

# Caring

Headlines

December 4, 2014

## Fall-prevention

*through vigilance, enhanced safety strategies,  
and patient-education*



*See stories on  
pages 4-5*

Physical therapist, Sonali Patel, PT, educates patient, Jim Lewis, and his wife, Suzanne, on strategies to prevent falls after discharge.

# Optimizing patient flow

*advancing patients thorough the system as safely and efficiently as possible*

Optimizing care-delivery so that patients can be discharged as soon as they're clinically ready is good for patients and good for hospitals... Every time a patient remains in the hospital beyond his or her optimal discharge date, another patient is prevented from being admitted.

**P**art of Excellence Every Day is ensuring that patients receive the care they need—no more, no less—in the safest, most efficient way possible. Optimizing care-delivery so that patients can be discharged as soon as they're clinically ready is good for patients and good for hospitals. It allows patients to return home or progress to the next level of care in a timely fashion, which is in their best interest, and it allows hospitals to continue to accept patients in need of care and services. Every time a patient remains in the hospital beyond his or her optimal discharge date, another patient is prevented from being admitted. Granted, it is a delicate balance, but one we must achieve if we're truly committed to providing the highest quality care to patients and families.

In our efforts to optimize patient flow, we've launched a number of initiatives recently. One involves a comprehensive look at length of stay by service and diagnosis to identify factors that may be hindering timely discharge. As you might expect, medical, surgical, neurological, and neuro-surgical patients tend to accrue the largest number of potentially avoidable days, so that's where our focus has been centered. (Potentially avoidable days are the difference between actual length of stay and expected length of stay, calculated on a risk-adjusted, population-based methodology). One intervention that has emerged that could potentially foster more timely discharges is the



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

judicious use of home-care services. We're exploring the possibility that patients in these four, high-length-of-stay populations could be discharged earlier if they had access to appropriate home-care services. As we continue to learn more about the factors affecting prolonged length of stay, we expect to be able to reduce length of stay by minimizing the number of potentially avoidable days patients remain in the hospital. We're ultimately targeting a reduction of one full day, to be phased in gradually over the next year.

In an effort to bring greater focus to discharge planning and make it easier to coordinate the many contingencies leading up to discharge, we've created an Estimated Date of Discharge (EDD) tool for use by all members of the inter-disciplinary team. The on-line tool allows clinicians to quickly and easily communicate information about:

- estimated date of discharge
- expected discharge disposition

*continued on next page*

If we are committed to Excellence Every Day; if we're committed to providing the highest quality care to patients and families, we must also be committed to ensuring that patients spend as much time as they need in our care—and not a moment more.

- barriers to discharge
- tasks that need to be performed before the patient can be discharged

The tool serves as a central repository for staff to document and retrieve key information. It has been demonstrated on units and reviewed by staff in the four, high-length-of-stay populations and presented at various other forums. Feedback has been very positive, and we'll continue to adapt the tool as we learn more from real-time, hands-on experience.

As mentioned in my November 6, 2014, column, guardianship can also account for delays in discharge. Guardianship is the legal mechanism by which a guardian is appointed by the court to make decisions on behalf of patients who are deemed clinically and legally incapable of making decisions on their own.

As a result of the Guardianship Pilot conducted in our neuroscience units, which included the introduction of a dedicated advanced practice nurse to help identify guardianship patients and manage the necessary paperwork, we're seeing some positive results in terms of optimizing patient flow. Data shows:

- a reduction in the overall length of time to process guardianship cases internally
- a decrease in the number of days from filing for guardianship to actual discharge
- 100% of guardianship patients were able to move to the next level of care when medically ready to do so
- the average length of stay for guardianship patients decreased 40% from baseline 2014

The pilot underscores the need for all patients to have healthcare proxies, and as caregivers, we each play a role in ensuring that happens. The guardianship pilot is now being expanded to include medical units.

