

Caring

Headlines

November 5, 2015

Is the care you provide LGBT-friendly?

Are you familiar with the terms below?

Are you comfortable talking about them with your patients?

LGBTQ

Lesbian, gay, bisexual, transgender,
queer/questioning

Gender identity

A person's internal sense of
their gender

Gender expression

How a person communicates
their gender

Sexual orientation

Describes who we're attracted to,
affectionately, erotically, romantically

Cisgender

A person whose biological sex and
gender identity are aligned
(for example, a person who self-
identifies as a woman and was
assigned female at birth)

Pansexual

A person who is attracted to
someone for who they are, regardless
of gender

Assumptions

Preconceived beliefs and ideas
that limit our ability to provide
effective care

See Jeanette Ives Erickson's column on page 2

Is the care you provide LGBT-friendly?

The MGH
LGBT Employee
Resource Group's
primary mission is
to help educate the
MGH community
around LGBT
health issues
and foster an
environment
supportive of
LGBT employees,
patients, families,
and friends.

Culturally, socially, ethnically, and economically, Boston is one of the most diverse cities in America. Diversity is part of our heritage; it's what makes our city and our hospital strong and proud, impressive and sought-after. As one of Boston's flagship hospitals, our mission is to provide equitable, high-quality care to all the communities we serve. In addition to delivering exceptional clinical care, that means creating an environment that is welcoming, inclusive, and accessible to all.

In 2008, to better meet the needs of our LGBT community, the MGH LGBT Employee Resource Group was formed. The group's primary mission is to help educate the MGH community around LGBT health issues and foster an environment supportive of LGBT employees, patients, families, and friends. The LGBT Employee Resource Group works in conjunction with Human Resources and has recently begun working closely with LGBT groups at BWH and other Partners institutions.

Among its many efforts, the Employee Resource Group organizes events to celebrate National LGBT Health Week each year, usually in March or April. This annual observance is an opportunity to educate patients and healthcare professionals about health issues specific to or prevalent in the LGBT population. Presentations during Health Week have focused on substance use, suicide, and home-



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

lessness among LGBT youth, and other topics relevant to the LGBT community.

During LGBT Health Week, the Employee Resource Group distributes rainbow ribbons to MGH employees who wish to show their support of the LGBT community. Rainbow ribbons are an important emblem in the LGBT community; originally a symbol of gay pride, they've come to symbolize awareness and support. At MGH, wearing a rainbow ribbon lets members of the LGBT community know they can be open and honest during visits with their healthcare providers; the ribbons help put LGBT patients at ease and pave the way for a more meaningful dialogue about their health.

The LGBT Employee Resource Group receives many inquiries from patients and employees looking for referrals to LGBT-friendly healthcare professionals. In the past, most referrals came by word of mouth, but recently, the Employee Resource Group has begun compiling a list of LGBT-friendly provid-

continued on next page

For the past two years, MGH has been recognized by the HRC as a leader in LGBT healthcare equality. One criterion for recognition is that employees participate in an on-line, LGBT patient-centered-care training session, and I'm happy to say that MGH exceeded the required number of training hours for the 2015 HRC survey.

ers. The list continues to grow as the group reaches out to more disciplines and departments. The list can be found on the LGBT Employee Resource Group website at www.massgeneral.org/lgbt (click on View our Provider Directory). If you'd like to be added to the list, e-mail LGBTmgh@partners.org.

Since 2008, MGH has participated in HRC's (Human Rights Campaign's) Health Equality Index. HRC is the largest LGBT civil-rights organization in the country; the Health Equality Index is a benchmarking tool they use to evaluate healthcare facilities' policies and practices related to equity and inclusion of LGBT patients, visitors, and employees. For the past two years, MGH has been recognized by the HRC as a leader in LGBT healthcare equality. One criterion for recognition is that employees participate in an on-line, LGBT awareness training session, and I'm happy to say that MGH exceeded the required number of training hours for the 2015 HRC survey.

As a result of our increased awareness over the years, the hospital has revised our Patient Rights and Responsibilities, Visitor, and Equal Employment Opportunity policies to include terms such as, 'sexual orientation' and 'gender identity.' And we've revised our Visitor Policy to make it explicitly clear that we support equal visitation for same-sex couples and same-sex parents.

