Caring
Headlines
August 20, 2015

Untangling the Gordian knot of health care

Lively discussion

The third international healthcare symposium hosted by Patient Care Services’ Institute for Patient Care
(See story on page 4)

Glynn
Slavin
Grant
Chisari
Zimmermann
Banister
Blanchfield
Barey

The newsletter for Patient Care Services
Massachusetts General Hospital
How do patient-satisfaction surveys translate into improving the patient experience?

Recently, I had an opportunity to sit down with Rick Evans, our chief experience officer. Every conversation I have with Rick is illuminating, but this one was particularly impassioned as he spoke about the current climate in health care and the focus on patient-satisfaction scores. It was so illuminating, I invited him to share his thoughts as guest editor for my column. I think you’ll enjoy hearing his perspective.

At MGH, our culture prizes evidence-based, best practice in every aspect of the care we provide. Often, we’re the ones who identify and develop those practices and share them with the field. We continually work to provide better outcomes by staying abreast of current research, learning from the findings of our peers, and testing those findings for our own edification and enhancement. Ensuring an excellent patient experience is no different. We have a responsibility to explore all viable sources to identify ways to improve and enhance the experience of patients in our care. Reviewing the literature and listening to the perspectives of others is an excellent way to ensure that our efforts to provide a positive experience reflect the latest, most informed, evidence-based thinking.

Recently, I had occasion to read a couple of articles on the patient experience that I found both stimulating and troubling. You can imagine how many of these articles I receive as chief experience officer at MGH. “The Problem with Satisfied Patients,” by Alexandra Robbins, appeared in the April issue of The Atlantic, and “Are Patient Satisfaction Surveys Doing More Harm than Good,” by Heather Punke, appeared in the June issue of Infection Control and Clinical Quality. Both articles expressed concern and skepticism over the way hospitals are focusing on patient satisfaction. Both articles, and many others, refer to a study called, “The Cost of Satisfaction,” conducted by Joshua Fenton, MD, in 2012. Fenton posits that the current focus on making patients happy is contributing to increased costs in health care, poorer outcomes, and a rise in mortality rates.

I read these articles with a sense of frustration—not because I think the authors are wrong, but because I believe they’re operating on a fundamental misconception of what patient-experience work is all about.

Before I get to that, I think it’s necessary to acknowledge that there has been a dramatic shift in recent years in how hospitals approach the patient experience.
Measuring patient satisfaction is not about determining what makes patients ‘happy.’ It’s about structuring care and communication to make the experience of care more seamless and consistent. It’s about conducting interactions with patients and one another in ways that help us better know our patients so we can address their needs and concerns in a more meaningful way.

With the advent of public reporting and shifting reimbursement structures, both from Medicare and private payers, there has been added pressure to raise patient-satisfaction scores. This development, for the most part, is good. It helps sharpen our focus on what patients want and need while engendering deeper partnerships with the individuals we serve. But some people are interpreting this focus on increased patient satisfaction as just a campaign to raise scores and not on the more important issue of substantively improving the way we deliver care.

While the articles I mentioned earlier highlight the dangers of these shifting dynamics, I believe they mis-characterize what the patient experience is, leading to erroneous conclusions and cynicism about our work to improve it. Measuring patient satisfaction is not about determining what makes patients ‘happy.’ It’s about structuring care and communication to make the experience of care more seamless and consistent. It’s about conducting interactions with patients and one another in ways that help us better know our patients so we can address their needs and concerns in a more meaningful way.

This is the real work of patient satisfaction. If it were up to me, I’d do away with the phrase, “patient satisfaction,” and replace it with “patient experience.”

I’d like to address some of the other points mentioned in these articles.