Those of you who work weekends know that weekend operations come with their own set of challenges in terms of optimizing patient flow. For that reason, we entered into a project with the MIT Healthcare Lab to analyze weekend vs. weekday discharge practices on the medical service with the hope of identifying recommendations for improvement. A team of MIT graduate students spent one week and one weekend observing operations on White 8, Ellison 12, and Ellison 16; collecting data; and interviewing nurses, residents, case managers, therapists, and social workers. They're in the process of finalizing their recommendations, but some of the factors they identified as driving delays in weekend discharges are related to staffing, consult issues, post-acute-care barriers, and patient and family preferences. I look forward to seeing their final report.

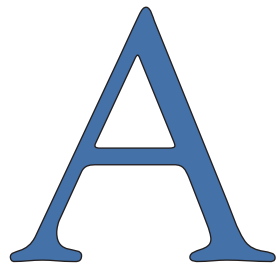
If we're committed to Excellence Every Day; if we're committed to providing the highest quality care to patients and families, we must also be committed to ensuring that patients spend as much time as they need in our care—and not a moment more. It's good for patients, it's good for the hospital, and it's good for health care.

## In this Issue

Preventing Falls.....	1	Health Literacy Month.....	8
Jeanette Ives Erickson.....	2-3	ESOL Program Takes a Field Trip.....	9
● Optimizing Patient Flow		Fielding the Issues.....	10
Preventing Fall-Related Injuries.....	4	● The IOM and MGH Medical Interpreters	
Younger Patients Fall, Too.....	5	Announcements.....	11
Clinical Narrative.....	6-7	HCAHPS.....	12
● Mimi Pomerleau, RN			

# Preventing fall-related injuries in elderly patients

—by Patti Shanteler RN, staff specialist



According to the Agency for Healthcare Research and Quality (AHRQ) anywhere from 700,000 to 1,000,000 patients fall in hospitals across the country every year. Many patients are at risk for falling; 30% of reportable falls result in injury.

Preventing falls is a crucial component of care-planning. Patients age 65 and older are more apt to sustain injuries from falls, so preventing elderly pa-

tients from falling is a high priority—one that requires effective communication and teamwork. In 2012, the Institute for HealthCare Improvement identified communication of risk status as one of six strategies that can effectively help reduce fall-related injuries. A new addition to the MGH Falls Toolkit is an improved communication form that's being rolled out this month.


The form, which was created with input from nurses, therapists, and patient care associates, has been piloted on a number of inpatient units. Forms are placed in close proximity to the patient and indicate the specific safety strategies that should be used when assisting the patient. The tool provides vital information to clinical staff, especially those who may be caring for the patient for the first time, and it ensures the entire team is receiving the same message about the patient's safety risks. Having the form in plain sight alerts families and visitors to the patient's need for assistance (or assistive devices) before attempting to move the patient on their own.

PCS staff are committed to keeping patients safe. Other strategies for patients at high risk for falling include:

- bed and chair alarms
- frequent rounding
- low beds and floor mats
- moving patients closer to the nurses' station
- assisted toileting
- patient sitters

For more information about fall-prevention efforts at MGH, call staff specialist, Patti Shanteler, RN, at 617-726-2657.


New addition to the MGH Falls Toolkit: an improved communication form is being rolled out this month.



MGH LEAF Program (Let's Eliminate All Falls)

**Fall Prevention Communication for the Care Team**

Patient Last Name \_\_\_\_\_



<b>PERSONAL HYGIENE</b>	<b>POSITIONING/MOBILITY</b>	<b>AIDS/EQUIPMENT</b>
<input type="checkbox"/> <b>Independent</b>	<input type="checkbox"/> <b>Independent</b>	<input type="checkbox"/> <b>Glasses</b>
<input type="checkbox"/> <b>Urinal-commode or bedpan only</b>	<input type="checkbox"/> <b>1 Assist</b>	<input type="checkbox"/> <b>Hearing Aid</b>
<input type="checkbox"/> <b>Assist to BR</b>	<input type="checkbox"/> <b>2 Assists</b>	<input type="checkbox"/> <b>Oxygen</b>
<input type="checkbox"/> <b>Stay in BR with patient at all times</b>	<input type="checkbox"/> <b>Cane</b>	<input type="checkbox"/> <b>Heart Monitor</b>
	<input type="checkbox"/> <b>Crutches</b>	<input type="checkbox"/> <b>Other</b>
	<input type="checkbox"/> <b>Walker</b>	<hr style="width: 100%;"/>
	<input type="checkbox"/> <b>Bed Alarm</b>	
	<input type="checkbox"/> <b>Chair Alarm/Self releasing Velcro</b>	



