Caring Headlines
February 5, 2015

Unconscious bias

(an unwitting inclination, feeling, opinion, or prejudice, especially one without merit)

We all have it.

What can we do about it?

(You can start by turning the page)

The newsletter for **Patient Care Services**
Massachusetts General Hospital

Jeanette Ives Erickson

Blindspot

Do unconscious biases affect our hiring, firing, work relationships, and the care we provide?

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

Do you think you're biased against people of other races or ethnicities? No matter what you *think* your answer is to that question, you'll be re-evaluating your sense of self-knowledge and self-truth after reading Mahzarin Banaji and Anthony Greenwald's book, *Blindspot: Hidden Biases of Good People*. Their book is an evidence-driven look at how our brains process information and the disconcerting realization that we don't know ourselves as well as we think we do.

As a framework for this conversation, let me remind readers of the 2002 Institute of Medicine's report entitled, *Unequal Treatment*, which found that black Americans and other minorities were the victims of disparities in the healthcare system that resulted in their receiving less effective medical care than white Americans. The same report went on to say that a plausible explanation for these disparities was implicit bias, stereotyping, and prejudice.

That report is as troubling today as it was when it was first published. I'm sure many of us, upon reading those words for the first time, conjured images of racist caregivers denying treatment to minority patients and wondered, 'Who *are* these professionals who are doing our patients such a terrible disservice?' Well, the answer to that question could be more troubling than you think.

According to Banaji and Greenwald's book, the human brain is subject to what they call, 'mindbugs,' ingrained habits of thought and behavior that lead to errors in how we perceive, remember, reason, and make decisions. They describe the human mind as, 'an automatic association-making machine,' which, when it encounters information—words, pictures, faces, anything at all—automatically relates that information to something familiar already stored in our memory banks. In so doing, the mind forms strong alliances with things and people that are familiar while developing subtle biases against those that aren't. Mindbugs aren't limited to our feelings about race and ethnicity, they apply to age, gender, religion, sexuality, the whole gamut of human experience. And the really unnerving part is that these biases exist in our minds without our knowledge or consent.

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At the heart of Banaji and Greenwald's research is something called the Implicit Association Test (IAT). The IAT was created by Greenwald in 1994 as a means of accessing people's true feelings without having to ask them questions. (Question-and-answer surveys were unreliable because the hidden biases Banaji and Greenwald sought to reveal were

continued on next page

unknown even to the people who held them). You can take the Implicit Association Test yourself by logging on to: implicit.harvard.edu, and I urge you to do so if you're curious about your own hidden biases. According to Banaji and Greenwald's study, 75% of those who take the Race IAT (including individuals of all races and ethnicities) manifest an unconscious bias for white over African American. And that includes the authors themselves. This was a startling discovery for Banaji and Greenwald, considering they and most of their research participants self-identified as open-minded, civil-rights-embracing, egalitarian individuals. But the data was irrefutable—there is a measurable disconnect between our conscious and unconscious thought processes; and our unconscious preferences influence decisions we make every day.

Which brings us to the concept of 'cognitive dissonance.' Some of you may be familiar with this term. Formulated by psychologist, Leon Festinger, in the 1950s, cognitive dissonance refers to the "uncomfortable mental state" we feel when there's a contradiction between our deeply held humanitarian beliefs and the actions we take in daily life. This awareness of simultaneously existing opposite beliefs violates our natural human instinct for inner peace and mental harmony. It's hard to accept that we have biases and preferences that have been shaped by influences outside our control—which results in cognitive dissonance.

Another fascinating revelation shared by Banaji and Greenwald is that the brain engages two very different clusters of neurons when we think about ourselves (and people we identify with) versus when we think about those who are different from us. We, of course, aren't aware we're tapping into different areas of the brain; but think of the implications this has on hiring and firing practices, rulings in legal cases, club memberships, and so many other situations.

I found *Blindspot: Hidden Biases of Good People* to be a provocative, unsettling, and very important book. Dr. Slavin has recommended it to members of the new MGH Diversity Committee, and I recommend it to everyone who works in health care. Unconscious bias needs to be part of the conversation as we continue to advance our diversity agenda.