The Employee Resource Group, in collaboration with BWH and many departments at MGH, has been working with the Partners eCare team to ensure that the new integrated health information system will have the ability to collect LGBT-specific infor-

mation and demographics. When eCare goes live next April, staff will be able to enter sexual-orientation and gender-identity information in the history section. Questions will include: "What is the patient's sexual orientation?" "What was the patient's assigned sex at birth?" "What is the patient's gender identity now?" Providers will have an opportunity to add comments after each question or be prompted to request more information from the patient. Sexual-orientation and gender-identity information will be viewable by the care team to ensure the patient's identity is known and respected.

The Employee Resource Group is currently working to develop educational sessions for clinicians around the importance of collecting sexual-orientation and gender-identity data and how to approach the subject knowledgeably and respectfully. LGBT awareness and educational sessions are also being developed for administrative staff.

MGH is engaged in numerous efforts to make our hospital a welcoming place for patients, families, visitors, and employees. But just as important as the clinical care we provide and the structural improvements we make is the attitude we project in our interactions with patients and one another. When it comes to creating an inclusive environment, there's no substitute for a warm, open, and welcoming attitude.

For more information about the work of the LGBT Employee Resource Group, about any of the initiatives or projects mentioned here, or to attend one of their after-work social events, send e-mail to LGBTmgh@partners.org.

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A nursing career remembered

—by Rita Devlin, RN, staff nurse, Ellison 7

After more than 33 years at MGH, I'm preparing to retire. As I look back at all the advances that have been made since I started nursing, I'm amazed at how much has changed while the fundamental role of nurses has remained the same. In 1982, I was a new graduate nurse. I had just completed my second bachelor's degree, this one, in Nursing. I arrived at MGH to interview for a staff position. I remember sewing new buttons on my coat to be sure I'd make a good impression.

I was hired that day with the understanding that if I didn't pass my nursing boards, I wouldn't be able to stay. I sat for my boards in the old, 'castle' building on Arlington Street, which is now a restaurant. After two days of testing (the old-fashioned way, with paper and pencil), I passed and officially became a registered nurse.

I began working on a general medical unit in June, 1982, in the Ellison Building, the newest MGH building at the time. I worked a day-night rotation, soaking up as much information as I could. Back then, all documentation and doctors' orders were hand-written. I recall having to page doctors to clarify illegible orders or question notes in the chart. Nurses would gather around orders trying to decipher the handwriting. We got very good at it!

I remember now hospital president, Peter Slavin, MD, when he was an intern on medical units here. Many of the doctors I met three decades ago are still dedicating their time and expertise at MGH. One of them, Jim O'Connell, MD, just published a book about his time as a, 'street doctor,' working with Boston's homeless population for many years. There is an incredible pool of talented people at this hospital.

In pre-computer days, medications weren't unit-dosed. A big cabinet held medicines in large, alphabetized bottles. I'd have the patient's medication sheet in hand as I opened numerous bottles and placed prescribed doses in a cup. Medications administered between 10:00pm and 6:00am were marked in red, while daytime medications were documented in black. Every individual grid on the medication sheet was timed and initialed. It was a laborious process that required total concentration to avoid mistakes.

When narcotics were in short supply, a call was made to the Pharmacy, and a nurse would go to the basement with a picture ID to get the medications, which were transported back to the unit in a discreet, brown paper bag. I remember scooting through the basement of the old Vincent/Burnham building quickly on more than one occasion.

I remember caring for one of the first AIDs patients back in the early 80s. It was a frightening time; very little was known about the virus. I remember being told to,



Rita Devlin, RN
staff nurse, Ellison 7

“Put on a mask, gown, and gloves, and get in and out of the room as quickly as possible.” Doors were kept closed, and infected patients were isolated. It was a frightening time for patients and caregivers, alike.

We've come so far in our understanding of infectious diseases. Once, in the late 80s, it was discovered that a patient with tertiary syphilis had been in contact with x-ray technicians, transport workers, doctors, and nurses before being diagnosed. Many of us had to receive painful, deep-muscle injections of penicillin.

Equipment has come a long way, too. IV fluids used to come in glass bottles with wire hangers attached to them. There were no pumps, so we titrated the drops to match the ordered rate. Every bottle had a strip of tape showing hourly infusion times. Occasionally, fluids would run too fast,

continued on next page

and we'd have to call the doctor. As you can imagine, it was a challenge to infuse fluids at the ordered rate.

Disposable plastic suction canisters weren't available in the early days of my career. Glass canisters would be used, emptied, and cleaned by the nurse to be used again. I remember dropping a full one on my foot once. Not a pleasant experience.

