

Caring

Headlines

March 16, 2017

Dobrodosli

أهلاً وسهلاً

Karibuni

Soo dhowaada

Bienvenue

歡迎

Byenveni

Welcome

Bienvenido

Hosgeldiniz

Hoan nghênh

Sa dhowaada

Bemvindo

Добро пожаловать

Benvenuti

خوش آمدید

We are a better organization *because of our diversity,* not in spite of it



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

For more than
two centuries, our
hospital has been
a safe haven for
patients from all
over the world.
We don't ask what
country they're
from—we ask
what's wrong with
them and how we
can help.

In the weeks since President Trump imposed his controversial executive order banning travel from seven predominantly Muslim countries, many MGH employees have expressed concern, dismay, and fear over potential consequences. While the constitutionality of the executive order is still being debated, I can assure you that within the walls of this hospital, *all people are welcome*.

For more than two centuries, our hospital has been a safe haven for patients from all over the world. We don't ask what country they're from—we ask what's wrong with them and how we can help. Students and clinicians of all backgrounds and nationalities come to MGH for training. We don't ask what religion they are—we welcome them to our hospital and share our knowledge, ingenuity, and values. And each time we open our doors to a visitor from another land, we get something in return. We expand our horizons, gain greater understanding of other cultures, and forge relationships that help edify future generations of caregivers. We are a better organization *because of* our diversity, not in spite of it.

It's troubling when any member of our community feels threatened or unsafe. I know many of our patients and colleagues worry about the lack of clarity and potential ramifications of the executive order. We're seeing an unprecedented number of

questions about deportation, hate crimes, and our stance regarding patients not wanting to be cared for by practitioners of certain races or ethnicities.

This is a complex, sensitive, unfolding situation. We're in the process of developing guidelines to help staff manage various scenarios they may encounter. A draft of those guidelines was brought to the hospital's Diversity & Inclusion Committee, and we're working to finalize that document as soon as possible. Guidelines will include recommendations on how to respond if a patient acts in a discriminatory fashion toward any member of the MGH workforce, what to do if you witness inappropriate behavior or interactions, and how best to comfort or reassure anxious patients and family members.

Employees, patients, and families should know that it is not our practice to accommodate requests to switch providers when those requests are based

continued on next page

We cannot let the current political climate give legitimacy to fear and prejudice. We must be visible in our support of diversity and inclusion... Thank-you to Colleen Gillen and every MGH employee who stands against prejudice, who walks the talk and lives those values every day.

solely on the provider’s race, ethnicity, religion, sexual orientation, gender-identity, or any other personal characteristics. To do so would only reinforce the fear and prejudice that leads to that kind of thinking in the first place.

It’s also not our policy to proactively report information related to a patient’s immigration status to any government agencies. We take the care and privacy of our patients very seriously. All MGH patients are treated with dignity, respect, and strict adherence to privacy and confidentiality policies.

I would never ask an MGH employee to put him/herself in harm’s way. At the same time, it’s imperative that we speak up for what’s right. I was so proud and impressed by the actions of physical therapist, Colleen Gillen, when she heard offensive comments being directed to a group of non-English speaking visitors in our Eat Street Café. She quickly interceded, making it clear that the remarks were inappropriate and

would not be tolerated at MGH. Police & Security were notified to help diffuse the situation. I applaud Colleen for intervening in such a professional manner to defend her own values and those of this hospital.

We cannot let the current political climate give legitimacy to fear and prejudice. We must be visible

in our support of diversity and inclusion. We’re currently updating many of our hospital policies and documents to strengthen the message of zero tolerance for any form of discriminatory behavior, and we’ll be introducing signage and tent cards to ensure the message is widely disseminated.

I feel fortunate to be part of an organization that embraces diversity, celebrates differences, and welcomes

people of all cultures and backgrounds. Thank-you to Colleen Gillen and every MGH employee who stands against prejudice, who walks the talk and lives those values every day.

Diversity

At MGH, diversity means recognizing, accepting, and respecting each person's unique differences in race, ethnicity, gender, sexual orientation, socio-economic status, age, physical ability, religious and political beliefs, and other ideologies.

It's the exploration of these differences in a safe and nurturing environment.

It's moving beyond tolerance to embrace and celebrate the many differences that make us all who we are.

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Protecting patients at risk for suicide

Tiger Team creates Suicide Prevention Checklist

—by Debra Frost RN, staff specialist, and Colleen Snyderman, RN, director, NPCS Office of Quality & Safety

Suicide is the tenth leading cause of death and the second among persons 15-34 years old in the United States. Because of the high incidence of suicide across the country, the Joint Commission issued a Sentinel Event Alert with recommendations for the assessment and treatment of patients who present with suicidal ideation.

