

Caring

Headlines

August 4, 2016

Compassionate care remembered more than a decade later



(L-): Lunder 8 neuroscience staff nurses, Annette Kavanagh, RN, and Kristin Baronas, RN, with director of the MGH Empathy and Relational Science Program, Helen Riess, MD.

IDEA grants

• Innovation • Design • Excellence
• Awards

That's the impetus behind the creation of the new innovation grants program, IDEAs. Employees of Nursing and Patient Care Services are invited to submit proposals for ideas that could improve the way we deliver care for patients and families.

Staff at the bedside, in exam rooms, at reception desks, and in other patient-care and support positions are intimately acquainted with the day-to-day operations of our hospital. Staff throughout Nursing and Patient Care Services are in a position to recognize inefficiencies and identify opportunities to improve care and services. That's the impetus behind the creation of the new innovation grants program, IDEAs. Employees of Nursing and Patient Care Services are invited to submit proposals for ideas that could improve the way we deliver care for patients and families. IDEA proposals must align with at least one prong of our mission (patient care, research, education, or community), and must be geared toward improving:

- care delivery (advancing the Aims of the IOM)
- eCare
- work flow
- the work environment
- the patient experience
- staff engagement
- cost containment

Ideas can focus on entirely new ways of working or they can suggest changes to existing systems that



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

would result in greater value for patients, families, colleagues, the departments within Patient Care Services, or the hospital at large. Proposals should begin with an idea that meets a need, closes a gap in service, or creates value by advancing, enhancing, or improving systems.

Anyone who works in Nursing and Patient Care Services is eligible to submit a proposal (manager/leadership endorsement will be required). Mentors and members of the IDEA Steering Committee will be available for consultation in preparing proposals (planning, budget preparation, implementation, and evaluation). Proposals will be submitted on-line, reviewed by the Steering Committee (which includes representatives from within and outside the MGH community), then co-chairs, Gaurdia Banister, RN, executive director of The Institute for Patient Care,

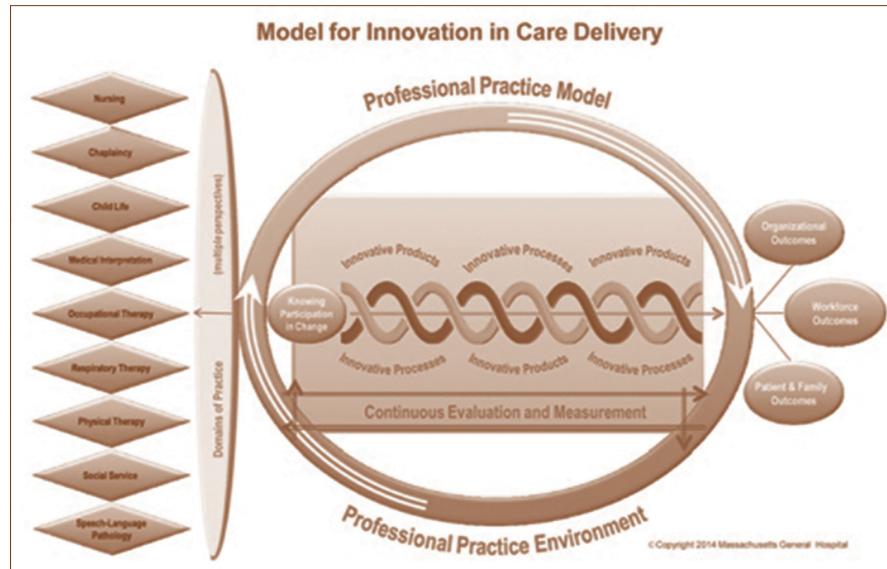
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Ideas are out there. We're hoping the IDEAs innovation grant program will help us find, develop, and implement these ideas to improve care and services. Proposals will be accepted through mid-October. Award recipients will be formally announced at a Nursing and Patient Care Services town hall meeting this fall.

and Marianne Ditomassi, RN, executive director for PCS Operations, will deliver the recommendations to me for final approval. Selection will be based on each proposal's alignment with our mission, feasibility for undertaking, and likelihood of success.

One or two awards will be given this year, with funding of up to \$5,000 (funding is for one calendar year). Grant applicants will be notified of their status, and award recipients will be formally announced at a Nursing and Patient Care Services town hall meeting this fall. Recipients will be required to provide status reports and disseminate their work.

