

Caring

Headlines

February 7, 2013



Out

New patient PICC Program

*Meeting
the growing
demand for
long-term IV
access*

*See
Fielding the Issues
on page 9*

Mark O'Connell, RN,
performs PICC-line
insertion.

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

Non-labor inpatient cost savings

Increasing efficiency through effective resource-utilization

What impresses me is a good idea that can save our hospital hundreds of thousands of dollars without negatively impacting our workforce. And that's what this past year has been about for the Inpatient and Emergency Department Direct Care Non-Labor Expense Management Team.

Helen of Troy was known as the face that launched a thousand ships. We've all heard the expression: 'A picture is worth a thousand words.' But what impresses me is a good idea that can save our hospital hundreds of thousands of dollars without negatively impacting our workforce. That's what this past year has been about for the Inpatient and Emergency Department Direct Care Non-Labor Expense Management Team. One prong of the Partners Patient Affordability Initiative, the Inpatient and Emergency Department Direct Care Non-Labor Expense Management Team has been exploring ways to reduce costs while making care more efficient and effective.

After a comprehensive review of all non-labor, inpatient expenses, the team identified five areas where cost-saving opportunities seemed optimal and achievable. They included:

- Pulse oximetry
- IV supplies
- Gloves
- Linen utilization
- Advanced wound care

For the fiscal year, 2010–2011, MGH was responsible for more than 68% of pulse-oximetry spending among all Partners entities. The Expense Management Team found that both clinical and financial data supported a shift to re-usable pulse-oximetry



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

probes versus the disposable probes that had been the norm. A conversion to disposable probes was implemented along with the practice of 'disposable by exception' when clinically warranted. Re-usable probes are cleaned and sanitized according to specified guidelines. The new approach was rolled out in December, resulting in a \$50,000 reduction in the cost of disposable probes in one month. Over an entire year this would yield a savings of \$600,000 (and probably more when the process is refined and fully implemented). *That's a good idea.*

In looking at IV supplies, the team determined that the greatest potential for savings could be achieved by consolidating disposable IV sets and solutions and possibly switching to a different large-volume pump vendor. After exploring options, the decision was made to convert to the newest version of Baxter Sigma pumps, which will require a corre-

continued on next page

As we delve deeper into product, supply, and spending practices, it has been illuminating to see the benefits of standardization (both clinically and financially). In many cases, having fewer choices leads to fewer errors. And from a purchasing standpoint, consolidating products into a smaller menu of styles and/or vendors is substantially more cost-effective.

sponding conversion of IV sets (from Hospira to Baxter). This conversion is expected to be complete by March of this year, and work is already underway to standardize sets and tubing prior to the conversion. This one change is expected to save MGH more than \$7,500,00 over the next five years.

As we delve deeper into product, supply, and spending practices, it has been illuminating to see the benefits of standardization (both clinically and financially). In many cases, having fewer choices leads to fewer errors. And from a purchasing standpoint, consolidating products into a smaller menu of styles and/or vendors is substantially more cost-effective. Gloves are a perfect example. Upon closer examination and test trials on a number of patient-care units, our Non-Labor Expense Management Team is recommending a Partners-wide conversion to Ansell as our new non-vinyl exam-glove manufacturer. Work on this conversion has already begun, and we hope to have it completed by spring. This translates into a savings of more than \$400,00 for MGH.

Sometimes you get lucky and the most cost-effective solutions are also the most environmentally friendly. This is the case with the team's recommendation for changes in linen utilization. The new practice is: Refresh linens daily, change as needed (or requested). This 'green' approach has the added advantage of:

- saving money without compromising patient care or comfort
- minimizing disruption to patients
- reducing waste
- utilizing natural resources more efficiently

While our over-arching approach will be to standardize processes throughout the hospital, our primary focus is meeting the individual needs of our patients, so there will be some exceptions:

- Isolation/ICU rooms will follow current practice to ensure linen is not a source of transmission for infection
- Units will maintain flexibility in meeting the linen needs of their unique patient populations

Complete bed changes should still take place when:

- bed linens become wet
- bed linens become soiled
- bed linens become contaminated with blood or bodily fluids
- *any time* the patient or family requests fresh linens

Staff and unit service associates are receiving training in this new approach, which will render a savings of more than \$200,000 for the hospital.