According to the National Institute of Mental Health, the majority of people who die by suicide receive healthcare services some time in the year prior to their deaths. It's imperative that patients be screened for suicide risk during healthcare encounters, and that immediate action be taken when a patient is deemed at risk for acting on suicidal intentions.

An inter-disciplinary Suicide Prevention Tiger Team (SPTT) was established following a rise in attempted suicides. The team consisted of representatives from Nursing, Psychiatry, Quality, Compliance, nurse

practitioners, and education and informatics specialists. The team assessed root causes and analyzed processes related to the care of this vulnerable patient population. Their efforts culminated with the creation of the Suicide Prevention Checklist (see opposite page) to aid staff in determining appropriate actions, identifying and eliminating potential hazards in the environment, safety monitoring, discharge teaching, and what to do in the event of an emergency. The Suicide Prevention Checklist was created for the inpatient, behavioral health, Emergency Department, and ambulatory care settings.

A comprehensive improvement plan has been developed. The Care of the Patient at Risk for Suicide: Policy and Practice reviews:

- Suicide Precautions Protocol Order Set
- Suicide Prevention Checklists to aid in assessment of a safe environment
- Patient and family educational resources, including the Suicide Hotline number

For more information on suicide prevention or the work of the Suicide Prevention Tiger Team, contact Colleen Snyderman, RN, director, NPCS Office of Quality & Safety, at 617-643-0435.

Suicide Risk Factors

- Psychiatric disorders
- Previous suicide attempts
- History of trauma or loss
- Serious illness/physical impairment
- Chronic pain
- Substance abuse
- Social isolation
- Aggressive or anti-social behavior
- Recent discharge from inpatient psychiatric care
- Access to lethal means coupled with suicidal thoughts, plans, or intent

Care of patients on suicide precautions (inpatient)

ELEMENTS	
Initial Actions	Notes
Order the suicide precaution bundle (any prescriber can order)	
* Psychiatry consult: history and suicide risk	
* 1:1 observation (family cannot act as observers)	
* Place patient in safe pajamas (no ties)	
* Social worker consult, if needed/recommended	
Safety Monitoring	Notes
Do not leave patient unattended at any time (including in bathroom and/or shower), patient must be in sight	
Alert clinical staff if unable to visualize patient and/or patient attempts to hurt self or flee	
Patient room signage — “Check with Nurse Before Entering”	
Check any items brought in by visitors and communicate those items must be taken home. For illegal items (weapons, illegal drugs, etc.), call Police & Security.	
* Patient restricted to unit. If patient requires medical care that cannot be provided on unit, staff members accompany patients and provide constant observation. Bring hospital phone for emergency communication. Receiving area notified patient is on suicide precautions.	
Environmental Monitoring	
* Search belongings in the presence of Police & Security. Remove environmental hazards which may include:	
• scissors/pill cutters	
• hospital gloves	
• plastic bags (including trash and patient belongings bags)	
• IV poles, bags and tubing not in use	
• electrical cords\telemetry wires	
• headphones	
• extra sheets, towels and tie pajamas	
• anything small enough to swallow, e.g. paper clips, pin tack, toothpaste	
• medical equipment/supplies that may pose risk	
• sharps box	
• glass and vases	
• pens and pencils	
* use paper dietary trays and items only, no cans, metal utensils, plastic cups, plastic lids, or breakable dishes. Count plastic utensils before and after use	
• scan environment around patient and continue to remove any new risks	
• If able, provide a private room and do not place patient's room near exit	
Discharge Information	Notes
Use discharge teaching/education documents (suicide thoughts) found in EPIC for patient and family	
Patient may not be discharged, including AMA, unless suicide precautions are discontinued	
Emergency Management of Patient Attempting Harm	Notes
DO NOT PLACE SELF AT RISK, wait for Police & Security to intervene with patient	
Call for “HELP” press panic button at bedside, page Dr. Johnson and/or call Security 6-2121, and page patient’s MD and Psych consult MD	
If patient is trying to leave, do not block patient but try to keep patient in sight. DO NOT PUT HANDS ON PATIENT	
Do not attempt to remove dangerous items from patient (weapons)	
Remove other patients from area, if able	
* Elements included in suicide order set	

Attending nurse brings consistency, compassion to continuum of care

Rob was a 33-year-old man transferred to MGH from an outside hospital... From the tone of report, it was clear the team had doubts whether Rob could survive the two procedures necessary to stabilize him.