Ideas are out there. We're hoping the IDEAs innovation grant program will help us find, develop, and implement these ideas to improve care and services. Proposals will be accepted through mid-October. For more information, call Amy Giuliano, senior project manager, at 617-643-9670.



The above Model for Innovation in Care Delivery provides a conceptual framework for our approach to innovation in terms of process, products, and evaluation of outcomes. The section on the left highlights the various domains of practice, promoting the idea that many different perspectives can engage in the innovation process. The inter-connectedness of products and processes is represented by the braid within the circle—innovation in one area can stimulate opportunities to innovate in other ways and other areas. The rectangle represents the continuous, dynamic process of evaluation, essential for measuring impact and sustainability, and optimizing outcomes within the organization.

In this Issue

Compassionate Care Remembered.....	1	Clinical Narrative	6-7
Jeanette Ives Erickson.....	2-3	• Catherine Holley, RN	
• IDEA Grants		Compassionate Care Remembered.....	8-9
Commentary.....	4	Announcements.....	10
• Deborah Washington, RN, Director, PCS Diversity		In Memoriam: Peg Ramage, RN.....	11
Fielding the Issues.....	5	HCAHPS.....	12
• New Pharmacy & Therapeutics Safety Committee			

Heartbreak, hard work, and healing in these heated times

—by Deborah Washington, RN, director, PCS Diversity

Can there be harmony in this climate of unrest? Yes. Our personal and professional identities bind us to a common purpose... We were called to the caring professions by a desire to heal, to help our fellow man, and to do good in this world.

Anger, despair, loss of bearings. Confusion, frustration, failure to understand. These are the feelings being shared with me in hallway conversations, phone calls, and e-mails. Why? On Friday, July 8, 2016, the fatal shooting of police officers in Dallas shocked the nation and re-defined the conversation on racism. One individual took it upon himself to kill five police officers following a string of fatal encounters between police and black citizens. The national dialogue has changed. Before Dallas, a growing tally of black deaths captured headlines. After Dallas, a generalized sense of danger invaded our consciousness. Our peace is shaken; our sense of security is no longer business as usual.

Fear, anger, and a potent sense of injustice are fueling a dangerous divide in our cities. Questions long asked by minorities are making their way into mainstream media: Are individuals racist, or is the system just not functioning? Are these isolated instances of racism, or is this institutional racism? We need to ask these questions. We can't settle for 'diversity lite' as we struggle with these issues. And most importantly, we cannot become a society that judges the many based on the actions of a few.

Yes, people are angry. Black people and white people are angry. Thinking, feeling, rational people are angry. We're supposed to be problem-solvers. We expect law and order and justice for all. But these acts of violence skew our civic equilibrium. They diminish our confidence in the belief that we control our own destiny.

But here's something to think about as we grapple with the tragedies in Baltimore, Ferguson, New York, Dallas, and Baton Rouge. Health care and law enforcement have something in common. Both are critically important entities that need to uphold society's highest ideals—integrity, transparency, and the fair and equal treatment of our constituencies. Both are charged with serving and protecting. And both are unable to fulfill their mission when prejudice and racism



Deborah Washington, RN
director, PCS Diversity

become part of the mix. Health care and law enforcement must be above reproach.

Our work around diversity has shown us that we all harbor unconscious biases. People of color experience those biases on a daily basis. Consciously or unconsciously, if those biases lead to the 'othering' of patients, families, or colleagues, we have failed in our charge to uphold society's highest ideals; and more importantly, we have violated a sacred trust with our constituents.

So where do we go from here?

With everything going on in the world, people are asking: Can there be harmony in this climate of unrest? And the answer is, Yes. Our personal and professional identities bind us to a common purpose. We were called to the caring professions by a desire to heal, to help our fellow man, and to do good in this world. So let us honor that bond, let us do the work we came to do, let us keep the lines of communication open. And let us stay true to our aspirations no matter the challenges. The stakes are too high to settle for anything less.

New Pharmacy & Therapeutics Safety Committee

Question: What is the new Pharmacy & Therapeutics Safety Committee?

Jeanette: The Pharmacy & Therapeutics Safety Committee (PTSC) was formally known as the Medication Education Safety and Approval Committee (MESAC). It was created to ensure excellence in medication management and safe medication practices.