Wound care is another area where the Non-Labor Expense Management Team found opportunities to save. They recommended converting to/standardizing a number of products, eliminating some areas of duplication, and streamlining the ordering process. These changes would save upwards of \$100,000. This work is on-going.

We're making good headway in our efforts to make care more affordable for patients and families. But I want to be clear, this is not a one-time, cost-saving initiative—this is a new way of doing business. We need to approach every decision with quality care and cost in mind. I look forward to hearing your feedback. I'm always interested in ideas to improve care and decrease costs.

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(Cover photo by Michelle Rose)

Our journey to become and remain a Magnet hospital

On September 4, 2003, MGH became the first Magnet hospital in Massachusetts designated by the American Nurses Credentialing Center (ANCC).

As many of you know, the term, 'Magnet' hospital, grew out of a study conducted by the American Academy of Nursing in the early 1980s to identify characteristics of a professional-practice setting that would 'attract' and retain highly qualified nurses. On September 4, 2003, MGH became the first Magnet hospital in Massachusetts designated by the American Nurses Credentialing Center (ANCC). At the time, only 88 hospitals in the world (or fewer than

1% of hospitals in the US) had attained Magnet status. Much work went into preparing for the review process: compiling extensive written evidence; educating the workforce about the meaning of Magnet recognition; creating a Magnet Steering Committee, forming workgroups, and identifying Magnet champions, culminating with a site visit where employees had the opportunity to showcase their practice and commitment to quality care.

Evidence told us that Magnet status benefitted patients, clinicians, and healthcare organizations as hospitals became better able to:

continued on next page

Seconds after receiving the news that MGH had retained its status as a Magnet hospital, senior vice president for Patient Care, Jeanette Ives Erickson, RN (second from right), and members of her leadership team and the Magnet Re-Designation Steering Committee, celebrate.



April 15, 2008

- attract and retain top talent
- improve care, safety, and satisfaction
- foster a collaborative culture
- advance nursing standards and practice
- grow business and financial success

Much work went into preparing for the review process: compiling extensive written evidence; educating the workforce about the meaning of Magnet recognition; creating a Magnet Steering Committee, forming workgroups, and identifying Magnet champions, culminating with a site visit where employees had the opportunity to showcase their practice and commitment to quality care.

And, indeed, that was the Magnet experience at MGH, leading to the culture of Excellence Every Day that has been our hallmark for the past decade.

In 2008, with the active participation of employees in all disciplines and at all levels of the organization, MGH was re-designated a Magnet hospital. As this article goes to print, we await the arrival of Magnet appraisers for our March 4–7, 2013, site visit to augment the written documentation submitted in

October. To learn as much as they can during their visit, appraisers will go to as many areas as possible, including patient-care units, ambulatory clinics, and health centers, meeting with and talking to employees in all departments and role groups.

For those who have not yet experienced a Magnet site visit, the best advice is: relax; have confidence in your yourself and your colleagues; if approached by an appraiser, articulate your practice to the best of your ability; and remember—you are the reason MGH is the #1 hospital in the country.

For more information about our Magnet journey or any facet of the Magnet Recognition Program, go to: <http://www.mghpcs.org/magnet>.

History of the Magnet Program

1983

The American Academy of Nursing (AAN) Task Force on Nursing Practice in Hospitals conducted a study to identify work environments that were able to attract and retain quality nurses. Institutions that were able to *attract* and retain nurses were described as ‘magnet’ hospitals. The characteristics that distinguished these organizations from others were known as the Forces of Magnetism.

1990

The American Nurses Credentialing Center (ANCC) was incorporated as a subsidiary, non-profit organization through which the American Nurses Association (ANA) could offer credentialing programs and services.

The ANA Board of Directors approved a proposal for the Magnet Hospital Recognition Program for Excellence in Nursing Services, building on the 1983 magnet hospital study.

1994

The University of Washington Medical Center in Seattle, Washington, became the first ANCC Magnet-designated organization.

1997

The program became known as the Magnet Nursing Services Recognition Program, and criteria were revised using The ANA’s Scope and Standards for Nurse Administrators.

1998

The program expanded to include long-term care facilities.

2000

The program expanded to recognize health-care organizations outside the US.