My name is Sarah Ballard Molway, and I am an attending nurse on the Ellison 19 Thoracic Care Unit. As an attending nurse, being present to patients is the cornerstone of my practice. I round with the Thoracic Surgery team every morning, and often I learn about patients in the ICU long before they come to our unit. Knowing their hospital course prior to arrival helps me anticipate their care needs upon transfer.

Rob was a 33-year-old man transferred to MGH from an outside hospital. His admission was memorable because his overnight arrival disrupted morning rounds. He was very sick. He had an esophageal perforation related to bleeding esophageal varices (enlarged veins in the esophagus) due to cirrhosis. From the tone of report, it was clear the team had doubts whether Rob could survive the two procedures necessary to stabilize him—a transjugular intrahepatic portosystemic shunt and an esophagectomy to remove the perforated portion of his esophagus. Fortunately, he did make it through surgery, and after a week in the ICU was transferred to Ellison 19.

Rob was a delight to take care of. He was upbeat and positive, eager to do whatever he could to get better. He never refused an offer to get out of bed or go for a walk despite multiple drains and tubes, including chest tubes, feeding tubes, a nasogastric tube, and a urinary catheter. He rejoiced at every little victory, like having a tube removed, taking his first sips of water, or tasting a popsicle.



Sarah Ballard Molway, RN, attending nurse

Rob talked about his family, particularly his young nephew and fiancée. He lived out of state, but his parents dropped everything to come to Boston when he was transferred to MGH. They were a constant presence on the unit. Because of my regular schedule during the week, I see patients and families throughout their stay. I made a point of interacting with Rob and his parents regularly to ensure they felt supported. I helped them interpret medical information. I requested a social work consult because I knew they were dealing with Rob's illness far from their home and support network. Sometimes our interactions were clinically focused, but often they were social or supportive in nature. Rob and his parents knew they could seek me out for help, and I was happy they did.

Rob continued to make slow progress, and we soon started to think about discharge. But one afternoon after I'd left for the day, Rob passed a large amount of bloody stool and blood clots. His vital signs and labs became unstable, and his kidney function declined. When Rob did not respond to intravenous fluids and blood transfusions on the unit, he was transferred to the Surgical ICU.

continued on next page

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But I know
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It speaks to
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continuum of
care.

When I returned the next morning, the team informed me of his rapid decline, saying, “He was sick, but stable.” This 33-year-old man who’d been doing well enough to be thinking of discharge a few days earlier was now in a drug-induced coma, intubated, ventilated, and receiving dialysis for his acute kidney failure. I kept tabs on his progress throughout the day and wondered how his parents were coping with this significant turn of events.

Rob had started bleeding again overnight and had received several units of blood and platelets. His blood was clotting almost as quickly as he was receiving it. The team was fast running out of options. Overnight staff had asked Rob’s parents to call his sister and fiancée so that they could come to Boston as soon as possible. I texted the attending nurse in the Surgical ICU and learned that a family meeting was planned for 10:00am. I asked her to let me know as soon as his parents arrived; I wanted to be present for them.

I went to the SICU around 8:30, and as soon as I walked into Rob’s room, every nursing instinct I had told me he was in trouble. I saw large amounts of blood in his nasogastric tube, rectal bag, and urinary catheter. His face was jaundiced. Rob’s parents sat beside him. I let them know I was there if they needed me, and I saw relief on their faces when they saw someone they knew and trusted. Rob’s mom held his hand, the only part of his body visible other than his face. She studied his nails and stroked each finger. In my mind, I could see her doing that to him as a child. I sat beside her and held her hand. I knew she knew what was coming.

She turned to me after a while and said, “Is this it?” All I could say was, “I think so.”

She asked me to come to the family meeting later that morning. Before the meeting, I talked to some members of Rob’s SICU team to share my knowledge about Rob and his parents.

We all crowded into a small conference room: nurses, ICU staff, social worker, the SICU attending nurse, and the thoracic fellow. I could only imagine what Rob’s parents were feeling. The ICU team explained that there were no more medical or surgical options available. Everyone agreed it was best to keep him stable until his fiancée and sister arrived, then withdraw care. Rob’s mom said she wanted to be the one to tell the family that Rob was dying, and she didn’t want ICU staff to be there for those meetings.

She turned to me. “You’ll be there with me, right?”

“Of course,” I said.