Question: Why the change from MESAC to PTSC?

Jeanette: MESAC was developed in 2004 to replace the Drug Therapy Committee and was specifically designed to be multi-disciplinary with a comprehensive scope. With the formation of the Partners-wide Pharmacy & Therapeutics Committee, there was an opportunity to review the MESAC structure. The new PTSC structure enhances medication safety, efficiency, and affordability at the local level while at the same time more closely aligning our efforts with others throughout the Partners network.

The committee is responsible for managing the formulary system; developing drug policies, procedures, and guidelines; and evaluating medication utilization to ensure safe, evidence-based, cost-effective medication practices. Four subcommittees support the PTSC's efforts:

- Medication Safety & Quality
- Medication Utilization
- Clinical Specialty Subcommittees
- Policy and Compliance.

The PTSC Executive Committee provides leadership oversight in support of PTSC goals, priorities, and allocation of resources.

Question: How do you request a new or updated medication policy, guideline, formulary addition, or addition to an infusion-pump medication library?

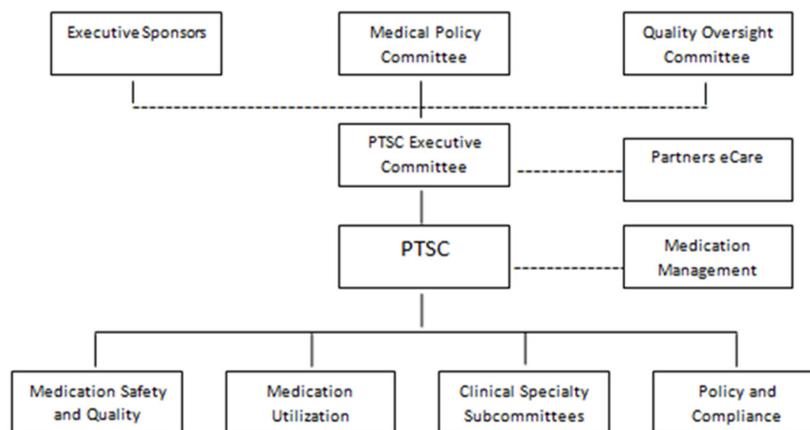
Jeanette: To request any of the above, contact Jackie MacCormack-Gagnon, RPh, drug policy clinical pharmacist, at 617-643-8362.

For more information about the new PTSC, e-mail any of the PTSC co-chairs: Christopher Coley, MD, assistant chief of Medicine for Quality; Christopher Fortier, RPh, chief pharmacy officer; or Kevin Whitney, RN, associate chief nurse.

Question: What is the new PTSC structure?

Jeanette: PTSC is a standing committee of the Medical Policy Committee with representation from registered nurses, physicians, advanced practice providers, and phar-

PTSC Committee Structure



Relationship-based care in the fast-paced setting of the OR

The first patient scheduled for surgery that day was 'Betty,' a breast-biopsy patient... Betty had seen doctors about the swelling. She'd been told it was lymphedema, but no one had ever offered suggestions on how to care for or treat it.

My name is Catherine Holley, and I am an operating room nurse on the Surgical Oncology/Trauma team. Each shift, I'm assigned to a specific operating room (OR). On this particular morning, I had the role of circulating nurse, responsible for managing all nursing care within the OR. As the circulating nurse, I have duties outside the sterile field, affording me a 'big-picture' view of the surgical process while assessing, observing, and assisting the team in creating and maintaining a safe environment for the patient. The first scheduled surgery that day was 'Betty,' a breast-biopsy patient.

A critical part of the circulating nurse's role, in addition to quality care and safety, is a comprehensive review of the patient's medical history. This helps inform a broader perspective of the patient's overall health, including emotional concerns, domestic issues, coping mechanisms, and makes me better equipped to anticipate patients' needs and advocate for them while they're anesthetized.

Relationship-based care is deeply woven into my practice. Engaging with patients on a personal level and identifying common areas of interest help build respect and trust in the nurse-patient relationship. In the perioperative setting, there's precious little time to get to know patients prior to surgery, so establishing trust is a kind of art form.

Betty arrived in the OR area tearful; she was concerned about the results of the breast biopsy. Impending surgery often causes anxiety; I knew I needed to support and validate her concerns.



