wouldn't be able to change his mind and discontinue treatment if he found it negatively impacted his quality of life. I assured him that if he changed his mind, he could discontinue treatment at any time, and we'd continue to support him throughout the process.

Mary Boisse, RN, hemodialysis staff nurse

I verified that Mr. P had a healthcare proxy (his wife) and encouraged him to express his wishes to her. I explained that most patients are able to live a high-quality, independent life as they adjust to dialysis treatment. I assured him that I appreciated how scary this was, but I was there to help them adjust to this 'new normal.' I encouraged them all to ask whatever questions they had, as it was clear Mr. P's wife and children wanted to help their husband/father as much as possible.

Before initiating treatment, I spent some time explaining the basics of hemodialysis—it was a painless procedure, the machines had many safety features, and there would be 'beeps and buzzes' coming from the machines, which didn't necessarily mean anything was wrong. I told him I'd be with him throughout the whole session, monitoring how he was responding both physically and emotionally to the process. Given that this was a new experience for Mr. P and his family, I let them know that many patients on dialysis pass the time by napping, watching TV, talking on the phone, or using their laptops during treatment.

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Prior to Mr. P starting at the outpatient clinic, I spoke with the nursing staff there about his treatment plan and emotional needs. I arranged for him to visit the clinic, meet the staff, and familiarize himself with the new setting... On one return visit, Mr. P told me he felt safe at the clinic. He'd made friends with some of the other patients and was now able to drive himself to treatments.

Although a lot of patient-education is required when someone starts dialysis for the first time, I've found that providing too *much* information can be overwhelming, resulting in anxiety and/or an inability to retain the information. I was careful not to give Mr. P and his family too much information all at once. Using the teach-back approach and allowing time for follow-up questions, I knew that Mr. P was absorbing and retaining the information, and it was okay to continue.

Upon initiating dialysis, Mr. P experienced several setbacks. He had an arteriovenous fistula, and although it was two years old, it was still fragile so he experienced some infiltration. I discussed this with the nephrologists and recommended that a fistulagram be performed (a form of X-ray to look at blood flow), which ultimately resulted in our using a more developed fistula that was easier to cannulate. It also helped relieve Mr. P's anxiety about needing multiple needle sticks.

Mr. P also experienced some chest pain and low blood pressures with treatments making much-needed fluid-removal difficult. I obtained an order from the nephrologist to initiate treatments with 5% albumin for blood-pressure support. I programmed the dialysis machine to remove a minimal amount of fluid at the outset and increase volume slowly throughout the treatment, a process called fluid profiling. Oxygen was administered at initiation of the treatment, which helped prevent chest pain and resulted in a more hemodynamically stable treatment. Once we optimized his fluid balance with dialysis, Mr. P would be able to resume an active lifestyle without shortness of breath or chest pain.

I always tried to position Mr. P so he'd be as comfortable as possible for his treatments. I consulted with the unit social worker to assist him and his family in adjusting to this change in their lives. I think Mr. P's anxiety was greatly reduced by having one consistent caregiver; it allowed him to express his feelings more openly, and we had a good rapport as I explained various procedures and answered his questions.

Once Mr. P stabilized on hemodialysis, he was transferred to an outpatient unit close to his home. While transitioning from an inpatient unit to an outpatient setting is a positive step, many patients come to know and trust their caregivers and appreciate the safety and familiarity of an inpatient unit, so it can be stressful to once again face the unknown. Patients often wonder: Will they be able to take care for me? What if something happens? They don't know me.

Understanding that this is a common fear, right from the beginning, I reinforced with Mr. P that our goal was to get him back to his normal way life (as much as possible). That meant getting him strong enough so that he could continue his treatments at an outpatient facility and not have to commute into Boston multiple times a week. It also meant ensuring the outpatient clinic could safely and compassionately care for Mr. P and his family. Knowing that that was the plan right from the outset helped Mr. P and his family prepare for the time when he'd be ready to transition his care.

I knew Mr. P valued his independence, so I notified Social Service to assist in finding transportation so he wouldn't have to depend on family members for rides to his treatments. He was grateful not to be a "burden on his family."

Prior to Mr. P starting at the outpatient clinic, I spoke with the nursing staff there about his treatment plan and emotional needs. I arranged for him to visit the clinic, meet the staff, and familiarize himself with the new setting. I knew it would help relieve his anxieties about leaving MGH.

On one return visit, Mr. P told me he felt safe at the clinic. He'd made friends with some of the other patients and was now able to drive himself to treatments. With his volume-overload resolved, Mr. P was able to resume many of the activities he enjoyed prior to starting dialysis. He thanked me for helping him manage his anxiety and advocating for him during a very stressful time in his life.