Banaji and Greenwald agree that more research is needed to find ways to short-circuit the unconscious biases we all harbor. But knowledge is power, and awareness is the springboard for change. MGH is a family of open-minded, egalitarian individuals. I predict that just knowing we harbor unconscious biases is going to give us a case of organizational cognitive dissonance that will spur us to new solutions and new practices.

I invite you all to join me for Patient Care Services' Black History Month event, "Lets talk about race: how to manage the conversation," February 18, 2015, at 11:00am, in O'Keeffe Auditorium. I'd like all our voices to be part of this important discussion.

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In this Issue

Multi-disciplinary surgical team training

The OR Learning Laboratory Simulation Suite

—by Maureen Hemingway RN, OR nursing practice specialist

The Operating Room Simulation Program is an example of a project that has helped change our culture to be more collaborative... Simulation experiences can be tailored to any skill level and can be programmed to model anything from best-practices to prepping a cardiac patient for the OR.

In 2001, the Institute of Medicine's *Crossing the Quality Chasm* recommended that health care be delivered by collaborative teams that share responsibility. The Operating Room (OR) Simulation Program is an example of a project that has helped change our culture to be more collaborative. With construction of the Lunder Building a few years ago, a number of operating rooms in the White Building became available, providing an opportunity to create the OR Learning Laboratory Simulation Suite, an educational collaborative dedicated to OR team training and skill-development. This kind of program is not found in many other institutions, so we had the pleasure, the challenge, and the opportunity to forge our own path as we created this new learning suite. The program has allowed us to contribute to the literature and affect the culture in real operating rooms.

With multi-disciplinary leadership and an interprofessional team, it's easy to see why this was an ideal opportunity to influence culture and enhance the patient experience. Simulation experiences can be tailored to any skill level and can be programmed to model anything from best-practices to prepping a cardiac patient for the OR. Currently, every other week a team of vascular OR nurses and interventional radiology physicians meet for a two-hour skill-building and team-training session using a sophisticated catheter-based simulator. Training on central-line placement has been integrated among anesthesia providers and surgical teams.

Perhaps the most 'multi' of our multi-disciplinary offerings is the Surgical Team-Training Simulation Program, a collaborative effort with two major course offerings. The first is a bi-monthly training with a specific team of nurses, attending surgeons, and attending anesthesiologists who come together to care for three patients in three different simulated scenarios. In this session, the mock patient often develops a critical complication, and the team must respond, communicate, and collaborate in handling a rare, high-risk situation.

The second session is shorter in duration, includes physician trainees, and serves as a quick team-building exercise. A small team of clinicians from various professions and disciplines is assigned to care for a patient who encounters an urgent or emergent crisis. Nurses are awarded CEUs for each session they attend. Feedback has been very positive, with comments such as, "Please keep having these sessions; they are so useful," and "Very good to see this [teamwork] in practice. These interactions may be easy to process mentally, but it's entirely different when you're actually doing it with a team."

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In the OR Simulation Suite (l-r): Maureen Hemingway, RN, nursing practice specialist; Kevin Synnott, Learning Lab program director; Jim Titus, simulation specialist; Sara Midwood, Learning Lab staff assistant; Roy Phitayakorn, MD, director of Surgical Education Research; and Rebecca Minehart, MD, instructor of Anesthesia, Critical Care, and Pain Medicine, prepare for multi-disciplinary team training with a simulated abdominal incision complete with instrumentation.

A conscious effort has been made to create scenarios where each clinician has an opportunity to engage in a new situation where he or she is called upon to communicate and contribute in new ways. A critical part of the simulation experience actually occurs after the simulation has ended. The debriefing session that follows is where the majority of the learning takes place as the team has a chance to discuss their performance, and facilitators have a chance to tease out lessons learned, further promoting teamwork and communication. These experiences are especially valuable because surgical teams share and reflect on practice alongside individuals they work with every day. They have an opportunity to hear other perspectives and experiences, which adds to their own knowledge and understanding.

The Surgical Team-Training Simulation Program is a major initiative that relies on multi-disciplinary support throughout the institution. Shared experiential learning is designed to foster authentic growth and culture change. Because the simulation is conducted in a real OR, the experience is convenient and familiar but offers realistic challenges. As the value of the simulation experience continues to be recognized, we expect that the OR Learning Laboratory Simulation Suite will be used for a growing number of educational approaches in the operating room environment.