2002

The name was officially changed to the Magnet Recognition Program®.

2007

ANCC commissioned an analysis of Magnet scores. The analysis resulted in the Standards of Excellence being clustered into more than 30 groups, yielding a new empirical model for the program.

2008

A new conceptual model was introduced that grouped the 14 Forces of Magnetism into five key components: Transformational Leadership; Structural Empowerment; Exemplary Professional Practice; New Knowledge, Innovations, & Improvements; and Empirical Outcomes.

2011

Approximately 6.61% of all registered hospitals had achieved Magnet status, according to the American Hospital Association Fast Facts on US Hospitals.

Compassion drives family-centered interventions for new nurse

The first thing I noted about Mr. A was that he had been diagnosed with a disease called hereditary hemorrhagic telangiectasia). I vaguely recalled this disease from my Pathophysiology class in nursing school.

My name is David De La Hoz, and I am a new graduate nurse in the Medical Intensive Care Unit (MICU). Since coming to work at MGH, every single day has been full of new experiences. As nurses, we know that when caring for patients, the whole family needs to be included. Every patient has a different situation and family dynamic, and every family plays a significant role in our practice. Incorporating families into the plan of care can have a powerful impact on a patient's hospital course.

One Monday morning, my preceptor, Richard, and I received report from the night nurse on Mr. A. The first thing I noted about Mr. A was that he had been diagnosed with a disease called hereditary hemorrhagic telangiectasia (HHT). I vaguely recalled this disease from my Pathophysiology class in nursing school. Aside from what the name suggested (hemorrhaging as a result of a hereditary disease), I didn't remember much else.



David De La Hoz, RN,
staff nurse, Medical ICU

Richard shared that he had cared for patients with this disease in the past. He explained that HHT (which has autosomal-dominant inheritance) causes abnormally formed blood vessels. These abnormal blood vessels are usually found around the mouth, nose, and lips. And many patients with HHT also have arteriovenous malformations (AVMs) in internal organs such as the GI tract, liver, lungs, brain, and/or the spine.

Mr. A had been brought to MGH by his wife after experiencing yet another bleed. He'd suffered a massive upper-GI bleed and was vomiting blood. His EGD (endoscopic exam) revealed an entire liter of blood in his stomach. From the moment I met Mrs.

continued on next page

Throughout the day, Mrs. A became progressively more and more relaxed, and by the end of our shift, she thanked us for helping her and her husband so much. I like to think it's the small things, like listening to her, reassuring her, showing empathy, and involving her in her husband's care that had such a positive impact on Mrs. A.

A, I could tell she was extremely anxious, fearful that her husband would re-bleed and it would go undetected. I reassured her that we were monitoring his vital signs very closely, and we would know immediately if his status changed. Unfortunately, it didn't do much to alleviate her concerns.

Mrs. A was adamant that she could tell when her husband was going to have a bleed because she knew certain 'warning signs.' I saw this as an opportunity to alleviate her anxiety. I asked her to tell me about the warning signs. She explained there were subtle cues that preceded each bleed, and she was acutely attuned to recognizing them. After talking about the warning signs for several minutes, she appeared to relax, just a little.

Although her overall anxiety abated, Mrs. A still panicked every time Mr. A did anything out of the ordinary, such as cough or sigh. I tried to think of something I could do to help her relax.

Again, I offered her reassurance and explained our monitoring system. Even though I was repeating the same information I had told her earlier, this time, it seemed to bring some relief.

She said, "Thank-you for explaining that to me."

I realized that her elevated level of anxiety had prevented her from hearing or comprehending what I had said the first time. I made a mental note that Mrs. A would require ongoing reassurance and explanations.

Soon, Richard returned and asked Mrs. A a question that hadn't even crossed my mind. He asked how long it had been since she'd gone home to rest or have a meal. Mrs. A said she hadn't slept since the night before she brought Mr. A to the Emergency Department. We realized that Mrs. A hadn't left her husband's side except for bathroom breaks since he arrived.

Richard took the opportunity to help Mrs. A understand that it was important for her to take care of herself, as well. Even though her husband was very sick and in the ICU, she needed to make sure she

got enough rest and nourishment, too. His words fell on receptive ears because Mrs. A immediately went to the cafeteria and had a good lunch. When she returned about forty-five minutes later, she looked almost like a different person.