Hospital versus hotel—Robbins talks about efforts to turn hospitals into hotels and emulate other business models, such as Disney. At MGH, this is not our goal. Though we do address some patients’ needs with hotel-inspired services, like valet parking, we’re not trying to be the Ritz Carlton. Our goal is to make it easier for patients with mobility issues to access our services. We can certainly look to Disney and the Ritz for what they can teach us about consistency, clear expectations, and exceptional customer service. We can learn from these models without compromising our own mission, vision, and values.

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The future of health care is uncertain. As clinicians, we’re trained to prepare for the unexpected. Care-delivery, reimbursement, and nearly all other aspects of health care are evolving; at the same time, we’re seeing unprecedented changes in technology, policies, and the overall economics of health care. It could not have been a more opportune time for The Institute for Patient Care to host its third international symposium, Healthcare and the Gordian Knot: preparing to lead through unprecedented change, challenge, and complexity. Held June 15 and 16, 2015, at the Joseph B. Martin Conference Center at Harvard Medical School, the symposium attracted a diverse audience of healthcare professionals, academics, consultants, and members of the Massachusetts House of Representatives.

In his opening remarks, MGH president, Peter Slavin, MD, spoke of the key changes facing health care today, saying, “It’s possible to unravel the Gordian knot of health care if we continue to look for ways to improve quality and safety while at the same time lowering costs. We need to innovate as quickly as possible to counter the economic forces that are making health care unaffordable in this country.”

Gino Chisari, RN, director of The Norman Knight Nursing Center for Clinical & Professional Development, facilitated a Power Panel with experts: Lynn Nicholas, chief executive officer of the Massachusetts Hospital Association; Alexander Green, MD, associate director of the Disparities Solution Center; and Lynn Nicholas, chief executive officer of the Massachusetts Hospital Association.

Power panelists (l-r): Peter Cahn, associate provost at The MGH Institute for Health Professions; Alexander Green, MD, associate director of the Disparities Solution Center; and Lynn Nicholas, chief executive officer of the Massachusetts Hospital Association.
Green, MD, associate director of the Disparities Solution Center; and Peter Cahn, associate provost at The MGH Institute for Health Professions. Panelists discussed key issues, sharing wisdom and insights from their various perspectives.

Executive director of The Institute for Patient Care, Gaudria Banister, RN, engaged the audience in an interactive session. Using real-time, electronic responses, she captured audience members’ views on factors influencing health care, such as leadership, values and ideals, and concerns about the future. Discussion was so lively and impassioned, it continued well after the session ended and into the reception that followed.

Deb Zimmermann, RN, chief nursing officer and vice president of Patient Care Services at Virginia Commonwealth University Health System, explored the Magnet framework and ideals, stressing the importance of strong leadership, structure, quality, and safety.

Other sessions offered insight into the critical variables affecting health care today: politics, economics, and technology. Tom Glynn, chief executive officer of the Massachusetts Port Authority, talked about the political influences on health care, saying, “Politics could learn a lot from health care. Politics is a powerful tool that can help produce big changes.”

Bonnie Blanchfield, senior scientist at BWH, provided an overview of the changing economic climate and the impact it will have on the future of health care. She spoke about the strategies needed to, “maintain fiscal viability, achieve successful outcomes, and support practice-improvement.”

Emily Barey, RN, director of Nursing Informatics for Epic, talked about “big data,” the wisdom required to apply it, and the impact it will have on leadership as we use data to improve practice and drive research initiatives.

Susan Grant, RN, chief nurse executive of Emory Healthcare, shared the trials and tribulations of her leadership journey in her keynote presentation, “From Ebola to eCare.” Grant spoke of the decision she made to treat one of the first Ebola patients to come to the US, saying, ultimately, she relied on the knowledge that her team was prepared. The phrase, “You can fear, or you can care,” became her mantra.

Feedback from the symposium was incredibly positive. Speakers and attendees lauded the “meaningful presentations” from which they gained “invaluable insight.” One participant noted, “I went to the symposium filled with doubt about the future of health care. I left feeling much more comfortable.” Healthcare and the Gordian knot provided a pivotal forum for examining the challenges that lie ahead. It helped shed light on strategies that will help us evolve as we work to maintain the integrity of our practice and the safety and well-being of our patients.