Catherine Holley, RN
operating room nurse

Offering those words that seem so obvious, I assured her that her surgeon was excellent and the OR team was prepared for her procedure.

As I completed her pre-surgical assessment, I had one more question. It's a simple question, but in my more than 35-year nursing career, it has become an essential part of my pre-surgical practice.

I asked, "Is there anything else you'd like me to know; anything else I should be aware of?"

Nodding, she motioned to her right leg.

"I have a problem with my leg," she said. "It's very swollen."

I lifted the blanket and saw that her leg was indeed edematous from thigh to ankle. I asked if she had a history of DVTs (deep vein thrombosis). I palpated her leg, inquiring if there was any pain or if she had any limitations with movement. She said it wasn't painful, but it was 'heavy.' She explained that it had developed after a prior surgery on that leg a few years before.

Betty had seen doctors about the swelling. She'd been told it was lymphedema, but no one had ever offered suggestions on how to care for or treat it.

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When I later reflected on my encounter with Betty, I realized that an unexpected outcome of our meeting was the impact it had had on me. The brief moments I spent with Betty prompted me to re-evaluate my journey with lymphedema. I realized that I, too, had a voice, and I should be sharing my knowledge to help educate others.

At that point, I reached down and pulled up the leg of my scrub pants, exposing my own swollen leg. I explained to Betty that I, too, had lymphedema. I'd had it for 30 years, also a result of surgery back when I was in nursing school.

Lymphedema occurs when the lymphatic system is unable to perform one of its basic functions—removing water and protein from tissues in a portion of the body. It can be caused by developmental abnormalities of the lymphatic system (primary lymphedema) or damage to the lymphatic system (secondary lymphedema) from surgery, infection, radiation, or trauma.

Betty had never met anyone with this condition before, and we even had it on 'the same leg.' She asked many questions about my experience with lymphedema, if there was anything that could help relieve the swelling, where I received treatment, and where to find compression stockings. I felt a genuine connection with Betty. This was an opportunity to share my knowledge with her as well as my personal efforts to find a specialist and some key points about lymphedema therapy.

I began to educate Betty about the chronicity of lymphedema and how it can be managed with positive outcomes with the help of physical therapy and customized compression stockings. This conversation brought our nurse-patient relationship to a new level. We were two people who shared an unusual medical condition. She was thirsty for knowledge, and her interest in learning more was palpable.

But I was surprised by how our conversation seemed to transform me, as well. I stepped into advocate mode, sharing websites, nationally recognized organizations, and other resources. Betty could become her own advocate and through her own research realize the tremendous resources available for those of us with lymphedema. Betty couldn't wait to tell her husband about our discussion; that she'd found someone who understood what she was dealing with on a daily basis.

Betty held my hand and thanked me, saying, 'fate' had brought us together. Her gratitude was so heartfelt, it brought tears to my eyes. It was obvious this was a special moment for me, too.

As the circulating nurse, my responsibility is to ensure a safe and protective environment for patients while they're anesthetized. By identifying Betty's lymphedema, and along with my own personal knowledge of the condition, I was truly able

to be her advocate as we moved forward with her procedure. My input was well received by the team, and as Betty's caregivers, we all took care to optimize her surgical experience.

Betty's procedure proceeded without incident or complication. The surgeon excised the breast tissue and the specimen was sent to Pathology.

Due to the nature of the perioperative setting, we seldom hear the final pathology results or learn the patient's condition once they leave the OR. But the following week, I sought out Betty's surgeon and learned that her biopsy had been negative for malignancy. She didn't have breast cancer and would continue to have mammograms every six months. I don't know what, if any, follow-up Betty received regarding her lymphedema. But I believe our honest and very personal conversation would have motivated her to take a greater role in her care, to advocate for herself, and to seek out the appropriate treatment.

When I later reflected on my encounter with Betty, I realized that an unexpected outcome of our meeting was the impact it had had on me. The brief moments I spent with Betty prompted me to re-evaluate my journey with lymphedema. I realized that I, too, had a voice, and I should be sharing my knowledge to help educate others. I was energized and empowered to reach out to my colleagues to educate them and raise awareness about the risk factors of lymphedema that can potentially affect all surgical patients.