Over the next few hours, Rob’s parents told me stories about Rob as a little boy, his hobbies, and his wedding plans. They suspected that Rob had known how ill he was because he’d said and done things before being admitted that were only now starting to make sense. When she arrived, we took Rob’s fiancée to the conference room, and Rob’s mom gave her the news. She looked to me hoping I’d refute the determination. I sadly shook my head.

We brought her to Rob’s room, and I did what I could to make her comfortable as she sat with her dying fiancé. An hour later, we repeated the process with Rob’s sister. Both were gutted by the news. I tried to stay present but out of the way as they grieved. I asked the chaplain to come before care was withdrawn. When the family was ready, I excused myself to give them some time alone with Rob. He passed away peacefully soon after life-support was withdrawn.

When I think back on this experience, I realize how little I actually said or did. But I know how much my presence meant to this family. I’ve thought about whether his ICU nurse could have taken my place that day—she was a skilled and caring nurse. While I know she could easily have stepped into the role, the relationship I’d built with Rob and his family had established a level of trust that was invaluable that day. His family knew I was invested in Rob and truly cared for them all. It speaks to the strength of the attending nurse role and the consistent presence we provide throughout the continuum of care.

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

“Every nursing instinct I had told me he was in trouble.” This sad realization propelled Sarah into comfort mode. She immediately focused on being present for this family in their grief.

Rob’s mom asked, “You’ll be there with me, right?” We can all relate to that quiet, desperate plea for comfort, for company, in those tragically difficult times. As Sarah herself observed, she didn’t do or say much, but her presence was a blessing to Rob’s mom and his family as he quietly passed away.

Thank-you, Sarah.

Future nurse learns lesson about teamwork and critical thinking

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 Jessica Pereira, RN.

'Terry' had come in for a scheduled Cesarean section. She was eligible for a C-section because of a prior myomectomy (surgical removal of fibroids from the uterus). Terry and her husband were anxious and excited to meet their new little girl. Paula, Terry's nurse, and I helped make Terry comfortable while preparing her for surgery. When Paula read in Terry's record that she had Von Willebrand disease (a bleeding disorder that interferes with the blood's ability to clot) she wondered whether blood had been drawn to see what type she was. Paula and the surgical team recognized that this could be a potential complication during surgery.

Terry was from Israel and had had her myomectomy there, which was when she'd been diagnosed with Von Willebrand. I did a little research and learned that Von Willebrand is a blood-clotting disorder that can lead to heavy bleeding that's difficult to stop. The team of nurses, anesthesiologist, hematologist, and the OB doctor discussed a number of options but ultimately decided to give Terry Humate-P, a blood-coagulation therapy that contains a clotting factor from human blood. They planned for Terry to receive the therapy 30 minutes before her C-section, a process that set her surgery back several hours.

Prior to putting this new plan in place, Terry had hoped to have an epidural and have her husband in the room during the birth. But the team now had to decide if there was a better/safer analgesic for Terry and the baby. I was very impressed at how the team presented this information to Terry and her husband and helped them weigh their options.

If Terry received an epidural, she'd risk getting a build-up of blood in her spine which could result in additional surgery or put her life at risk due to risk of increased bleeding. The other option was general anesthesia, which would mean she'd be asleep for the birth of her baby, and her husband wouldn't be able to be in the room. It was a difficult decision, and the team was very resourceful and accommodating.



Jessica Pereira, nursing student

Doctors and nurses explained that if they chose general anesthesia, she'd still be able to breast feed and her husband would be able to come into the OR after the baby was born and cut the umbilical cord. He could do skin-to-skin contact with the baby while Terry was recovering. I thought this was a great compromise. The other downfall associated with general anesthesia was the potential effect on the baby. She could need intervention if she was exposed for too long and developed respiratory distress.

Terry and her husband took some time, but in the end, because of the risk, they opted for general anesthesia. The team showed great integrity during the whole process, giving Terry and her husband their honest opinions and having Terry's best interests at heart. The anesthesiologist and hematology team showed great wisdom explaining each scenario and sharing their knowledge of Von Willebrand disease.

I truly believe if Terry had given birth somewhere else, the fact that she had Von Willebrand could have resulted in a very different scenario.

The team went ahead with administration of Humate-P and were able to do the surgery according to Terry and her husband's wishes. The process took a lot of knowledge, critical thinking, teamwork, and nursing skill. I was happy to see a good outcome for this family.