Mrs. A was more relaxed that afternoon but still somewhat anxious. I recalled how in nursing school they ingrained in us the importance of involving the patient's family in our care. I tried to think of ways Mrs. A could participate in caring for her husband. I started with the most basic activity—washing and combing his hair. Mrs. A was thrilled to have something contributory to do. She had felt helpless sitting in the background watching everyone else care for Mr. A. She said she was the one who provided all his care at home.

Throughout the day, Mrs. A became progressively more relaxed, and by the end of our shift, she thanked us for helping her and her husband so much. I like to think it was the small things, like listening to her, reassuring her, showing empathy, and involving her in her husband's care that had such a positive impact on Mrs. A.

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

Patients and families place tremendous trust in their caregivers. Trust doesn't come from being the #1 hospital in the country. Trust comes from relationships. Patients and families see first-hand the care, commitment, and skill of their care team as clinicians and support staff take the time to 'know' them.

David recognized Mrs. A's need to tell her husband's story. He knew he needed to listen—to be present for her, to let her know that Mr. A was important to him and that Mrs. A's knowledge of his condition was equally important. I'm certain Mrs. A would not have left her husband's side had she not felt known and cared for by David. *That's* trust.

Thank-you, David.

“There is nothing permanent except change”

—by Gino Chisari, RN, director,

The Norman Knight Nursing Center for Clinical & Professional Development

We are undertaking a comprehensive assessment of our products and services with an eye toward increasing efficiency, reducing redundancies, eliminating waste, and linking professional development, education, and training to measurable outcomes.

I'm not sure who it was who said, “There is nothing permanent except change,” or whether, like so many other things, it's just become an anonymous part of our public domain. But whoever said it, it's true. Can you remember a time when we weren't in the midst of substantive change, both here in the hospital and in the world at large? Not everyone is a fan of change. Some resist it with great zeal. As an educator, I have a different mind-set (as most educators do). Education is all *about* change. At MGH, that means we strive for the integration of complex knowledge, skill, ability, and attitude in the hope of producing a change in behavior—an improvement in behavior that ultimately benefits our patients.

The Norman Knight Nursing Center for Clinical & Professional Development is once again diving into the deep end of the ‘change pool.’ We are undertaking a comprehensive assessment of our products and services with an eye toward increasing efficiency, reducing redundancies, eliminating waste, and linking professional development, education, and training to measurable outcomes. It's not going to be easy, but then, the important things never are.

Some of the changes we're preparing to roll out include a more streamlined approach to role-specific orientation programs offered by the

Norman Knight Nursing Center. The goal is to decrease the amount of time employees spend in the classroom away from patient care. The strategy is to employ more multi-media options that staff can access from any computer. We're designing a more robust system for pre- and post-assessment of knowledge gained from continuing education. We're developing a menu of innovative, unit-based, educational pilots focusing on sensory-motor-skill acquisition. We'll be incorporating more on-line course work to standardize curriculums such as BLS and PALS, and video-streaming Nursing Grand Rounds and other presentations such as those conducted by our advanced-practice nursing colleagues. Perhaps most important, we're looking at ways to capture competency and proficiency as documentable evidence. And we're very excited about the prospect of automating program registration, attendance, and evaluation. This is just a partial list of the many tasks on our, “To-do list.”

Stay tuned for more information as we begin to implement these changes. And as always, I look forward to hearing your ideas, suggestions and feedback.

Note: as an educator, I couldn't resist. The opening quote is attributed to Heraclitus, a Greek philosopher circa 400 BC, known for espousing change as a central component of the evolution of the universe. Talk about ahead of his time!

New Outpatient PICC Program

meeting the growing demand for long-term IV access

The program is available Monday through Friday from 9:00am–1:00pm. All services are provided in the Center for Perioperative Care (currently located on White and Ellison 12 soon to be re-located to Wang 3).

Question: I heard there's a new program for peripherally inserted central-line catheters (PICCs). Can you tell me more about it?