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

Caregivers know that illness affects the whole family, not just the patient. Mary recognized the lack of control Mr. P and his family felt. Through education and her presence, she helped them move beyond the disruptive aspects of dialysis to how they could all lead full lives. This narrative demonstrates a high level of critical thinking, engagement, and compassion. Mr. P was fortunate to have Mary as his nurse for his introduction to dialysis.

Thank-you, Mary.

Annual Advance Care Planning Information Booth

—by Gail Alexander, RN; Cynthia LaSala, RN; and Tara Logan, RN,
for the Ethics in Clinical Practice Committee

On April 11, 2017, the PCS Ethics in Clinical Practice Committee hosted its 17th annual Advance Care Planning Information Booth for patients, visitors, and staff. National Healthcare Decisions Day (held annually on April 16th) is an initiative to encourage patients to express their wishes regarding health care and urge providers and facilities to respect those wishes, whatever they may be. A proclamation from Governor Baker reinforced the importance of advance care planning as an essential part of patient care.

The booth is held each year to raise awareness about advance care planning. Committee champions provided consultation and a variety of resources, including copies of the Massachusetts Health Care Proxy and Medical Orders for Life Sustaining Treatment (MOLST), a medical order intended to communicate a patient's treatment preferences across all care settings. The MOLST form can be completed for patients of any age at any stage of illness to state their preferences for life-sustaining treatments such as CPR, dialysis, or the insertion of breathing tubes.

Sample copies of the Massachusetts Health Care Proxy form and Five Wishes, another advance directive form, were available.

Successful advance care planning often starts with a single conversation. The Advance Care Planning Booth gives visitors, patients, and staff an opportunity to begin that conversation with a caring and knowledgeable healthcare professional.

The MGH patient-education document, Planning in Advance for Your Health Care, is available in English and Spanish on inpatient units (order #84669). To obtain a copy, visit the Blum Patient & Family Learning Center. The document can be accessed electronically in the Partners Handbook, PCOI (Primary Care Office InSite), or in the Patient Instruction section of the patient's medical record. This valuable resource was produced by the PCS Ethics in Clinical Practice Committee and the Blum Patient & Family Learning Center.

Five Wishes forms can be obtained in the Blum Patient & Family Learning Center, or on-line at: www.agingwithdignity.org.

To obtain information about MOLST, visit www.molst-ma.org.

To download a copy of the Massachusetts Health Care Proxy form (in English and other languages), go to: Partners Applications>PCS Clinical Resources>Health Care Proxy forms.

For more information about advance care planning, contact Cynthia LaSala, RN, advisor, PCS Ethics in Clinical Practice Committee, at 617-724-6010 or the Blum Patient & Family Learning Center, at 617-724-4410.

Staffing the April 11th Advance Care Planning Educational Booth are Jennifer Alvis, RN (in pink); Brian Cyr, RN; and Lee-Ann L'Heureux, RN.

Clinical recognition programs vs. clinical ladders

While clinical-recognition and clinical-ladder programs are both advancement programs they operate very differently. A clinical recognition program recognizes clinicians based on their practice over a period of time. A clinical ladder looks at past achievement to determine future advancement.

Question: Why is a clinical recognition program important at MGH?

Jeanette: In the past, being recognized, financially and/or organizationally, for excellent clinical practice, usually meant the clinician had to move away from the bedside. We realized that if we wanted to help clinicians advance their professional development without leaving the bedside, we needed to create a clinical recognition and awards program to celebrate that development.

Question: What's the difference between a clinical recognition program and a clinical ladder?

Jeanette: While clinical-recognition and clinical-ladder programs are both advancement programs they operate very differently. A clinical recognition program recognizes clinicians based on their practice over a period of time. A clinical ladder looks at past achievement to determine future advancement.

Question: How does a clinical recognition program work?

Jeanette: According to the literature, most clinical recognition programs in nursing are based on Hubert and Stuart Dreyfus' Model of Skill Acquisition, which was adapted and applied to nursing by Patricia Benner. Skill acquisition refers to how one develops from advanced beginner (new graduate) to expert. Our PCS Clinical Recognition Program uses Benner's approach of reviewing narratives that describe how clinicians think and how their decision-making drives their practice.

Question: How does a clinical ladder work?

Jeanette: Clinical ladders usually use a point system where applicants engage in a number of professional activities (such as attending conferences or educational programs, participating on committees, earning certification, etc.) each of which is worth a certain number of points that lead to advancement. The belief is that by engaging in these activities the clinician will acquire the knowledge and skill necessary to practice at the next level.

Question: Why did Patient Care Services choose a clinical recognition program rather than a clinical ladder?

Jeanette: Patient Care Services has a history of using narratives as a tool for reflection and professional development. We also have a relationship with Patricia Benner, so building a program on clinical reflection through the use of narratives was a natural fit. We know that expertise comes from both theory (educational programs, certification, etc.) and clinical practice, so using a model that focuses only on one wouldn't truly reflect clinical excellence.