For more information about the OR Simulation Program, call Maureen Hemingway, RN, OR nursing practice specialist, at 617-724-1652.

(Photo by Michelle Rose)

Clinical knowledge and nursing intuition help ED nurse recognize suicidal ideation

My name is Maria Vareschi, and I am an ED nurse. A recent patient situation took place in the Acute/Trauma area of the Emergency Department. It was a brisk morning in late spring with temperatures in the low 50s (that's relevant to the story). When I arrived at work for my 7:00am shift, the ED was busy. I took report from the night nurse on two patients, then proceeded to introduce myself to them, obtain baseline vital signs, and perform a brief assessment. It's important to assess patients in a timely manner in the ED because the workload can change unexpectedly in just a few minutes. Checking in with my patients paid off, because moments later the CMED radio (the state emergency communication system) alerted us that a 59-year-old woman staying at a local hotel had been pulled from the harbor. She was alert and cold with a body temperature of 95.5. She reported that she had slipped off the rocks and fallen into the water during the night. Her other vital signs were stable.

The CMED radio (the state emergency communication system) alerted us that a 59-year-old woman staying at a local hotel had been pulled from the harbor. She was alert and cold with a body temperature of 95.5.

Invariably, when patients come through the ED, there are a lot of unknowns. So I ask a lot of questions to learn as much about the patient's history as possible. The radio call was brief leaving me with many questions. I began to go over the possibilities. I wanted to be prepared for the patient's arrival. I recalled how cool it was that morning and knew that water temperature in late spring is extremely cold. I

Maria Vareschi, RN
staff nurse, Emergency Department

expected the patient to arrive hypothermic. I was also concerned that she may have aspirated during the time she was in the water. I started to prepare the trauma bay with the anticipated items such as IV insertion supplies, oxygen, cardiac monitoring, blankets, and fluid warmers. I consulted with my ED team (nurses, the ED attending, and ED resident) to discuss the array of medical issues we should prepare for. The doctors wanted to be prepared for intubation, so I went to the trauma bay to collect everything I'd need to assist in the event the patient needed to be intubated. I asked the coordinator to page a respiratory therapist to the resuscitation bay in case intubation was needed upon arrival.

'Mary' arrived on a back board with a cervical-spine collar in place, then she was carefully transferred to an ED stretcher. I introduced myself and let her know that there would be several clinicians in the room, giving report, placing IVs, taking vital signs, and performing a head-to-toe evaluation. I

continued on next page

said it might seem chaotic, but assured her that everyone had a reason to be there.

I removed Mary's wet clothes and placed a blanket around her for warmth and comfort. EMS began the process of bedside hand-over to the entire team. As I documented the information, one nurse from our team obtained vital signs, another established IV access and drew labs, and the resident performed a trauma assessment.

As I had anticipated, repeat vital signs showed that Mary continued to be hypothermic. The nurse at the bedside initiated warm fluids and set up the blanket warmer. As I listened to the resident's assessment, I watched and assessed Mary from a distance. I noticed that she wasn't making eye contact with any of the staff around her. She wouldn't elaborate on the circumstances around the accident. I wondered why a person would be wearing a nightgown in a public place in the middle of the night. I sensed there was more to the story than Mary was telling. I thought she might open up more in a private conversation rather than in front of the whole team.

My primary thought was to ensure a safe, calm environment. When Mary became stable, I'd find time to sit with her and try to learn more about the circumstances of her situation. I heard the medical resident ask Mary if she was suicidal, and she adamantly denied having suicidal ideation. I wasn't convinced, and I wasn't comfortable leaving her until I had a chance to hear her story in private.

I stayed with Mary to monitor her vital signs, cardiac status, and make sure she was warm. As I escorted her to CT scan and X-ray, I had an opportunity to begin to develop a trusting relationship with her. Once she was stable and her body temperature came up to normal, I sat with Mary. I tried to get a sense of her emotional state and get her to open up about the circumstances of her accident.

I asked Mary what really happened and how she ended up in the water on this chilly early morning. Mary confided that she was lonely and desperate. As I continued to talk with her, I learned that she had had some recent health issues and had no support system. She admitted that she had intended to take her own life by jumping off of the rocks into the ocean. I held her hand and comforted her as she tearfully told her story. I reiterated that she was in a safe place and the entire team was there to take care of her.