Advances in wound care have been remarkable. In the early years of my career, there were no vac dressings or the multitude of wound-care products we have today. Wet-to-dry dressings were done three times a day, some elaborate cases taking a significant amount of time. You'd always hate to finish an involved dressing only to have it taken down by a doctor to inspect the wound. You'd have to re-dress it all over again.

PM, or evening care, saw patients with Foley catheters given basins of warm soapy water to be used to clean the insertion area. New sheets were provided, and they were given a back rub with lotion. Toothbrushes and toothpaste were offered, denture care was performed, and the patient was essentially 'tucked in' for the night.

Patient teaching has always been an integral part of nursing. On medical units, newly diagnosed diabetic patients required instruction on insulin-dosing and injection technique. New glucometers were coming out all the time. I remember having to learn new machines right along with patients. At discharge, information was provided and questions answered. Everything was written out long-hand. You can imagine how time-consuming it was.

When my husband and I started to grow our family, four children over the course of six years, I worked different shifts so we could share the child-rearing responsibilities. I was lucky to be able to work 'status 6' weekend shifts. Years later, I joined the 'float pool' where I was able to coordinate my schedule with my husband's shifts as a fire-fighter. I

went wherever there was a need. Sometimes, I was sent to three different units in one shift. It was a challenge to hand-write care notes for each patient then move on to the next assignment where nurses would be waiting to give report.

I had the privilege of working in the Emergency Department, on the Burn/Plastics Unit, and the Phillips House. It gave me the opportunity to always learn new skills,

meet new colleagues, and get a feel for the great variety of patients who are treated at MGH.

In the late 90s, after floating to the Ellison 7 Surgical Unit a few times, the nurse manager offered me a permanent evening position. It was a great practice environment, so I accepted. And now, as retirement looms, I know that Ellison 7 was a wonderful place to finish my career. Thirty years later, I still have questions, but someone always has the answers or knows where to find them. The teamwork and camaraderie on our unit made all the challenges we encountered surmountable.

Care-delivery isn't the only thing I've seen change. Patients have changed, as well. Patients and families are more informed, thanks to the media, technology, and the Internet. More questions are asked, and patients take a more active role in their care.

Over the years, I have been both humbled and honored to be part of patients' lives. I've seen how 'little things' can make a big difference in a patient's day. I've seen patients fight valiant battles with illness and disease. Many were able to return home, some were not. Providing empathetic, compassionate care has been a gift I'll remember and cherish always.

I'm proud to be part of the MGH team. I've met an outstanding group of caregivers and made life-long friends and acquaintances. We've all played a part in making MGH the #1 hospital in the country. I truly believe that the essence of nursing is a delicate balance of compassion and knowledge.



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Non-clinical experiences can have profound effect on practice

It was about a month into Mr. W's admission, and I was going to be his third physical therapist. I entered his room along with my student. I didn't realize at the time that meeting Mr. W was going to change my day, my week, and my year.

My name is Stephanie Lane, and I am a staff physical therapist. I had been working on the Ellison 10 Cardiac Step-Down Unit for about nine months when I went in to meet Mr. W.

It was about a month into his admission, and I was going to be his third physical therapist. I entered his room along with my student. I didn't realize at the time that meeting Mr. W was going to change my day, my week, and my year.

Mr. W: "I'm not going to do anything today. I'm beyond frustrated. Doctors tell me one thing, then they change the plan. I've been here for a month! I can't take it anymore."

Stephanie: "Mr. W, I completely understand that you're frustrated. I just wanted to come in and introduce myself. I'm going to be working with you to progress toward your goals and hopefully get you out of bed. My name is Stephanie. I'm a physical therapist. I saw in your chart that you're from my home town."

He looked at me.

Mr. W: "Stephanie. What's your last name?"

Stephanie: "Lane."

Mr. W: "Are you Pam Lane's daughter?"



Stephanie Lane, PT
physical therapist

Stephanie: "Yes, I am."

Mr. W: "Stephanie, I'm so sorry. I think I'm going to cry."

Mr. W and I looked at each other, tears welling up in both our eyes. We shared a moment of silence as a place as enormous as MGH suddenly became very small.

For most of my time on Ellison 10, no one had known that I lost my mom in a tragic accident. I had rotated from Ellison 19 a month before it happened. I'd gotten used to no one knowing what had happened. I could come to work and once I got to the cardiac unit, no one looked at me with those, 'Poor girl,' eyes.