Violence Intervention Advocacy Program

—by Kathleen Haskins, VIAP program coordinator

The goal of the Violence Intervention Advocacy Program is to support patients in their emotional and physical recovery from trauma, help facilitate a de-escalation of violence, subvert the cycle of retribution, and reduce recidivism.

Violence-related injuries result in more than 2 million emergency-department visits per year in this country and have a profound effect on both physical and mental health. Every day, an average of 13 young people between the ages of 10 and 24 die as the result of a violent attack. Homicide is the leading cause of death for black youths, aged 15–25, and the second leading cause of death for all young people in that age group. As many as 40% of youths injured by violence return to the ED with violence-related injuries, and as many as 20% become victims of homicide within the next five years. The statistics are sobering.

The MGH Violence Intervention Advocacy Program (VIAP) was created to help break this cycle of violence. A collaboration between Social Service and the Emergency Department, VIAP is part of a city-wide initiative started by former Boston mayor, Tom Menino, and supported by Mayor Walsh. It works with survivors of violence committed in public places by individuals not related to the victim, including robberies, muggings, physical assault, bullying, or gang-related attacks.

The goal of the Violence Intervention Advocacy Program is to support patients in their emotional and physical recovery from trauma, help facilitate a de-escalation of violence, subvert the cycle of retribution, and reduce recidivism.

In addition to support and crisis-intervention, services include:

- brief negotiated interviews related to retaliation and substance use

- referral to community resources such as victim compensation, counseling, GED programs, etc.
- coordinated contact among or between victims and advocates within the court system, probation officers, the Department of Children and Family Services, school counselors, teachers, etc.
- linking young victims with mentors
- assistance with job searches, attending school meetings, or accompanying participants to court

VIAP staff continue to follow patients post-discharge for as long as needed. In 2016, the Violence Intervention Advocacy Program saw 136 patients, 105 of who were new referrals. Assaults, stabbings, and gunshots accounted for a third of the cases; 68% of victims were between 15 and 40 years old.

This innovative program includes collaborative partnerships with local police departments, district attorneys, Boston Medical Center street-workers, and community agencies such as Roca (whose mission is to disrupt the cycle of incarceration and poverty by helping young people transform their lives). The Violence Intervention Advocacy Program was accepted into the National Network of Hospital-Based Violence Intervention Programs.

Services are available during regular business hours; off-hour referrals are addressed promptly. The Violence Intervention Advocacy Program offers staff training on community violence and the various components of the VIAP program.

The department of Social Service is highlighting the Violence Intervention Advocacy Program as part of its National Social Work Month observance.

For more information or to make a referral, call 617-643-4303 or page 2-7341.

Idioms can change everything

Don't try to interpret without the assistance of a professional medical interpreter

—by Gustavo Garcia-Barragan, CMI

You might think it's simple for a Spanish interpreter to interpret for any Spanish-speaking person. But depending on where that Spanish-speaking individual comes from, there may be differences in meaning and usage, especially when idiomatic expressions are involved. For example:

Provider: How are you feeling? [Interpreter interprets]

Patient: Me siento bolo.

In some Central and South American countries, 'bolo' means, 'drunk.' In other countries, it can mean, rock, or a type of beverage, etc. In my native Peru, it doesn't mean anything at all. But the word, bolos (plural), means bowling. As a medical interpreter, it's important to ask for clarification.

Provider: I heard you missed an appointment due to a misunderstanding with the secretary. How do you feel about that? [Interpreter interprets]

Patient: Me siento muy abusada.

Taken literally, this response means, "I feel very abused." In my native Peru, it would likely mean he/she had been physically or sexually abused. In this case, it meant she felt she'd been treated disrespectfully.

Provider: What color was the discharge? [Interpreter interprets]

Patient: Café.

'Café' usually means black or dark brown, but it can mean something else. It's important to ask

for clarification. 'Coffee,' the literal translation, is usually met with confusion.

Provider: How do you feel? [Interpreter interprets]

Patient: Estoy tonto.

This literally means, 'I feel dumb,' but in a medical context, it usually means, 'dizzy.'

These subtle differences underscore the importance of using professional medical interpreters who are continually educating themselves about the nuances of language.

In the Medical Interpreters Office, we post unusual phrases on a white board to share what we've learned from our encounters or to ask colleagues for their input on particular words or phrases. Many linguistic subtleties can influence the patient-provider encounter. A medical interpreter's training, education, and experience provide the foundation for an accurate and complete interpretation of the situation.