# Younger patients fall, too

## fall-prevention requires vigilance for all age groups

— by Patti Shanteler RN, staff specialist

**A**t the 2014 SAFER Fair this past September, members of the Fall Prevention Committee called attention to the fall rate of middle-aged and younger patients (see poster on this page). The committee reviews patient-fall activity monthly and discovered a higher than expected percentage of falls among patients younger than 65 years old in 2013 and 2014. This was a surprise as the assumption has always been that elderly patients are more likely to fall.

One of the biggest factors for falls in this age group is the tendency for patients to overestimate their strength and mobility coupled with their desire for privacy. It can be difficult to convince a man in his 50s that he needs assistance getting to the bathroom.

An effective fall-prevention strategy is conveying the message that it's our responsibility to keep patients safe, and that includes minimizing their risk of falling. Open communication and partnering with patients to create a fall-prevention plan is crucial to

getting the 'buy-in' required to implement the MGH LEAF (Let's Eliminate All Falls) program.

As you can see from the quotes in the poster, a key component of the safety plan is connecting with patients about the seriousness of their risk for falling.

Members of the Fall Prevention Committee suggest:

- sharing risk-assessment findings with patients and pointing out the reasons they're at risk, despite age and functional ability prior to hospitalization
- explaining that they're in unfamiliar surroundings

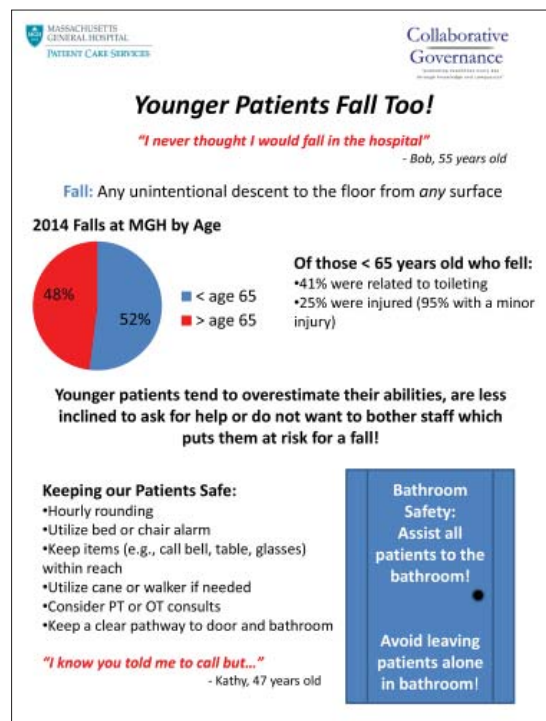
which increases their risk of falling

- reinforcing that it's our job to keep them safe and that includes bathroom safety. Most falls that occur in the hospital are related to toileting

- stressing that if patients suffer an injury from a fall it could add time to their hospitalization (patients are highly motivated to return home as soon as possible)

For more information about falls and fall-prevention efforts at MGH, call Patti Shanteler, RN, staff specialist, at 617-726-2657.

Open communication and partnering with patients to create a fall-prevention plan is crucial to getting the 'buy-in' required to implement the MGH LEAF (Let's Eliminate All Falls) program.



# Balancing the benefits of breast-feeding with the needs of the patient

Knowing that even a sip of formula can undermine successful breast-feeding, today, nurses reassure mothers that it's okay if babies don't eat right away, as long as the breast is offered and the baby is put skin-to-skin to foster bonding.