Walking into Mr. W's room now, meeting a patient who had known my mother well enough to bring him to tears was unexpected and a complete

continued on next page

Since meeting Mr. W, I've kept this patient story with me, especially when encountering similar situations. It helps me remember that we never really know what's going on in people's lives despite reading their charts or reviewing their documentation.

emotional shock. I wasn't prepared. And to make matters worse, I had an audience—my student had no idea what was happening or why I was now crying with a patient we'd literally just met. I collected myself. I dried my face and, knowing I'd see Mr. W tomorrow, told him I'd give him the day to focus on his medical issues and see him tomorrow.

When I returned to Mr. W's room the next day, he could not have been more apologetic about how he'd acted the day before—when he hadn't yet realized who I was.

I told him it was okay, but he looked at me and said, "No, it's not."

Mr. W and I continued to foster a personal and professional relationship as we reminisced about our lives in our home town. Mr. W told me he remembered me when I was a little girl. When I was 6 years old, our parents had been friends and I'd had play dates with his daughter.

I started to look forward to working with Mr. W. I'd think about him on my way in to the hospital. I realized that it meant a lot to me to have him express such strong emotion and empathy for my loss. I wanted to help him get better. I want all my patients to get better, or course, but there was something different going on here. I guess, in a way, I felt I couldn't help my mom, but I could help improve the life of someone she had touched in such a positive way.

Mr. W had not stood in more than a month. I wanted him to be able to stand and look out the window, to see the view of the river he missed so much. Together, we worked on rolling over in bed, sitting at the edge of bed, and a number of other exercises. After about a week, I re-assessed his condition and found he was getting stronger. Clinically, I felt he had the strength to stand—I just had to convince Mr. W he could do it.

Mr. W looked at me as if I were crazy. He was worried that I wouldn't be able to support him with my small frame. But with encouragement, he agreed to give it a try. Mr. W finally stood! The smile on his face was unforgettable. We were so happy, we took a picture to send to the people in our home town. I can't explain the joy it gave me to help him achieve this goal.

Looking back at my career as a physical therapist, there have been many occasions when I've walked into patients' rooms only to bear the brunt of their frustration for one reason or another. Sometimes, it's the hardest part of my day. On the day I met Mr. W, in the most difficult year of my life, bearing the brunt of his frustration was more difficult than ever before.

As a physical therapist in an acute-care setting, I'm always going to be meeting people at some of the worst moments in their lives. I have an opportunity to make their lives better even though the road may not always be easy.

Since meeting Mr. W, I've kept this patient story with me, especially when encountering similar situations. It helps me remember that we never really know what's going on in people's lives despite reading their charts or reviewing their documentation.

I also think of this patient story for personal reasons. Because as much as Mr. W needed me to help him progress functionally, I needed that interaction with him to see how my mother had impacted his life in such a positive way. I don't think Mr. W will ever know how much that meant to me.

Being a physical therapist requires patience and care as well as enough tactful persuasion to be able to 'push' patients through hard times. I think this story perfectly captures the highs and lows of this past year and my growth and development as a therapist.

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

Not all professional development comes from textbooks and classrooms and training. There is much to be learned from our everyday interactions with patients. I'm certain that Pam Lane is proud of her daughter, Stephanie, for recognizing the opportunity to enhance her practice when it presented itself in the form of Mr. W. Stephanie's contribution to Mr. W's recovery not only enabled him to stand and re-gain precious functionality, it honored her mother's memory. That is indeed, a very bright spot in a very difficult year.

Thank-you, Stephanie. I'm sorry for your loss.

Now enter nursing certification in PeopleSoft

We all understand the value of lifelong learning and seeking certification in specialty practice areas. Both represent significant milestones in a clinician's professional development, and both instill confidence in the minds of patients and families. Magnet hospitals, especially, place a high premium on continuing education and specialty certification as they both demonstrate a commitment to delivering the highest quality care.

In many ways, advancing one's knowledge and expertise is its own reward—and certainly, it's of great value to patients and families—but there's also merit in being able to document and track certification data within departments and throughout the organization. Historically, that has not been easy to do for nursing because of the sheer number of nursing sub-specialty certifications available. Which is what prompted the creation of a new data-collection option in PeopleSoft. Effective immediately, nurses can now enter their certification information in a new form under the Qualifications tab of their Current Profiles section.

One of the criteria for becoming a Magnet hospital is the number of national certifications held by nurses. The goal of the American Nurses Credentialing Center is for 70% of nurses at Magnet hospitals to be board-certified. Being able to enter and track that information in PeopleSoft will make it easier to report certification data when it comes time to re-apply for Magnet designation.