It's frightening to think what could have happened if Mary had been discharged back to her hotel without my intervention. I'm thankful I was able to get Mary the appropriate consulting services she needed and help avert a potentially harmful situation.

I wanted to make sure that Mary had access to all the resources she needed. I knew an acute psychiatric consult was called for, and that a Section 12 would have to be issued (an involuntary commitment for individuals who present a potential danger to themselves or others). From Mary's room, I contacted the resource nurse to request an observer to stay with her. When the observer arrived, I went to the resident to share my findings with him. The resident thanked me for sharing the information because Mary had stabilized and he had planned to discharge her.

After discussing my assessment, the resident and I developed a plan of care. The consulting physician from the Acute Psychiatry Service was able to come and speak with Mary immediately. It was ultimately decided that it was necessary to issue a Section 12 because we were unable to ensure Mary's continued safety. Mary was transferred to a locked area within the Acute Psychiatry Service where she would be safe. I knew the APS staff would assist Mary in finding the appropriate psychiatric services so she would be able to function safely and independently again.

I feel like I was in the right place at the right time. My nursing intuition and judgment kicked in, and I was able to provide Mary with exceptional nursing care. It's frightening to think what could have happened if she'd been discharged back to her hotel. I'm thankful I was able to get Mary the appropriate consulting services she needed and help avert a potentially harmful situation. I'm grateful I was able to use my clinical knowledge and nursing intuition to have a positive effect on my patient's outcome.

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

Maria was observant, patient, caring, and persistent—she was everything Mary needed her to be that chilly spring morning. Maria's curiosity and intuition told her something wasn't right about Mary's behavior. She knew, even before Mary confided in her, that she had tried to take her own life. We can only imagine the level of despair and hopelessness that drives a person to such an extreme. And we can only applaud Maria for recognizing the signs and following through on her intuition. She may very well have saved Mary's life.

Thank-you, Maria.

Suicide-prevention

an MGH priority and a National Patient Safety Goal

—by Patti Shanteler, RN, staff specialist

In 1998, The Joint Commission (TJC) issued a Sentinel Event Alert (see definition below) aimed at preventing patient suicide in the hospital setting. Despite efforts of hospitals across the country to eliminate these tragic events, successful suicide attempts continued to be reported. As a result, The Joint Commission added suicide-prevention to its 2007 list of National Patient Safety Goals (NPSGs). The focus of NPSG #15 was the implementation of processes to identify patients at risk for suicide who are hospitalized for emotional or behavioral disorders despite the unit or clinical setting they're assigned to.

In 2010, another alert was issued to call attention to the fact that patients with mental-health diagnoses aren't the only ones at risk for suicidal ideation. JC-accredited hospitals were charged with performing suicide-risk assessments for all patients who enter their facilities.

MGH has a robust suicide-prevention program. Safe care for our patients includes suicide-related screening questions. For example, all patients admitted to medical and surgical inpatient units are asked, "Sometimes people feel life isn't worth living. Are you having thoughts about harming or killing yourself?"

If patients answer, Yes, they're asked, "Do you have a plan?"

If the patient is found to be at risk for suicide, immediate steps are taken to provide a safe environment while a plan of care is developed (see the narrative on the preceding page as an example). Nurse(s) remain with the patient until a constant observer or 1:1 sitter can be assigned. Providers are notified to implement the Suicide Prevention order, which encompasses a 'bundle' of strategies designed to keep the patient safe while in the hospital. These interventions include a safety search of the patient's belongings and room by Police & Security, special hospital gowns with snaps instead of ties, paper food trays and plastic utensils, and a consult to Psychiatric Consultation Services. Once the patient is deemed safe, a discharge plan is established for outpatient services.

MGH is committed to meeting all of the National Patient Safety Goals issued by the Joint Commission. Our primary goal is to create a safe environment for patients and families and provide the best possible opportunity for healing and a return to health.

For more information about suicide-prevention or any of the other National Patient Safety Goals, contact Patti Shanteler, RN, staff specialist in the PCS Office of Quality & Safety, at 617-726-2657.

MGH has a robust suicide-prevention program. Safe care for our patients includes suicide-related screening questions and numerous other strategies designed to keep patients safe while in the hospital

Joint Commission Sentinel Events

A sentinel event is a patient-safety event (not primarily related to the natural course of the patient's illness or underlying condition) that results in death, permanent harm, or severe temporary harm requiring intervention in order to preserve life. The Joint Commission issues *Sentinel Event Alerts* to raise awareness among healthcare providers and offer best-practice strategies to minimize the occurrence of similar events in the future.