For more information about the symposium, contact Jane Keefe, RN, at 617-724-0340, or Karyn Besegai at 617-724-3019.
MGH Youth Programs
paving the way for careers in health care

— by Susan Leahy, communications manager, Center for Community Health Improvement

This summer, college students, Yadira Cuevas and Jenny Bermudez, are working in supportive roles on Bigelow 11 and White 10, respectively, thanks to a special collaboration between the MGH Youth Scholars program and the department of Nursing.

MGH has a long history of providing jobs for students interested in careers in health care. Says Tracy Stanley, senior manager of Youth Programs, “The MGH Alumni Internship Program provides college students with full-time, paid, summer internships in areas related to their interests and college majors. Students get real-world experience interacting with patients and professionals at MGH.”

For many nursing students, the process of building skills begins in high school. Shadowing nurses allows them to learn basic skills and determine whether a career in nursing is what they’re looking for.

In college, many students have a more clearly defined idea of their career paths. As part of the internship, first- and second-year nursing students are often placed in outpatient settings where they can train as medical assistants, taking patients’ vital signs, and assisting the team with special projects.

Bermudez, a student at Regis College, wants to be a labor and delivery nurse. Says Bermudez, “Working at MGH has brought the true patient experience to what I’ve read about in textbooks.”

Once students complete their clinical exams in their junior year, they can train as personal care assistants on an inpatient unit. Internships help students strengthen their skills, build confidence, and gain a clearer understanding of nursing practice.

Bigelow 11, nursing director, Patricia Fitzgerald, RN, says, “Students like Yadira work as helpers, and nurses enjoy passing on their knowledge and experience. Nurses often invite interns to observe something new or interesting, like an unusual wound dressing. Everything they see makes an impression.”

White 10 nursing director, Jennifer Mills, RN, notes, “As personal care assistants, students are working with patients on activities of daily living, taking vital signs, giving bed baths. Jenny is actually working on a special project for us, helping us pilot test new glucometers.”

Cuevas is enrolled in the Nursing Program at Bunker Hill Community College. While she’s unsure of what area she’d like to specialize in, she sees many options that appeal to her. “Having worked here at MGH, I now have a much better idea of what to expect in departments like Anesthesia, or Cardiology, and on inpatient units.”

For more information about the MGH Youth Scholars Alumni Program, call Tracy Stanley, senior manager of Youth Programs, at 617-724-6424, or go to: massgeneral.org/cchi.
On June 11th and 12th, in recognition of the contributions of cardiac nurses, the department of Nursing welcomed nurse scientist and former Yvonne L. Munn nurse researcher, Diane Carroll, RN, as this year's Cardiac Nursing visiting scholar. Celebrating its 10th anniversary, the program honored Carroll for her expertise, mentorship, and career-long impact on cardiovascular nursing research.

In her first presentation, Carroll spoke about interventions to treat psychological distress during cardiovascular procedures, touching on the contributions of many MGH nurses. Carroll's presentation was followed by a panel discussion with cardiac staff nurses, Chimwemwe Clarke, RN, and Kelly Daniels, RN; heart-lung transplant patient Benard Basant; and director of the MGH Adult Congenital Heart Disease Program, Ami Bhatt, MD. Clarke, Daniels, and Bhatt described their roles in caring for Basant up to his successful transplant. Basant spoke about the extraordinary relationships he formed with his nurses and physicians, the incredible care he received, and the loving support of his family.

Carroll's second presentation focused on family needs and nursing interventions, again highlighting contributions of MGH nurses. And in the final presentation, Kathy Ahern Gould, RN, editor in chief for Dimensions in Critical Care Nursing, spoke about publishing opportunities in nursing research.