As a nurse, there's no greater feeling than knowing you made a difference in a patient's experience or had an impact beyond the few moments you spent with them in the OR. I know that meeting Betty certainly made a difference in my life.

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

Building trust is a two-way street. Sometimes, that means disclosing information about ourselves so patients don't feel like they're in a one-sided relationship. Whether, when, and how much personal information we share depends on the patient, the situation, and the clinician. Cathy's choice to share her lymphedema experience with Betty came at exactly the right time and was for exactly the right reasons. In that one brief exchange, Cathy gave her patient much-needed information, comfort in knowing she wasn't alone, and most importantly, hope for the future.

Thank-you, Cathy.

Compassionate care remembered more than a decade later

—by Ann Kennedy, RN, nursing director, Lunder 8 Neuroscience Unit

“They may forget your name, but they will never forget how you made them feel.”

—Maya Angelou

Thirteen years ago, Mr. J was admitted to the Ellison 12 Neuroscience Unit (now Lunder 8). He had suffered a debilitating stroke with significant speech deficits and paralysis on his left side. Mr. J was in his early 50s, in the prime of his life. At the time of his stroke, Mr. J and his family had been preparing for the wedding of his eldest daughter, Brandy, in just a few days. Dealing with the stroke was draining for the entire family, but Mr. J, especially, was devastated that he wouldn't be able to walk his daughter down the aisle, a time-honored rite of passage in a father-daughter relationship.

As the weekend of the wedding approached, Mr. J became more depressed. He had requested a day pass to attend the wedding, but the medical team deemed his condition too unstable with the possibility of a second stroke too high. On the day of the wedding, a sense of melancholy permeated the unit. In addition to Mr. J's sadness, staff were dejected that he wouldn't be able to walk his daughter down the aisle or participate in Brandy's big day. Coincidentally, at the time, several staff members were immersed in planning their own weddings, so they really empathized with Mr. J's situation.

Annette Kavanagh is an exceptional nurse. She investigates every aspect of her patients' lives: medical, physical, emotional, social. She takes the time to learn about them as individuals, find out who they were prior to their neurological events.

This is how Annette described that day in a clinical narrative published in the July 21, 2005, issue of *Caring Headlines*.

When I entered the room that morning, I could see the sadness and disappointment in Mr. J's eyes. He had a flat affect and responded with one-word answers. I pulled a chair up beside the bed and told Mr. J that I'd learned of his daughter's wedding and empathized with him about how difficult it must be for him. Instantly, Mr. J became more engaged in the conversation, telling me how his daughter had picked out her dress in college, long before she even knew she was getting married.

We talked about his illness and current limitations. Mr. J quickly returned to the topic of his daughter's wedding and informed me that his daughter was coming to the hospital that afternoon. He asked if I'd be working late that night. When I told him I was scheduled to leave at 3:00pm, he became anxious and started to weep.

“My daughter is coming at three o'clock with the photographer,” he said. He asked if I'd help him get dressed in his tuxedo so he could have pictures taken with his daughter. He was concerned that it might not be possible as his daughter's arrival coincided with change of shift.

I assured Mr. J that I would have him ready and not to worry. (As it turned out, someone called in sick that day, and I ended up staying until 7:00). After attending to his medical needs, Mr. J and I decided he should have a beard-trim and haircut for the big event. A stylist came to his room from the MGH Hair Salon, and with Mr. J's guidance, I trimmed his beard.

As I continued with my morning rounds, I was paged to take a telephone call. It was Mr. J's wife. I could only imagine what she must be going through with the excitement of her daughter's wedding and the anxiety of her husband's illness. Mrs. J expressed deep gratitude for the care her husband was receiving and asked if it was going to be possible to get Mr. J ready considering that it was going to be change of shift. I assured Mrs. J that we would have him ready.

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Relationship-Based Care (continued)

As the day progressed, extended family members visited and offered support. Mr. J's cousin arrived at 2:00 with tuxedo and accessories in hand. Word had spread on the unit that there was going to be a 3:00 wedding, and staff and patients alike were getting excited. At 2:15, with the help of my colleagues, Kristen, Suad, and others, I started to get Mr. J ready. We got him into his tux, but he was worried about all the equipment and monitors being in the pictures and whether there'd be enough space to take family pictures in his room. So we transferred Mr. J to a cardiac chair and moved him to the solarium for picture-taking. We used 30-foot IV tubing so no IV poles would be visible in the pictures.