It's impossible to know when an idiomatic expression will be used—they come up in even the simplest exchanges. I've learned to ask for clarification whenever anything seems a little odd. Usually, it's an unfamiliar colloquial expression that, once clarified, helps grow my understanding of the language and my ability to interpret accurately for patients. We all encounter similar situations in our daily work, but in my case, these little surprises help me to be a better interpreter and add to my enjoyment of my work.

For more information about the work of medical interpreters, call 617-726-6966.

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Distribution

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Submissions

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

Next Publication

April 6, 2017

Global Health Service Awards

Do you know a colleague dedicated to solving health inequities locally or abroad? Nominate him/her for a Global Health Service Award. Global Health Service Awards were established to honor innovation, dedication, and commitment in the field of Global Health. The three areas of recognition are:

- Teaching and Mentoring: awarded to an employee who has demonstrated exemplary leadership through education and mentorship of local or foreign faculty and students
- Excellence in Research: awarded to a researcher whose work improves care for vulnerable populations through the creation and sharing of new knowledge
- Humanitarian Care: awarded to an employee whose actions and commitment demonstrated extraordinary compassionate care for a local, national, or international community in dire circumstances

All MGH employees with projects benefiting local, national, or international communities are eligible. Re-nomination of prior nominees is encouraged. Recipients will be announced at the Global Health Expo on May 10, 2017.

For more information or to submit an application, go to: <http://www.globalhealthmgh.org> or e-mail globalhealth@partners.org. Applications are due by March 31st.

Blum Center Events

"Top 10 Sleep Questions"

Friday, March 31st

12:00–1:00pm

Join Kenneth Sassower, MD, to learn more about sleep health. 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.

Advance Care Planning Booth

The NPCS 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.

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

Name change for collaborative governance committee

To better represent their focus, the NPCS Diversity Committee is changing its name to the Committee on Diversity and Inclusion. The name better reflects their goal of promoting, endorsing, and supporting inclusion and is in line with the newly revised MGH Credo Statement. The name change explicitly validates the importance of inclusion by acknowledging that there cannot be diversity without inclusion. Inclusion ensures that individuals from diverse backgrounds or presenting diverse ideas do not feel excluded.

For more information, contact committee co-chairs, Kelsey Conley, RN and Zeina Marshall.

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: acsl@partners.org, or call 617-726-3905

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

2017 Staff Perceptions of the Professional Practice Environment Survey

The 2017 Staff Perceptions of the Professional Practice Environment Survey (SPPPE) will be e-mailed to staff in Nursing and Patient Care Services by the end of March, 2017. It will remain in the field for one month.

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 NPCS, 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: NPCS; 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.

Staff Perceptions of the Professional Practice Environment Survey

Question: Is the Staff Perceptions Survey going to be conducted this year?

Jeanette: The 2017 Staff Perceptions of the Professional Practice Environment Survey (SPPPE) will be e-mailed to all staff within Nursing and Patient Care Services by the end of March. The survey takes approximately 45 minutes to complete and provides NPCS leadership with a meaningful assessment of organizational characteristics that influence staffs' perceptions of and satisfaction with the MGH professional practice environment.

Question: How are the responses used?

Jeanette: Over the years, survey responses have influenced the strategic direction of Nursing and Patient Care Services and helped identify opportunities to improve the practice environment. Survey results are examined by leadership throughout Nursing and Patient Care Services and guide our strategic planning. The survey is a good barometer of how changes have been received by staff and helps us monitor the impact of those changes on the practice environment.

Question: Can you give us a sense of what's in the survey?

Jeanette: This year's survey contains a newly revised measure of the eight organizational characteristics The Professional Practice Work Environment Inventory; a seven-item Job

Enjoyment Scale; a newly revised 12-item Power as Knowledge for Practice Scale; a demographic profile; a question measuring overall satisfaction; and an open-ended question where staff can enter comments in their own words. There's also a revised measure for nurses only—a streamlined assessment of common patient problems that are assessed, managed, and documented by nurses.

Question: Is the survey anonymous?

Jeanette: All answers are confidential. No individual data will be reported unless agreed to by the participant at the beginning of the survey. Data from the survey is reported at three organizational levels: Nursing and Patient Care Services, by discipline, and at the unit level. Results are used to trend data over time, stimulate discussion at staff and organizational meetings, evaluate the impact of change, guide new innovations, and create a best-practice work environment that supports clinicians, patients, and families. All responses are important. Every voice counts.

Question: When will the survey be distributed?

Jeanette: The survey will be in the field from March 26th to April 29th. For more information, contact Gaurdia Banister, RN, executive director, The Institute for Patient Care, at 617-724-1266.



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