For more information, go to: http://www.mghpcs.org/ipc/programs/Recognition/Index.asp, or call Mary Ellin Smith, RN, professional development manager, at 617-724-5801.

Remembering Yvonne L. Munn, RN

"Yvonne was proud when we became a Magnet hospital; she loved that Nursing & Patient Care Services had a strong voice in the institution; and she was incredibly honored to have her name on our nursing research program."

The MGH community was saddened to learn of the passing of Yvonne L. Munn, RN, a beloved member of the MGH family and a pioneer in nursing and nursing research. Munn died May 21, 2017, at the age of 88. She served as associate general director and director of Nursing at MGH from 1984 to 1993, and in 2008, helped establish the Yvonne L. Munn Center for Nursing Research.

A native of Edmonton, Canada, Munn's nursing career spanned more than four decades and included positions at the Edmonton General School of Nursing, Medicine Hat General Hospital in Alberta, Sharp Memorial Hospital in San Diego, and Presbyterian-St. Luke's Hospital in Chicago. Prior to coming to MGH, she served as vice president of several divisions at Methodist Hospitals of Dallas.

Munn was passionate about fostering collaboration among nurses at all levels of practice. One of the hallmarks of her career was the support and encouragement she provided to advance nursing research before nursing research was fashionable. She believed, "If you begin to ask questions about your own practice—every aspect of it—and you don't like the answers, study it, change it. That's what research is."

The Yvonne L. Munn Center for Nursing Research supports an impressive inventory of research-related programs and activities that allows nurses at all levels of practice to engage in studies of consequence to them, to the profession of nursing, and to health care at large.

Yvonne L. Munn, RN, associate general director of Nursing from 1984-1993.

Said senior vice president for Nursing & Patient Care Services, Jeanette Ives Erickson, RN, "It's fitting that we celebrated Nursing Research Day this year with 45 nursing research posters and honored two nurses and mentors with Yvonne L. Munn Nursing Research Awards. I know Yvonne would be thrilled to see her dream realized through the work of these dedicated nurses.

"And on a personal note, I will be forever grateful to Yvonne for always checking in with me to share how pleased she was about the work we were doing. She was proud when we became a Magnet hospital; she loved that Nursing & Patient Care Services had a strong voice in the institution; and she was incredibly honored to have her name on our nursing research program. Her legacy will live on in this important work."

Announcements

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

See 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.

Office Ergonomic Champion Program

Interested in learning how to make yourself or your co-workers more comfortable at the computer? Ever wonder whether a sit-stand workstation might be a good option?

Join us for the Ergonomics Champion Program

Friday, July 14, 2017
9:00am–12:00pm
Yawkey 2-230

Presented by Aaron R. Ross, ergonomics specialist, Occupational Health Ergonomics Program
Register on HealthStream

For more information, call 617-726-2217.

Call for nominations

The 2017 Brian A. McGovern, MD Award

The MGPO is now accepting nominations for the 2017 McGovern Award for Clinical Excellence. Nominate a physician who is patient-focused, a superb clinical role model, and considered an 'unsung hero.' Physicians in good standing in every clinical department are eligible to be nominated.

Anyone associated with MGH can nominate a physician, including attending and trainee physicians, nurses, other employees, volunteers, students, and patients.

Nominations are due by July 17, 2017.

To submit a nomination, go to https://mgpo.massgeneral.org/mcgovern/, or e-mail project specialist, Emma Leestma.

For more information, call 617-724-7337.

Post-Graduate Trainees: Future Academic Clinician-Educators

Applications are now being accepted for this three-day intensive program geared to post-graduate trainees (residents and fellows) seeking to enhance their skills as future academic clinician-educators. The course focuses on two major themes: Skills in Teaching and Learning; and Developing Scholarship in Medical Education.

Scholars are asked to apply with a medical-education project in mind that would benefit their current or future training program. Program is co-sponsored by MGH Institute of Health Professions, Harvard Macy Institute, Boston Children's Hospital, and the Icahn School of Medicine at Mount Sinai.

December 9–11, 2017
MGH Institute of Health Professions
Charlestown Navy Yard

Deadline to apply is June 30, 2017. Learn more and apply at: harvardmacy.org/index.php/hmi-courses/pgme

For more information, e-mail: cpd@mghihp.edu, or call: 617-724-6674.

ACLS classes

Two-day certification program

Day one:
July 13, 2017
8:00am–3:00pm

Day two:
July 14, 2017
8:00am–1:00pm

Re-certification (one-day class):
August 9, 2017
5:30–10:30pm

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

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

Nursing student emulates qualities of experienced practitioners

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, Sarah Mularz.