Optimizing Inpatient Flow

Did You Know?

—submitted by the Patient Progression Improvement Team

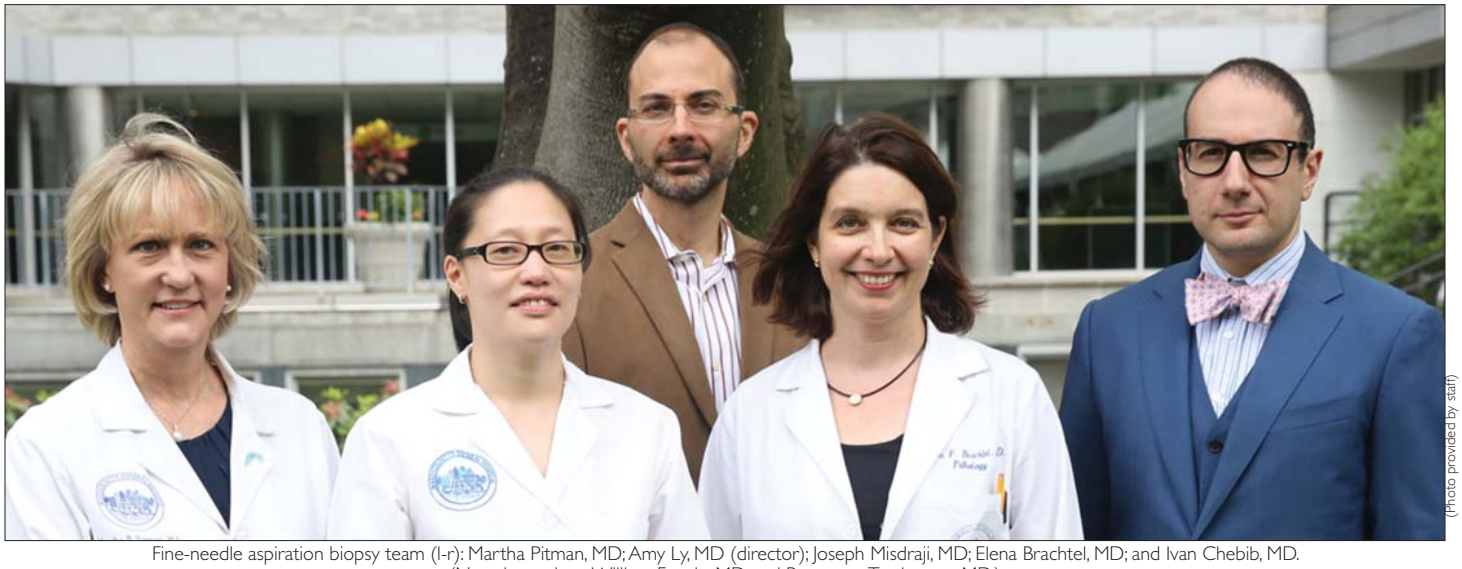
Did you know that MGH has a service that can perform fine-needle aspiration (FNA) biopsies on superficial nodules at the bedside? The service is equipped to perform biopsies on palpable and non-palpable masses on the breast, superficial lymph nodes (e.g., neck, axilla, groin), thyroid, salivary gland, and any other superficial/subcutaneous lumps under ultrasound guidance. FNA biopsy material can be sent for special studies, including flow cytometry, immuno-histochemistry, molecular testing, cytogenetics, and cultures. Preliminary diagnoses are available within an hour of the biopsy procedure. Schedule fine-needle aspiration biopsies in advance to help reduce wait times and optimize patient progression.

- FNA biopsies are available Monday–Friday, 9:00am–5:00pm
- Same-day service is available
- To schedule a biopsy, call 617-726-3980
- When making an appointment, know the patient's name; medical-record number; biopsy site; nature of the mass (palpable, non-palpable/ultrasound required); whether special studies will be needed (flow cytometry, molecular, etc); and the ordering physician's name and contact information

Says Kevin Hughes, MD, co-director of the Avon Breast Center, "The FNA service is responsive and accurate. I find them extremely helpful in managing palpable breast masses."