At exactly 3:00, Mr. J's daughter and the bridal party stepped off the elevator. His daughter was truly surprised to see her dad in his tux. Mrs. J arrived and, holding back tears, went to embrace her husband. All the nurses who were scheduled to leave at 3:00 put their plans on hold and stayed to celebrate with Mr. J and his family. Few words were spoken, just the passing of Kleenex to members of the bridal party, staff, and patients.

After all the pictures were taken, Mr. J insisted that the family continue on to the reception. While taking Mr. J back to his room, he thanked me profusely then joked, "Now get me out of this tux!"

Neuroscience nurses identify and overcome barriers. Thanks to the efforts of Annette and her colleagues, stroke notwithstanding, Mr. J was able to be 'the father of the bride.'

Fast-forward to 2016, when Helen Riess, MD, director of the MGH Empathy and Relational Science Program, attended a symposium of the Gold Foundation for Humanism in Medicine Research in Chicago. One of the speakers was Mr. J's daughter, Brandy, who's now an advocate for compassionate care at the Foundation. In her presentation, Brandy spoke about Annette's care of her father on her wedding day. And according to an e-mail sent by Riess to Annette, "The story of your kindness moved everyone at the symposium."

On May 24, 2016, Brandy reached out to Annette directly via e-mail. She reflected on Annette's many kindnesses 13 years before and brought Annette up to date on her dad's progress. On her one-year anniversary, the family had re-enacted Brandy's wedding, and Mr. J, dressed in his tuxedo, officially walked his daughter down the aisle.

In her e-mail Brandy wrote, "Please know that your work, your care, your time, your effort were so appreciated that day, and even now. Thank-you for providing my family with such genuinely compassionate care. It meant the world to me."

Essential to the art of nursing is the nurse's ability to be present, to understand, and be compassionate. Mr. J's story beautifully illustrates the power of the art of nursing. We're invited into the

lives of patients and families when they're most vulnerable and frequently unable to advocate for themselves. Nursing is a privilege, a gift.

Nurses should never underestimate the impact they have on patients and families. Annette created a lasting memory for Mr. J and his family. And contrary to Maya Angelou's famous quote, Brandy not only remembered how Annette made them feel, she also remembered her name.



In 2005 in the Ellison 12 solarium, (l-r): bride, Brandy; Mr. J; Brandy's sister; and Mrs. J.

(Photo by Kristin Duarte)

Announcements

MGH Nurses Alumnae Association fall reunion and educational program

This year's theme:
"Nurse Leaders Making a Difference"
Friday, September 23, 2016
O'Keefe Auditorium
8:00am–4:30pm

Sessions will include: "The Development of the Nursing Leadership Academy," "Doctor of Nursing Practice Program," "Global Nursing," "Advancing Peer Review," and more.

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

Blum Center Events

"Psoriasis: causes, related health problems, and treatments

Thursday, Aug 4
11:00 AM – 12:00 PM
Haber Conference Room

Psoriasis is an autoimmune skin condition linked to serious health problems, such as obesity, heart disease, and arthritis.

Program is free and open to MGH staff and patients. No registration required.

For more information, call 4-3823.

SAFER Fair and community outreach event

Join collaborative governance champions to learn how they're working to make a SAFER environment for patients, families, and staff.

And bring socks!

Please bring a pair (or two) of new socks to be donated to a local community shelter.

There will be games, refreshments, and prizes.

Wednesday, October 19, 2016
12:00–2:00pm
Under the Bulfinch Tent

For information, call Mary Ellen Smith, RN, at 4-5801.

Global Nursing: a Force for Change Improving Health System Resilience

October 14-15, 2016
9:00am–5:00pm
at MGH

Join nurse leaders, clinicians, and educators to discuss the critical role of nursing in strengthening health systems around the world.

Abstract submission deadline is September 1, 2016. Acceptance notifications will be sent via e-mail by September 15, 2016.