Jeanette: In December, 2012, the IV Therapy Nursing Team, in collaboration with the Center for Perioperative Care and the department of Anesthesia, Critical Care, and Pain Management, initiated a new Outpatient PICC Program. The program was developed in response to an increasing demand for long-term IV access for patients receiving antibiotic therapy, chemotherapy, parenteral nutrition, and hydration. Making PICC-line placement available in the outpatient setting will minimize the need for patients to be hospitalized or come to the Emergency Department and promote the safe care of patients at home.

Question: What services are encompassed in the Outpatient PICC Program?

Jeanette: The Outpatient PICC Program offers PICC-line insertion and removal to MGH patients referred by an MGH practitioner. The program is available Monday through Friday from 9:00am–1:00pm. All services are provided in the Center for Perioperative Care (currently located on White 12 and Ellison 12, soon to be re-located to Wang 3).

Question: What is the referral process for this program? And how is information about the procedure shared?

Jeanette: Ambulatory patients who require PICC-line insertion or removal can be referred to the IV Therapy Team by paging the IV resource nurse at 2-6571. The IV nurse will respond by sending a form requesting some basic patient information and the order for the PICC-line insertion or removal; guidelines for accessing home-care nursing services will be included with the response. The IV Team will book the patient through the OR scheduling process, which will trigger insurance authorization. And the IV nurse will document both inpatient and outpatient PICC-line insertions in the LMR (electronic Longitudinal Medical Record). Information about the PICC-line insertion will be available immediately (electronically) to all the patient's care providers.

Question: Whom can we contact for more information?

Jeanette: For more information about the Outpatient PICC Program, contact Janet Mulligan, RN, nursing director for the IV Therapy Team, at 4-7453 or pager 3-2692.

Announcements

Magnet Site Visit scheduled

The Magnet appraisal team will conduct its re-designation site visit, March 4–7, 2013. Details will be shared as they become available.

Congratulations to staff for earning the opportunity to showcase our inter-disciplinary patient- and family-centered care during this important external review.

For more information, or to stay abreast of all our Excellence Every Day activities and Magnet preparations, go to: www.mghpcs.org/PCS/Magnet

ACLS Classes

Certification:

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

Day one:
February 11, 2013
8:00am–3:00pm
O’Keeffe Auditorium

Day two:
February 25th
8:00am–1:00pm
Their Conference Room

Re-certification (one-day class):
March 13th
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.

Ash Wednesday

February 13, 2013
MGH Chapel

- Ashes distributed in the Chapel 9:00am–5:00pm
- Roman Catholic Mass, 11:00am
- Ecumenical Ash Wednesday Service, 12:15pm
- All Chapel services broadcast on MGH Channel 16
- Catholic TV is available 24/7 on Channel 17
- Ashes distributed on patient care units once between 8:00am and 4:00pm

Ashes will also be distributed at: the Charlestown Navy Yard Charlestown Health Center Chelsea Health Center Revere Health Center Schrafft Center Massachusetts Eye and Ear Infirmary

For more information, call 6-2220.

Save the Date

Connell Visiting Scholar

Angela Barron McBride, RN, international nurse leader and Connell Visiting Scholar is coming to MGH to work with staff, leaders, and Connell scholars to advance the nursing research agenda.

McBride will present, “Orchestrating a Career for Nursing Leadership,” to the MGH community

April 5, 2013
9:30am

O’Keeffe Auditorium

Internationally renowned for her scholarship on leadership-development and career-planning, McBride is currently chair of a Nursing Advisory Board for the Robert Wood Johnson Foundation.

For more information, call 3-0431.

Celebrating the legacy of Martin Luther King, Jr.

Friday, February 15, 2013
1:00–2:00pm

Shriners Auditorium
Shriners Hospitals for Children
51 Blossom Street

speaker:
Carol R. Johnson, superintendent of Boston Public Schools

For more information, call 617-724-3965.

Fundamentals of Medical Terminology I

Space is available in the 10-week, Fundamentals of Medical Terminology course for employees considering transitioning to a clinical role. \$120 fee includes textbook. Class meets on Tuesdays, March 5–May 15, 2013 5:00–7:00pm
Haber Auditorium

Enroll via PeopleSoft.

For more information, call 617 724-3368.

“Did You Know?”

It’s easier than you think to author a DYK poster

The PCS Research and Evidence-Based Practice Committee is seeking clinicians from all disciplines to author “Did You Know?” (DYK) posters. Distributed throughout the MGH community, DYK posters are a great way to share clinical expertise.