To enter your certification information, log in to PeopleSoft, select HRMS Production>Main Menu>Self Service>Learning and Development>My Current Profile>Qualifications. Below Honors and Awards and Memberships, you'll see Magnet Certification. Click on Add New Magnet Certification, and a data-entry form will open.

Most of the fields are self-explanatory, including the drop-down box where you'll see an extensive list of nursing certifications and choose the appropriate entry. Certifications are listed according to how they're abbreviated (ACNP, acute care nurse practitioner; CCRN, certified critical care nurse; CEN, certified emergency nurse, etc.)

The one field that may not be intuitive is Content Item ID. Click on the magnifying glass at the right and select MAGNETCERT.

The screenshot shows a 'Details' form with the following fields and values:

Details	
*Effective Date:	05/26/2015
*Content Item ID:	[Empty field with magnifying glass icon]
Nursing Certification:	[Dropdown menu]
Date Issued:	[Empty field]
Expiration Date:	[Empty field]

Buttons: OK, Apply and Add Another

The PCS Management Systems and Financial Performance team partnered with the MGH HRIS team lead by Bonnie Welch to create this new data-entry option, which will be used throughout the Partners network.

For information about certification—including reimbursement for the cost of certification and re-certification offered by nationally recognized professional organizations—go to the EED portal page at: http://www.mghpcs.org/eed_portal/EED_profdev.asp.

Understanding the PCS budget process

Question: I'm guessing that Patient Care Services accounts for a significant portion of the hospital's overall operating budget. Is that true?

Jeanette: Patient Care Services (PCS) accounts for about 45% of the hospital's FTEs (full time equivalents). But when looking at our annual budget for salary and non-salary dollars, PCS accounts for less than 30% of the overall MGH budget.

Question: How is PCS's staffing budget determined?

Jeanette: As you can imagine, it's a complex process. First, MGH is a member of Partners. The budget process begins with Partners establishing a margin target for the whole system that will ensure our solvency over the next five years. Each Partners hospital is then assigned a corresponding margin target to achieve its share of the goal.

Anticipated revenue is based on departmental volume combined with expected rate changes from the various payors. Changes in the market, especially increases implemented by payors (1-2% annually), influence revenue growth. Changes in the types of payors (government vs. commercial) and services provided (surgery vs. medical, inpatient vs. outpatient) influence funding for expense growth. And of course, hospital initiatives, such as Partners eCare are also factored in.

Second, each MGH department must meet certain budgetary targets. Targets vary based on priorities determined by senior leadership. In PCS, we're fortunate to have significant data on which to base our budget modeling. For units using Quadramed (our patient acuity tool), staffing budgets are developed using Quadramed data and adjusted in conjunction with input from leadership. For units not using Quadramed, staffing models are employed that were created specifically for budget development. There's actually quite a bit of art and science in establishing these budgets.

Question: What about the non-salary budget?

Jeanette: The PCS non-salary budget is significantly smaller than the salary budget. This includes supplies, service contracts, laundry charge-backs, meal charge-backs, and rental space. Budgets in these categories are adjusted annually based on utilization, contracts, and cost-reduction initiatives.

Question: How long does the full budget process take?

Jeanette: The budget process begins in February and after a number of revisions is usually done by July or August. While it is somewhat time-consuming, it does take into account the needs, priorities, initiatives, and challenges of the entire organization. A strictly finance-driven budget process might take less time, but it wouldn't be as meaningful or aligned with our mission and goals.

Question: Who puts this all together?

Jeanette: PCS's Management Systems and Financial Performance (MSFP) team works closely with the MGH Budget Office throughout the budget process. MSFP compiles the budgets for Nursing and enters them into the electronic budget. Our colleagues in the health professions do the analysis and entry for their respective budgets working closely with the MSFP team.

For more information about budgeting or the work of the Management Systems and Financial Performance team, call 617-724-1649.

Product Value Analysis Committee

improving patient comfort and cutting costs

In addition to patient-care benefits, the new bariatric bed represents a new approach for MGH—we're using an own/rent model. We've purchased a certain number of beds, and we'll rent more if/when/as the need arises. We anticipate a \$95,000 annual savings using this new model.

Question: I'm thrilled to have new mattresses on our unit. How did that come about?