**M**y name is Mimi Pomerleau, and I'm a staff nurse in the Newborn Care Unit. I've been sold on the benefits of breast-feeding for many years. I know that breast-feeding is linked to health benefits for mothers and newborns as well as the psychological and developmental benefits for human flourishing. As a new nurse, I soon realized that not everyone embraced the importance of breast-feeding. I remember my mother telling me that she wanted to breast-feed (in 1961) but nurses (under doctor's orders) gave her a shot to dry up her breast milk. The decision was taken away from her.

As researchers began documenting the benefits of breast-feeding, it soon became clear that breast milk was superior to formula, and public health officials have made breast-feeding a national health goal. The Joint Commission has also made breast-feeding a core quality measure. Many hospitals, including MGH, promote a 'baby-friendly' breast-feeding environment.

Even as breast-feeding is widely recognized as best practice, sometimes situations arise that make breast-feeding difficult or impossible—early induction of labor, epidurals, separation of mother and baby after birth, or a mother's exhaustion after a difficult labor can all be deterrents to breast-feeding. As a nurse, part of my job is to help foster the breast-feeding process and assist moms in getting their babies to breast-feed before they're discharged from the hospital.

'Sandra' was a first-time mother who delivered a daughter vaginally after being induced with Pitocin.



Mimi Pomerleau, RN, staff nurse.  
Newborn Care Unit

She had an epidural for pain-relief, and the baby was born at six pounds, two ounces. She was a 'sleepy' baby and didn't feed. In the past, nurses may have given formula to sleepy babies. But knowing that even a sip of formula can undermine successful breast-feeding, today, nurses reassure mothers that it's okay if babies don't eat right away, as long as the breast is offered and the baby is put skin-to-skin to foster bonding.

We reassured Sandra not to worry for the first 24 hours; the baby would soon "wake up" and eat. She offered her breast, but the baby would cry and settle for a few minutes on her chest.

After 24 hours, the parents wanted to give the baby something. Mom attempted the breast pump but was unable to express milk. She kept the baby skin-to-skin and the baby soon fell asleep.

I took over the baby's care at 32 hours of life. I received report that the baby had lost 8% of her birth weight, was sleepy, and had gone to breast a few times but just slept. She wouldn't suck no matter what position Mom tried. Luckily, she wasn't being discharged today. I knew this would be a crucial day in terms of helping Sandra fulfill her desire to

*continued on next page*

I left that night wondering if I'd done the right thing. Introducing formula is so contrary to my beliefs and recommendations for successful breast-feeding. But Mom was smiling and happy with her baby feeding at her breast. The next morning, I was pleased to learn that the baby fed at breast all night.

breast-feed. It's very hard for a mother to resist formula when her baby is crying and just won't suck.

I went in to assess Sandra and the baby to develop a plan. Sandra was comfortable and appeared to have normal breast anatomy. I showed her how to hand-express colostrum, and she was readily able to produce that golden fluid. She told me she had tried pumping but nothing came out, so she was worried she didn't have enough milk. I explained that that was normal and not to expect a lot from pumping the first few times. I took some time to explain milk-production and gave her some educational materials to review at home. We talked about the importance of outpatient support groups for new mothers.

The baby's skin was jaundiced, a normal finding after 24 hours, but she hadn't stoolled since birth and had only voided a few times. She had a normal palate and I was able to elicit her rooting and sucking reflex. My assessment woke the baby, and she started to cry, so we decided to try to put her to breast. She went to her mother and opened her mouth, but fell asleep. If she had been less than 24 hours old, I would have suggested skin-to-skin contact and waited to try again later. But this baby had not eaten since birth with the exception of a few drops of formula through a syringe. I wondered if she was lethargic and didn't have the energy to suck or was just taking her time to breast-feed.

The baby had lost 8% of her birth weight and had not stoolled. It was time to intervene. The baby was quiet on Mom's chest, so I took the opportunity to have a conversation with the parents. They told me they wanted to breast-feed because they knew it was good for the baby, and they wanted only the best for her. But they were concerned; they were afraid the baby wasn't getting the nutrition she needed.