Carroll visited the Cardiac Catheterization Lab, the Cardiac ICU, and Cardiac Surgery ICU to participate in unit rounds. The Cardiac Visiting Scholar Program provides cardiac nurses with an opportunity to share and discuss the clinical needs of their patients and learn from an expert. Carroll's visit reinforced, not only her direct influence on nursing practice at MGH and beyond, but the importance of collaboration.

For more information, contact Erika Ehnstrom Carr, RN, at 4-3771, or Cris Bethune, RN, at 4-5020.
A little reassurance goes a long way in the OR induction area

My name is Lyndsey Farrow, and I’ve been a nurse in the Operating Room for five years, the most rewarding years of my adult life. I’ve focused my nursing practice on the plastic surgery environment, which includes primarily reconstructive procedures.

As a surgical nurse, you only have a short time to greet patients, get their history, perform a physical, and ask the necessary questions related to their surgery. You hope, in that time, to instill confidence and gain your patient’s trust. I feel extremely fortunate and grateful to have had the opportunity to meet and care for ‘Anna.’

Anna came to MGH for a second opinion after a long, complex, surgical journey at another hospital. Three years prior, Anna had been diagnosed with a serious brain tumor, which had been resected numerous times but was continually complicated by persistent wound infection. This non-healing wound is what brought Anna to see a well-known plastic surgeon at MGH. After much research and consideration, a plan of care was formulated for Anna and shared in great detail with the operating-room team. Anna’s first few procedures were going to involve irrigation and debridement of the non-healing wound. Once the wound was free of infection, the plastic surgeon would perform a free-muscle transfer and skin graft to cover the scalp defect. That’s when a muscle is removed from one area of the body and re-attached to an artery and vein in a different area. Though time-consuming and somewhat risky due to Anna’s poor wound healing, the team was hopeful.

I was the circulating nurse on the first of Anna’s many procedures. I knew Anna would be nervous as most patients are when they arrive in the OR induction area. I made it my priority to ease her mind, gain her trust, and keep her comfortable in the brief time I had with her. When Anna and her husband arrived, I greeted her with two warm blankets and a big smile. I introduced myself to Anna, who was quiet, and to her husband, who was anxious and fidgety. Because of Anna’s scalp wound and exposed cranium, her head was wrapped in a bandage and protected by a helmet. She looked at me with big, fearful, blue eyes. I wanted nothing more than to comfort her and instill hope in the next, challenging leg of her journey.

I asked about her medical history, allergies, implants, range of motion, and other concerns. Further complicating matters was that Anna’s ability to speak was limited due to a prior stroke. It was fortunate that her husband was present and so involved.
Unfortunately, Anna was unable to receive the free-tissue muscle transfer due to her extremely poor wound healing. This was a major disappointment to Anna and her family, and to me, as well. My heart ached for her when I heard the news. I continued to enjoy a strong professional relationship with Anna and her family as they continue to explore other options.

I'm currently the team leader for the plastic surgery service, but whenever Anna comes in to the operating room, I step out of that role and into the role of primary caregiver. I remain active in her care and work hard to share aspects of her case with staff and educate them on Anna's lengthy history. I always try to be present when Anna arrives in the induction area, and I can see by the look on her face that she's happy to see me.

With each surgery, I re-assess Anna and try to keep her comfortable, relaxed, and confident as she falls off to sleep. I've noticed a dramatic improvement in her spirits each time she's come in. And her husband seems just as pleased. It's extremely rewarding to see those signs of trust and relief.

In the short time I've known Anna, my nursing practice has developed dramatically. Before Anna, I knew the importance of reassurance and continuity of care. But now I know first-hand the impact it has on fearful, anxious patients. I have a better understanding of what it means to patients and families.

Unfortunately, Anna was unable to receive the free-tissue muscle transfer due to her extremely poor wound healing. This was a major disappointment to Anna and her family, and to me, as well. My heart ached for her when I heard the news. I continue to enjoy a positive relationship with Anna and her family as they continue to explore other options. On some level, caring for Anna has helped me connect with other patients. Her unwavering drive to live a productive life has given me hope and inspiration that carries over into other aspects of my life.