Jeanette: Nurses and unit service associates brought the need to replace mattresses on our general care units to the attention of the PCS Product Value Analysis Committee (PVAC). In collaboration with Partners Purchasing, the PVAC identified five options for potential new mattresses. Last fall, the PVAC held a Mattress Fair to get recommendations from staff on which mattresses should be trialed. Based on that input, two mattresses were trialed on Ellison 7 and Ellison 16. Evaluations of those two mattresses resulted in a clear decision in favor of the Arjo-Huntleigh Pressure IQ Evolve.

The cost of replacing the mattresses exceeded \$650,000. But with strong support from MGH president, Peter Slavin, MD, 924 new mattresses were ordered. They were delivered in waves throughout August and September, and nurses, patient care associates, unit service associates, and Materials Management staff replaced the old mattresses with as little disruption to patients as possible. In addition to their clinical and comfort benefits, the new mattresses are expected to save the hospital \$50,000 by eliminating nearly all rentals of wound surface overlays. Thanks to all who identified the need, guided the selection process, and helped to replace the old mattresses. For more information, please reach out to your clinical nurse specialist.

Question: One of my patients just tried the new bariatric bed. It's great. How did that come about?

Jeanette: The PVAC was asked to identify opportunities to reduce bed-rental expenses. They consulted with the Wound Care Task Force and our

bed-rental supplier and found a better bariatric bed that also reduces our operating expense. The bed was evaluated by clinical staff and was found to be better than the bariatric beds we were renting. The new bed can accommodate patients up to 1,000 pounds. It is completely automated and has a width expansion of 40-50 inches. Input from staff about the beds has been consistently positive. In addition to patient-care benefits, the new bed represents a new approach for MGH—instead of exclusively renting or owning equipment, we're using an own/rent model. We've purchased a certain number of beds, and we'll rent more if/when/as the need arises. We anticipate a \$95,000 annual savings using this new model.

To make this new approach as simple as possible for staff, and to provide the necessary inventory-management, our goal is to have no change in the process for requesting the pick-up or delivery of a bariatric bed. Once the clinical decision is made that a bariatric bed is needed, all requests will be directed to the manufacturer by calling 1-800-638-2546. When the patient no longer needs the bed, staff should immediately call the same number to request a pick-up.

Question: If I have an idea for a cost-saving product, whom should I call?

Jeanette: We'd love to hear your ideas. You can reach out to your clinical nurse specialist, nursing director, or department head, and they can assist you in getting your idea to the Product Value Analysis Committee. Or you can contact the PVAC directly by calling Chris Annese, RN, staff specialist, at 617-726-3277.

Announcements

Blum Center Events

Please note the different times for each program.

“Chronic obstructive pulmonary disease (COPD): a commonly overlooked disease”
Tuesday, November 10, 2015
1:00–2:00pm
presented by Scott Harris, MD

“Helping patients with serious illness live well: the role of palliative care”
Monday, November 16th
11:00am–12:00pm
presented by Juliet Jacobsen, MD

“Quit smoking to win”
Tuesday, November 17th
1:00–2:00pm
presented by Nancy McCleary, RN

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.

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.

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.

ACLS Class

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

Day one:
February 19, 2016
8:00am–3:00pm

Day two:
February 29th
8:00am–1:00pm

Re-certification (one-day class):
January 13th
5:30–10:30pm

Instructor class:
December 2, 2015
7:00am–3:00pm

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

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

Published by

Caring Headlines is published twice each month by the department of Patient Care Services at Massachusetts General Hospital

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617-724-1746

Next Publication

November 19, 2015

Inpatient HCAHPS

2015 calendar year, to date

Measure	2014	2015 Year to Date	2014- 2015 Change
Nurse Communication Composite	82.1	83.1	1
Doctor Communication Composite	81.6	83.4	1.8
Room Clean	72.2	72.7	0.5
Quiet at Night	49.7	51.4	1.7
Cleanliness/Quiet Composite	60.9	62.0	1.1
Staff Responsiveness Composite	63.8	65.8	2
Pain Management Composite	71.7	73.5	1.8
Communication about Meds Composite	65.8	66.3	0.5
Discharge Information Composite	91.6	91.1	-0.5
Overall Rating	79.8	81.4	1.6
Likelihood to Recommend	90	90.8	0.8

Our current patient experience survey scores continue to perform extremely well. We are making excellent strides in our three target indicators: Quiet at Night, Staff Responsiveness, and Pain Management—all are well above our goals.

Data complete through August, 2015
 All results reflect Top-Box (or 'Always' response) percentages
 Pull date: October 15, 2015



Returns only to:
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