If you have a topic you’d like to share, or if you’d like to learn more about the process of creating a DYK poster, contact Carolyn Bleiler at cbleiler@partners.org.

Senior HealthWISE events

All events are free for seniors 60 and older

Lecture Series
“Macular Degeneration”
Thursday, February 7, 2013
11:00am–12:00pm
Haber Conference Room
Speaker: Chirag Shah, MD, Ophthalmologist, Ophthalmic Consultants of Boston
Shah will discuss causes of macular degeneration, current treatment options, and new treatments being investigated.

Hypertension Screening:
Monday, February 25th
1:30–2:30pm
West End Library
151 Cambridge St.
Free blood pressure checks with wellness nurse, Diane Connor, RN.

For more information, call 4-6756.

Blum Center Events

Benson-Henry Talk:
“Exercise for Heart Health”
Thursday, February 14, 2013
12:00–1:00pm
Speaker: Molly Deisroth-Kim

Book Talk:
Almost a Psychopath
Thursday, February 21st
12:00–1:00pm
Speaker: Ronald Schouten, MD

Shared Decision-Making:
“Living with Coronary Heart Disease”
Tuesday, February 26th
12:00–1:00pm
Speaker: Doreen Defaria-Yeh

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.

Changes to the eligibility criteria for the PCS Clinical Recognition Program

with new roles come new opportunities

—by, Ann Jampel, PT, and Christine McCarthy, RN
co-chairs of the Clinical Recognition Program Review Board

As you know, in March of 2012, Patient Care Services embarked on an ambitious initiative to improve care and reduce costs with the launch of 12 Innovation Units.

Central to the success of Innovation Units is the new attending nurse role. Attending nurses function as clinical leaders, working with staff nurses, inter-disciplinary team members, patients, and family members to manage the care of patients on their unit from admission to discharge. Later this month, 27 more inpatient units will adopt the Innovation-Unit approach. And Innovation Units are just one area where nurses are practicing in expanded roles.

To ensure our Clinical Recognition Program continues to reflect and embrace the full spectrum of nursing practice, effective immediately, all grade-55-level staff nurses are eligible to apply to the program. This change includes attending nurses (ARNs), resource nurses, and other

grade-55 nurses who collaborate with and/or support direct-care nurses through coordination of the patient care plan and/or coordination of the daily clinical operations (resource nurses). Staff nurses unsure of their grade level should consult their nursing directors.

The decision to include these role groups in the Clinical Recognition Program reflects the changing roles of nurses in the evolution of health care and the emergence of the attending nurse role within the Patient Care Services care-delivery model.

Regardless of role, all applicants seeking recognition at the advanced-clinician and clinical-scholar levels must demonstrate through their portfolio and interview that their practice meets the criteria for the level being sought.

For more information about the Clinical Recognition Program or changes to the eligibility criteria, send e-mail to: MGH PCS Clin Rec.

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Submissions

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

Next Publication

February 21, 2013

Inpatient HCAHPS Results

2010–2012 YTD–January

Measure	2010 <i>(Top Box Result)</i>	2011 <i>(Top Box Result)</i>	2012 YTD* <i>(Top Box Result through December 31, 2012)</i>
Nurse Communication Composite	78.8	79.4	80.9
Doctor Communication Composite	80.4	81.9	81.7
Room Clean	71.4	69.8	72.9
Quiet at Night	45.9	45.2	48.3
Cleanliness/Quiet Composite	58.7	57.5	60.6
Staff Responsiveness Composite	63.1	63.6	64.9
Pain Management Composite	70.7	71.5	72.1
Communication About Meds Composite	62.0	62.7	64.2
Discharge Information Composite	89.8	89.8	91.3
Overall Rating	78.4	79.1	80.1
Likelihood to Recommend	89.3	89.4	90.4

The hospital's performance on nearly every indicator has improved from December to January, most notably, Nurse Communication and Pain Management. We are still on track to meet all targets set for 2012.

Data complete through 1/1/13
 All results reflect Top-Box (or 'Always' response) percentages
 Pull date: 1/16/13

*Note: 2012 data will be complete as of February 15, 2013.



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 MGH, 55 Fruit Street
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