Being a nurse is a humbling experience. It's why I love my career as an OR nurse and continue to develop confidence in my practice. I try to instill that feeling of excitement and dedication in new graduates and new OR nurses who join our service. I enjoy teaching, empowering, and influencing the next generation of nurses, encouraging them to enhance and develop their own nursing practice.

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

For patients, families, and even many clinicians, the OR is a scary place. But Lyndsey showed us, and Anna, that it's actually a place of great compassion, support, and understanding. Lyndsey picked up every clue and nuance in Anna's behavior and provided reassurance every step of the way. Stepping out of her role as team leader to be Anna's primary nurse gave Anna a sense familiarity, continuity, and peace of mind. It's a testament to the power of the nurse-patient connection, that Lyndsey and Anna continue to enjoy a strong professional relationship even as she continues to explore other options.

Thank-you, Lyndsey.
Help ensure safe transport for outpatients coming to MGH

Thouands of patients come to MGH every year for outpatient appointments, tests, and procedures. It’s often presumed that outpatients require less clinical support than inpatients. But many outpatients come from rehabilitation, long-term care, or skilled nursing facilities and require the same level of care and observation that inpatients do. Arriving on stretchers, with tracheotomies, oxygen, or mechanical ventilation, many outpatients are unable to communicate or care for themselves. Proper hand-offs are essential to ensure their safety and comfort while in out care.

In 2011, the Safe Patient Transport (SPT) initiative was launched to improve communication between MGH and Spaulding Rehab facilities to ensure patients coming to MGH for same-day appointments and procedures were safely managed. The SPT initiative established a standardized process of communication between the sending facility and the receiving department at MGH prior to patient transport. The process is considered best practice throughout Partners HealthCare. Reaching beyond the Partners network, the SPT Strategic Planning Team has shared the communication tool with more than 50 referring facilities to date and hosted a Safe Patient Hand-Over Summit with clinical leaders from 25 facilities that routinely send patients to MGH.

Effective communication of patient information for patients coming to MGH from Spaulding facilities has improved from 14% in 2011, to 37% in 2014, but more work is necessary, especially with institutions outside the Spaulding network.

The Safe Patient Transport team is asking for your help in ensuring that the need for detailed hand-off communication is understood by all institutions that transfer patients to MGH for outpatient appointments and procedures. Two forms are now available on inpatient units that should be included in discharge packets when patients are transferred to other facilities.

For more information, call Shawn Bonk, project manager, at 617-643-5412.

“The single biggest problem in communication is the illusion that it has taken place.”

— George Bernard Shaw
The Ben Corrao Clanon Memorial Scholarship

by Mary Ellin Smith, RN, professional development manager

The Ben Corrao Clanon Memorial Scholarship was established in 1987 by Regina Corrao and Jeff Clanon in honor of their son Ben, to recognize NICU nurses who demonstrate exemplary practice, a commitment to primary nursing, and advocacy for patients and families. This year’s ceremony was held July 24th and recognized the exceptional practice of staff nurse, Monica DiSipio, RN.

Said Clanon, “After the loss of a child, what helps you survive, is knowing that everything possible was done to save your son or daughter. The nurses here in the Newborn Intensive Care Unit did everything possible to save our son, and we will always be grateful for that.”

Said DiSipio, “During those times of anxiety and uncertainty, seeing a familiar face, someone who knows your child and knows your story, is comforting to families as they navigate an unfamiliar world. Primary nursing creates a connection, a continuity between nurses and parents who are going through the most difficult time of their lives.”

Nursing director, Peggy Settle, RN, spoke of the importance of the Corrao Clanon scholarship after all these years. “The scholarship recognizes the value of primary nursing in the lives of patients and families and in the practice of NICU nursing.” Settle shared that DiSipio’s narrative told about a mom who would only leave her baby at night because she knew Monica would be there and that Monica was a ‘close second’ in her daughter’s heart.