Says, Kenneth Tanabe, MD, chief of Surgical Oncology and deputy clinical director of the MGH Cancer Center, "I've found the FNA team to be incredibly responsive, dedicated to their work, and even more dedicated to patients. They're always quick to communicate with me. My patients have benefited significantly from their expertise, flexibility, and attentiveness. I couldn't ask for a better service."

For more information about fine-needle aspiration biopsies or to schedule an appointment, call 617-726-3980.



(Photo provided by staff)

Fine-needle aspiration biopsy team (l-r): Martha Pitman, MD; Amy Ly, MD (director); Joseph Misdraji, MD; Elena Brachtel, MD; and Ivan Chebib, MD. (Not pictured are William Faquin, MD, and Rosemary Tambouret, MD.)

Self-care as the Marathon bombing trial begins

Question: I'm finding that the media coverage around the trial of the marathon bombing suspect is bringing up a lot of feelings. Are you hearing this from others, as well?

Jeanette: It's perfectly natural for intense feelings to be triggered by media coverage of past events. The trial forces us to revisit a tragic time; media outlets show disturbing footage over and over. It's bound to elicit unwanted thoughts and feelings. Some responses may be fleeting, others may evoke more intense, sustained emotions. Understanding that these reactions are normal can help us support one another and practice good self-care, as well.

Question: What strategies do people use to help deal with these feelings?

Jeanette: Self-awareness and self-reflection are excellent tools. Caregivers need to develop self-care techniques to help reduce distress and build resiliency. Recognizing and attending to our own needs allows us to provide the best possible care to patients and families.

Some good self-care practices include:

- Have fun. Participate in enjoyable activities; spend quality time with loved-ones
- Take care of your body. Get regular exercise, maintain a healthy diet, get enough sleep, consider the MGH Be Fit Program
- Engage in meditation, spiritual practices, and narrative work such as journaling; Be Fit and the Benson-Henry Institute offer free weekly guided-meditation sessions—watch All-User e-mails for dates and locations
- Create a routine to mark the end of the work day, such as listening to music on the train, changing your clothes when you get home, or taking the dog for a walk
- Make a conscious list of things that make you feel good about what you do every day
- Ask your colleagues and/or manager for ideas about how you can support one another

Additional resources:

- The Partners Employee Assistance Program (EAP), a free and confidential resource for MGH employees with a focus on self-care and building resilience. Go to: www.eap.partners.org, or call 617-726-6976
- The Massachusetts Resiliency Center offers a range of free, supportive services for survivors of the Marathon bombings, their families, first responders, medical personnel, and witnesses who were profoundly impacted. Go to: www.MAresiliencycenter.org, or call 844-787-6641.

Question: What about those who were at the scene of the bombings and/or injured in the blasts? Are there still resources for them?

Jeanette: The One Fund has shifted its focus from financial support of those injured in the bombings. Currently, the One Fund Center at MGH and the Massachusetts Eye and Ear Infirmary, in conjunction with the Benson Henry Institute, are offering supportive services to those affected. Injured parties (and their families) are already in touch with the center, which proactively reaches out to them.

For more information, contact Barbara Thorp, LICSW, program director, at 617-391-5995 or bthorp@mgh.harvard.edu.

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For more information, call: 617-724-1746

Next Publication
February 19, 2015

Announcements

Blum Center Events

National Health Observance Talks:
"Women and Heart Disease: Separating Fact from Fiction"
Friday, February 6, 2015
12:00–1:00pm
Speaker: Maria Vivaldi, MD

"Mind Body Medicine and Heart Health"
Tuesday, February 17th
12:00–1:00pm
Speaker: Michelle Dossett, MD,
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.

ACLS Classes

Certification:

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

Day one:
February 9, 2015
8:00am–3:00pm
O'Keeffe Auditorium

Day two:
February 23rd
8:00am–1:00pm
Their Conference Room

Re-certification (one-day class):
March 11th
5:30–10:30pm
Founders 130 Conference Room

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

Classes are subject to change; check website for current dates and locations.