For more information, or to submit an abstract, go to:
<http://www.massgeneral.org/globalhealth/>

Open to the public

ACLS Classes

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

Day one:
November 10, 2016
8:00am–3:00pm

Day two:
November 11th
8:00am–1:00pm

Re-certification (one-day class):
August 10th
5:30–10:30pm
and August 13th (Saturday)
8:00am–12:00pm

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

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

MGH HAZMAT Response Team

Consider volunteering for the MGH HAZMAT Response Team. Comprised of 80 MGH employees, the HAZMAT team is trained to respond to large-scale disasters involving hazardous materials.

Employees interested in learning about the HAZMAT Response Team and what it takes to become a member should plan to attend one of these informational sessions:

Wednesday, August 17, 2016
11:00am–12:00pm
or 12:00–1:00pm
or Tuesday, August 23rd
3:00–4:00pm
Haber Conference Room

For more information, contact Jacky Nally, RN, at 617-726-5353, or go to: <http://sharepoint.partners.org/phs/hazmat/default.aspx>.

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.

Submit an abstract for MGH Clinical Research Day

On Thursday, October 6, 2016, MGH will celebrate the 14th annual Clinical Research Day. The Division of Clinical Research invites investigators to submit abstracts by September 6th.

Research must have been conducted at MGH and may include manuscripts published after September 1, 2015.

- Awards for best abstracts:
- \$5,000 team award
 - \$1,500 translational research award
 - \$1,000 individual award
 - Departmental awards

Clinical Research Day will begin at 8:00am with a keynote address by Sandra Glucksmann, chief operating officer, Editas Medicine.

To submit an abstract, go to:
<https://crp2016.abstractcentral.com/>

For more information, e-mail Jillian Tonelli or call 617-724-2900.

A tribute to friend and colleague, Peg Ramage, RN

—by Lesley Secrest, RN; Ellen Brown, RN; and Marie Barry, RN

A memorial service was held July 15, 2016, to remember and celebrate the life of dear friend and colleague, Margaret ‘Peg’ Ramage, RN. Ramage passed away peacefully, July 10, 2016, here at MGH, the hospital she loved.

Ramage began her career at MGH in 1971 as a new graduate nurse. Coming from the state university in Buffalo, New York, Ramage moved to Boston and took her first nursing position on the Baker 5 Nursing Service. She used to say it took her months to figure out what people were saying because she couldn’t understand their Boston accents.

Ramage loved being a nurse at MGH and was so proud of her role as a clinical nursing supervisor. As a nursing supervisor, she cared for patients, families, visitors, and caregivers throughout the institution. And she wasn’t shy when it came to making sure people got what they needed. Helping staff navigate through the complex systems of MGH, it often seemed like she made the impossible possible. She was quick to help those less fortunate; she’d give you the shoes off her feet if it would help you get to work.

Ramage’s love of MGH was only surpassed by her love of family. Though she lived miles apart from



Peg Ramage, RN
clinical nursing supervisor

many members of her family, she was always just a phone call away. She loved spending time with her many nieces and nephews, and could often be heard bragging about their accomplishments to anyone who’d listen.

During the course of her long career, Ramage helped so many people. Always putting the needs of others before her own, no task or favor was too big or too small. Whether related to work or personal life, Ramage took care of colleagues in need. Her kindness and generosity will be missed.

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Submissions

All stories should be submitted

to: ssabia@partners.org

For more information, call:

617-724-1746

Next Publication

September 1, 2016

Inpatient HCAHPS

Current data

HCAHPS Measure	CY 2015	CY 2016 Year-to-date (as of 7/14/16)	% Point Change
Nurse Communication Composite	83.0%	82.1%	↓ -0.9%
Doctor Communication Composite	83.5%	82.4%	↓ -1.1%
Room Clean	72.9%	70.0%	↓ -2.9%
Quiet at Night	50.8%	49.0%	↓ -1.8%
Cleanliness/Quiet Composite	61.8%	59.5%	↓ -2.3%
Staff Responsiveness Composite	65.8%	63.8%	↓ -2.0%
Pain Management Composite	73.1%	72.3%	↓ -0.8%
Communication about Meds Composite	66.6%	65.5%	↓ -1.1%
Care Transitions	62.4%	59.2%	↓ -3.2%
Discharge Information Composite	91.1%	91.0%	↓ -0.1%
Overall Hospital Rating	81.2%	80.6%	↓ -0.6%
Likelihood to Recommend Hospital	90.9%	88.5%	↓ -2.4%

Data is complete through April, 2016; partial data is available through July.

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



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