DiSipio thanked The Corrao Clanons for continuing to fund the scholarship. She thanked her colleagues for nominating her and for their support in always being there for her.

Clanon thanked NICU nurses, saying, “You make all the difference. You make the unbearable, bearable. Thank-you.”

For more information about the Ben Corrao Clanon Memorial Scholarship, contact Mary Ellin Smith, RN, professional development manager, at 617-724-5801.
Fielding the Issues

Estimated Date of Discharge Tool version 2.0
some much-anticipated updates

Question: What is the Estimated Date of Discharge Tool?
Jeanette: The Estimated Date of Discharge (EDD) tool was originally launched in December, 2014, as a fast, simple way to assist the care team in communicating a patient’s expected date of discharge, their discharge destination, and key barriers to discharge. The EDD provides a consistent mechanism to communicate within the team and with patients.

Question: How does it work?
Jeanette: The estimated date of discharge is the date the patient is expected to be medically ready for discharge. It is determined by the responding clinician in collaboration with the care team. Upon admission, the responding clinician enters the estimated date of discharge; the case manager enters the expected discharge location; and the entire team reviews and updates the tool as necessary to reflect key barriers and tasks required for discharge.

Question: Was the EDD tool recently updated?
Jeanette: Yes. Version 2.0 of the EDD tool, went live June 29, 2015. It incorporates feedback received from clinicians in all disciplines. Some of the changes include:

- Selecting the estimated date of discharge and discharge disposition location are now separate functions to avoid confusion
- The discharge disposition location is no longer abbreviated. Once selected, the full name of the location is displayed
- The ‘TBD’ option in the discharge disposition pick list has been removed. It’s important that the team select the most likely discharge disposition location upon admission, then update the tool as needed
- A list of common discharge barriers and tasks has replaced the free-text-only option. This should help improve consistency in communicating barriers and tasks and help the team identify and respond to the most common barriers in a timely fashion
- A new ‘Medically Ready’ check box has been added so the team can indicate when the patient is deemed medically ready. Checking this box dates and time-stamps the entry, allowing the patient progression team to identify and manage any other barriers that might be contributing to delays for patients who are medically ready to be discharged
- The new EDD tool now has sorting and reporting options. Clinicians can sort according to the estimated date of discharge, the post-acute care location, and/or the medically ready status. The reporting option assists the patient progression team in reviewing how and how frequently the tool is being used and what might be contributing to discharge delays

Question: How often should the EDD tool be updated?
Jeanette: It’s important for the EDD tool to be updated at least daily. One way to ensure daily updates is to open the tool during rounds so that all disciplines can have input into updating the information. Identifying the top two or three barriers is helpful so the team can focus on resolving those barriers as soon as possible.

Question: How do I access the EDD tool?
Jeanette: You can access the EDD tool by opening ONCALL (Apprentice) MGH eBridge via the Partners Start menu. For details, go to the length of stay (LOS) portal at: http://intranet.massgeneral.org/LOS/. For more information, call Nga Yan Chow, administrative fellow, at 917-322-9042, or Kevin Whitney, RN, associate chief nurse, at 617-724-6317.
Recently updated policies, products, and procedures

The following were reviewed by Patient Care Service’s Policies, Products, and Procedures Committee during June and July and have been updated in ellucid.

New:
CVVH via ECMO
- Procedure outlines CVVH access through the ECMO circuit (both VV and VA) providing a safe means of hemo-filtration without the complications of separate large bore cannulation

Mini Tracheostomy Care
- A narrow cannula is inserted into the trachea through the cricothyroid membrane. Patient can have 1-2cc of NS, then it’s immediately capped to promote coughing and tube patency

Nasal Bridle System
- Placed in the ICU, the system prevents patients from accidentally removing their nasogastric tube. The system stays in place for the life of the tube, so nurses in general care areas will be seeing this system

Pulmonary Artery Catheter–Cardiac Output Measurement
- Details on what information needs to be entered into the computer to be able to perform the calculation automatically

Tracheal T Tube
- Tube is positioned vertically into the tracheal airway while the horizontal extension projects out of tracheal opening in the neck. Procedure details the care of the tube, suctioning, and discharge teaching materials for the patient.