The wisdom of a veteran doctor

As our day on the postpartum unit was wrapping up, my clinical instructor asked if another classmate and I would like to observe a circumcision. It was our last day on this rotation, and I was excited to witness the procedure. As she escorted us into the nursery, I was drawn in by the scene in front of me. A baby lay under a warmer with his legs in padded stirrups to keep him from moving. He was exposed from the waist down and had a blanket over his belly. He wore a small hat and was alternately sucking on a pacifier and drifting in and out of sleep. He looked absolutely peaceful.

The doctor performing the surgery was standing in front of the baby and motioned for us to come closer. In a calming voice that had a hint of a South American accent, she walked us through the procedure she was about to perform and asked us a number of questions. Before she started, she put some music on her iPhone at a low volume and placed it in the crib beside the baby's head.

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"Music helps calm the baby," she said. "It distracts him." She set up the sterile field and began the procedure. She pinched the baby's skin at the base of his penis and injected an anesthetizing mixture subcutaneously. "See," she said. "He didn't even stir. The pinch distracts him from the pain." She made three more injections around the base of the penis. As we waited for the lidocaine to take effect, she talked about the risks of painful circumcisions and the effect that pain memory can have later in life (i.e., fear of needles when the child is older). She talked about the risk of infection and the importance of teaching parents to wash their hands before changing diapers.

Sarah Mularz, nursing student

After a while, the doctor placed a clamp on one side of the baby's foreskin to check for pain. Again, the baby appeared calm and comfortable. With the area numb, she gently began the procedure. At one point, a healthy arc of urine escaped the baby and sprayed all over her. She laughed.

"A baby's urine is sterile for the first couple days of life," she said. She waited until he was done peeing, then picked up where she left off. Nothing fazed her.

I was grateful for the opportunity to observe this doctor who was so professional, so unflappable, and so full of wisdom—all qualities I hope to embody when I become a nurse.

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Sometimes you just need a nurse

It was my first time watching a circumcision and as a student nurse, I was completely enthralled with the procedure. The baby was calm and content under the warmer as the doctor worked; and the doctor herself had a composed demeanor that every new clinician should aspire to. I was absolutely fascinated.

When the doctor was about half-way through the procedure, I was shocked to find myself feeling a bit dizzy. I blinked a couple times to steady myself as I tried to pay attention. But I couldn't shake that light-headed feeling. I excused myself, sat in a chair nearby, and put my head between my legs.

The doctor asked, "Are you okay?"

Embarrassed and not wanting to distract her, I said I was fine, hoping I hadn't drawn attention from the procedure.

One of the nurses in the room brought me some water and asked if I needed anything. Everyone was so kind to me, but all I could think was how much I wanted to shake this feeling so I could continue watching and listening. I tried to focus on my breathing to calm myself, but my body was having none of it. I was wearing light-weight scrubs but it felt so hot in there. I asked one of the nurses to escort me to the nurses' station.

I sat down and tried to re-group. But I guess I didn't look so good because the nurses at the nurses station took one look at me and became very concerned. They brought me juice and crackers and started telling stories to make me feel better.

The nurse I'd been working with said, "It happens to the best of us. It happened to me my first time."

The nursing director laughed and said, "I don't think I ever told anyone here this story, but the first time I saw a baby being born, I fainted." She recalled how she'd been comforting a woman giving birth, and just as the doctor asked the woman to give a good push, she lost consciousness and fell to the floor. "Thank God I didn't fall on top of that poor woman!" she said.

I found myself laughing and grateful for their compassion. It was so kind of them to share their experiences with me to try to make me feel better. I secretly hoped that one day I'd work with nurses as kind and compassionate as they were.

Between the doctor's wisdom and the nurse's kindness, humility, and compassion, that circumcision was one hell of a learning experience.

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

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Inpatient HCAHPS

Current data

HCAHPS Measure	CY 2016	CY 2017 Year-to-date (as of 5/29/17)	% Point Change
Nurse Communication Composite	83.0%	84.3%	↑ 1.4
Doctor Communication Composite	82.6%	84.5%	↑ 1.9
Room Clean	71.2%	72.0%	↑ 0.8
Quiet at Night	49.9%	53.0%	↑ 3.1
Cleanliness/Quiet Composite	60.5%	62.5%	↑ 2.0
Staff Responsiveness Composite	64.9%	67.0%	↑ 2.0
Pain Management Composite	72.8%	74.0%	↑ 1.3
Communication about Meds Composite	65.8%	66.4%	↑ 0.6
Care Transitions	61.0%	61.4%	↑ 0.4
Discharge Information Composite	91.9%	93.0%	↑ 1.2
Overall Hospital Rating	81.9%	82.9%	↑ 1.0
Likelihood to Recommend Hospital	89.8%	91.1%	↑ 1.3

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

2017 data is complete through the end of March; with partial data through May. All scores to date remain higher than those for 2016. We're on track to achieve targets in Quiet at Night and Staff Responsiveness.

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