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

Save the Dates

Local NENIC educational events

February 10, 2015
5:30–7:30pm
"New Nursing Informatics Scope and Standards of Practice" presented by, Paulette Fraser RN, ANA Scope and Standards Revision Workgroup member; Nursing Informatics Specialist, Dartmouth Hitchcock

April 30, 2015
8:00am–4:00pm
"Trends in Clinical Informatics: a Nursing Perspective"

To register or submit an abstract about practice innovation or informatics research, go to: http://www.nenic.org.

For more information, contact Mary Kennedy, RN, at program@nenic.org; or Joanna Jung, RN, at 617 549-2812.

Senior HealthWISE events

All events are free for seniors 60 and older

"Thinfluence"
Thursday, February 5, 2015
11:00am–12:00pm
Haber Conference Room
Speaker: Malissa Wood, MD, cardiologist
Discussion will focus on how to use social networking to improve health.

"Heartburn"/Gastroesophageal Reflux Disease (GERD)
Thursday, February 19th
11:00am–12:00pm
Haber Conference Room
Speaker: Sarah Emami, MD, geriatric fellow
Discussion will focus on causes, symptoms, treatments, the physiology of heartburn, and behavioral modifications that can help to alleviate the discomfort of GERD.

For information on any of the above events, call 4-6756.

Lets talk about race

How to manage the conversation

Recent events have moved race-related issues to the forefront of national news. When conversations about race arise—involving patients, colleagues or others—certain skills are critical to managing the dialogue.
Attend this skills-based session to understand perspectives and a new frame of reference around race. This teaching-from-the-headlines event will focus on increasing confidence in the ability to build relationships through affirmation and acceptance.
Join the discussion and invite a colleague from a background or tradition different from your own.

A Black History Month event
February 18, 2015
11:00am
O'Keeffe Auditorium

facilitated by
Deborah Washington, RN, director, PCS Diversity

For more information, call 4-7469.

Interdisciplinary Grand Rounds

Understanding Post-Acute Levels of Care

A well-planned discharge that places the patient in the most appropriate post-acute care setting can improve clinical outcomes, decrease re-admissions, and reduce the cost of care. All members of the healthcare team, including the patient and family, need to understand the options.

Thursday, February 12, 2015
1:30–2:30pm
O'Keeffe Auditorium

presented by:
Robert Dorman, PT; Laurene Dynan, RN; Steven Knuesel, MD; and Rachael McKenzie, RN

Contact hours and CMEs will be awarded.

For more information, call Laurene Dynan, at 617-724-9879.

MGH Safety Reporting

Same system, new look

It's an exciting time for MGH safety reporting. In 2006, an electronic safety reporting system was introduced. This year, it's getting a new look and feel.

Using the MGH Safety Reporting System, safety events, concerns, and near-misses are entered into the system and immediately sent to the Center for Quality & Safety (CQS). Reports are triaged with the most serious events investigated by CQS and unit-based quality staff (and/or reported to external agencies if necessary). Less acute events are sent to department representatives for follow-up. All reports help identify safety concerns and set the agenda for quality and safety improvements.

The new system offers:

- access for all MGH employees
- improved ease of use
- same questions, better design
- training
- resources available on how to use the system

For more information, call the Center For Quality & Safety at 617-726-9282 or email: mghsafetyreporting@partners.org

Inpatient HCAHPS Results

2013–2014

Measure	2013	2014 Year to Date	2013-2014 Change
Nurse Communication Composite	81.9	82.1	0.2
Doctor Communication Composite	82.5	81.6	-0.9
Room Clean	74.5	72.1	-2.4
Quiet at Night	50.2	49.4	-0.8
Cleanliness/Quiet Composite	62.4	60.8	-1.6
Staff Responsiveness Composite	64.7	64	-0.7
Pain Management Composite	72.3	71.8	-0.5
Communication about Meds Composite	65.5	66	0.5
Discharge Information Composite	91.8	91.7	-0.1
Overall Rating	81.2	79.9	-1.3
Likelihood to Recommend	90.4	89.8	-0.6

Data complete through November, 2014
All results reflect Top-Box (or 'Always' response) percentages
Pull date: January 20, 2015 (2014 data finalized February 16th)

2014 Nurse Communication and Communication about Medication scores continued to outperform baseline 2013. Scores for Overall Rating of the Hospital, Likelihood to Recommend MGH, and Discharge Information continue to be among the best in the nation. December surveys are still being received and added to the database (until February 16th, when the 2014 data will be finalized.

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February 5, 2015

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