Reviewed with changes:
Electrocardiogram Procedure for 12 Lead (please share with all staff who perform ECGs)
- Revision: If patient only has a 7-digit MR number starting with 00, all 12-lead ECGs will be transmitted to MUSE as soon as possible, no less than daily; in an emergency, the responding clinician reviews all ECGs immediately; every ECG transmitted with an active order will be formally interpreted; if there is no order in POE, the ECG will not receive formal interpretation but will be stored and available for viewing

Initiation and Termination of CRRT with a Tunneled or Nontunneled Catheter
- Revision: Use of new caps. See Leur

Manual Disimpaction, Adult
- Revision: Greater detail on contra-indications and vagus nerve stimulation

PA Catheter Removal
- Revision: Aligns with other central-line removal procedures

Tracheostomy Care
- Revision: Incorporates management of high-risk airway; Respiratory Therapy administers all aerosolized medications to trached patients. Tracheostomy Care Guidelines and Tracheostomy Care Algorithm are attached. The guideline is a quick reference on the role of Nursing and Respiratory Therapy in the care of trached patients. The algorithm provides a decision tree for the care of trached patients

Virden Rectal Catheter Retention Enema
- Use of the catheter is contra-indicated in patients with a recent myocardial infarction; updated references

Vital Signs
- Procedure adds that oxygen saturation is a core component of patient assessment and reflects current practice; changes the minimum time vital signs are to be collected from every 24 to every 12 hours; identifies methods to measure oxygen saturation

Reviewed with no changes:
Bladder Irrigation, Manual-Adult
Bladder Irrigation Using a Three-Way Urinary Catheter and Irrigation Set
Foot Care
Malecott Catheter
Milk and Molasses Enema
Speaking Valve on Tracheostomy Tube; Patient Care
Urinary Leg Bag; Drainage and Cleaning

Retired:
High-Risk Airway
Ultra-Filtration
Announcements

One-stop intranet site for strategic priorities

Want to know more about the Partners-MGH patient care re-design, patient affordability, and budget review initiatives? Wondering about the timeline? To read the latest articles about this work, or if you have a cost-reduction idea or better way to deliver patient care, visit the new MGH/MGPO intranet site: http://priorities.massgeneral.org.

The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

- Tuesday, Wednesday, Thursday, 7:30am – 5:30pm
- Friday, 8:30am – 4:30pm (closed Monday)
- Platelet donations:
  - Monday, Tuesday, Wednesday, Thursday, 7:30am – 5:00pm
  - Friday, 8:30am – 3:00pm

Appointments are available. Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

MGH Nurses Alumnae Association fall reunion and educational program

This year’s theme: “Historical Reflections and Nursing Innovations”

Friday, September 25, 2015
O’Keeffe Auditorium
8:00am–4:30pm

Sessions will include: “MGH Graduate Nurses Who Served in the Military During the Vietnam War”; “Veterans, Post-Traumatic Stress Disorder and the Role of Equine Therapy”; “Nurses as Innovators,” and others.

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

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in Caring Headlines. All submissions should be sent via e-mail to: ssabia@partners.org.

For more information, call 4-1746.

ACLS Classes

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

- Day one:
  - September 11, 2015
  - 8:00am–3:00pm
- Day two:
  - September 21st
  - 8:00am–1:00pm

Re-certification (one-day class):
- October 14th
- 8:30–10:30pm

Locations to be announced. Some fees apply.

For information, contact Jeff Chambers at acls@partners.org.

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

On-line prerequisite courses at the IHP

If you’re preparing for graduate school in Nursing, Occupational Therapy, Physical Therapy, or Physician Assistant Studies and need to take science or other prerequisite courses, the MGH Institute of Health Professions offers a full range of on-line courses and labs.

Classes begin September 14, 2015.

Employer’s vouchers may be used to take one or more courses for free. Register or view full list of course offerings at mghihp.edu/science. For more information, call 617-724-6362 or e-mail: cips@mghihp.edu.
honed these skills, but not by handing them a script. We provide staff with key words and concepts that they incorporate into their verbal exchanges with patients. This method is driven by both safety and satisfaction. Having a list of key words ensures that all relevant topics are covered, but the conversation takes place naturally in the clinician’s own words and voice. This communication technique allows for a thorough exchange of information without the ‘cookie-cutter’ feeling conveyed by scripted interviewing techniques.

Happy versus satisfied
Perhaps the most troubling point in these articles is the idea that we’re becoming so worried about making patients happy, we’re giving them what they want whether it’s clinically appropriate or not. This, ‘customer is always right,’ approach makes patients happy but not necessarily healthy. And in the process, it drives up healthcare costs. This is a real concern in the current environment.

In our experience, most patients want honesty and the best clinical advice they can get. When patients ask about a particular test or prescription, clinicians need to find out the underlying reasons for the request and address those issues. Often, that means advising against the test, medication, or treatment. When communicated simply and appropriately, most patients will appreciate the honesty, accept the advice of a professional, and feel satisfied that they’re receiving high-quality care. It’s when patients leave with unanswered questions or concerns that they feel they haven’t been heard.

Looking at patient satisfaction as a choice between panicking about patients or providing good care is a spurious argument. Study after study shows that superior outcomes are linked to good communication and patients who are engaged in their own care. Many of the MGH providers highly rated by our patients are also very skilled communicators with records of stellar clinical outcomes.

While I might have been frustrated by some of the conclusions drawn in these articles, I think it’s a good thing that these issues are being talked about. The world of health care is changing; we need to remain vigilant, proactive, and focused on the needs of our patients. Yes, there’s a lot of pressure to receive high scores and good numbers. But as I said at the outset, MGH is a leader in the industry; we’re in a position to influence the direction of health care toward a more patient- and family-centered system. If we do that, the numbers will take care of themselves.

I’d like to thank Jeanette for this opportunity to share my thoughts on these issues. And I’d like to thank the MGH community for its continued commitment to doing the best for our patients every single day.
Remembering Lisbeth Rodríguez
— by Anabela Nunes, director, Medical Interpreter Services

“As we recover from the shock of Lisbeth’s death, the shining light that was her life will also be her legacy. She touched and inspired so many, who now go forth to foster peace, justice, and respect for one another.”

It is with great sadness that we share the news that Lisbeth Rodríguez, medical interpreter at MGH since 2009, died tragically in a motor-vehicle accident, June 20, 2015. The MGH community, the patients and families she so faithfully served, and her medical interpreter family will miss her deeply. Rodríguez was a staunch advocate for her Spanish-speaking patients and families, always striving to ensure they received the safest, highest-quality care for which MGH is known around the world.

Rodríguez was committed to improving the community and educating Latinos and others. She was actively involved with the Committee for Latino Initiatives and was a dynamic example of advocacy in action.

On a broader scale, Rodríguez spoke of living in a community where peace, sharing, and caring were common values. In her strong, quiet manner, she lived those values every day. Her passion for alternative medicine, caring for the body, mind, and spirit are lessons that will stay with those who knew her for years to come.

Says Anabela Nunes, director of Medical Interpreter Services, “As we recover from the shock of Lisbeth’s death, the shining light that was her life will also be her legacy. She touched and inspired so many, who now go forth to foster peace, justice, and respect for one another.”

Lisbeth Rodríguez will be missed.