I shared with them my hesitancy to give the baby formula because it could impede the baby's ability to suck at the breast. On the other hand, I was concerned that she hadn't breast-fed at more than 32 hours old. At that point, the pediatrician came in to examine the baby, and she, too, was concerned about the weight loss, elimination issues, and jaundice. She suggested we wait a few more hours, and if we couldn't get the baby to nurse, the baby would need nourishment. Getting this baby to sustain sucking at the breast would be a challenge.

The parents and I developed a plan based on all options. We tried to get the baby to sustain sucking at breast; we tried expressing a little colostrum; we tried giving her colostrum on a little spoon; we tried the breast pump again, all with no success. Mom began to

cry; the baby was screaming and wouldn't settle. As care partners, we decided to try a supplemental nursing system (SNS), an external device used to augment natural breast-feeding. Because Mom could not express any milk, we used a 10-15ml formula with the SNS. The baby got on and continued sucking. Mom was amazed. It was like night and day—the baby learned to suck at breast with the help of the formula.

The pediatrician stopped by later and was pleased with the progress. She recommended continuing the SNS for the night and reevaluating in the morning. Before I left for the evening, we discussed the plan for weaning off the formula. We decided to stick with the plan of using the SNS overnight then gradually decrease the amount and flow.

I left that night wondering if I'd done the right thing. Introducing formula is so contrary to my beliefs and recommendations for successful breast-feeding. But Mom was smiling and happy with her baby feeding at her breast. The next morning, I was pleased to learn that the baby fed at breast all night, so Mom had decided to only use the SNS for every other feeding. That wasn't the plan we discussed, but it made me happy that this mother was confident enough with her breast-feeding skill and understood the needs of her baby.

A few weeks later, I got a note from this couple letting me know their baby had regained all her weight and was breast-feeding exclusively. As I think back on this family, I'm reminded that the key to evidence-based practice is patient preference. My own mother's preference wasn't heeded back in 1961. Today, we practice according to the best available evidence as we weigh all the individual nuances of the patient's experience.

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

What a wonderful narrative. It gives us a glimpse into Mimi's clinical decision-making and her desire to integrate evidence-based practice into her care of Sandra and her family. She's fully aware of her own personal feelings, clinical knowledge, and experience, but the realities of Sandra's situation make it impossible for her to breast-feed in the traditional way. A skilled clinician, Mimi introduces a viable compromise that allows Mom and baby to reap all the benefits of feeding at the breast.

Thank-you, Mimi.

# Health Literacy Month at MGH

—by Anna Pandolfo, translation specialist, and Denise Flaherty, RN, patient advocate,  
for the Patient Education Committee

**T**his past October, in observance of National Health Literacy Month, the PCS Patient Education Committee joined with the Maxwell & Eleanor Blum Patient and Family Learning Center to host the third annual Blum Visiting Scholar Lecture and health-literacy booth in the Main Corridor. The events were intended to foster awareness of resources available to help strengthen patient-provider relationships through effective communication.

On October 23, 2014, MGH welcomed Blum visiting scholar, Nancy S. Morris, RN, associate professor of Nursing at UMass, Worcester, and nurse scientist in the Yvonne L. Munn Center for Nursing Research. Morris's recent research focuses on health literacy and its impact on behavior and health outcomes of adult patients, especially those living with chronic diseases. Her presentation, "Health Literacy Matters," highlighted the importance of recognizing that more than a third of adults in the United States have limited health literacy. Elderly patients, patients with limited English proficiency, lower socio-economic status, or living with chronic illnesses are at higher risk for not understanding health information.

Morris shared ways to improve communication between patients and providers, such as creating a welcoming environment for patients; prioritizing information and presenting it in small quantities to foster understanding; presenting information clearly and in plain language. She suggested using pictures, illustrations, and the 'teach-back' method to ensure information is being understood.

On October 29th, the Patient Education Committee hosted its annual health-literacy informational booth with a variety of patient-education materials for patients and clinicians. Materials for patients focused on preparing for appointments and managing medications. Pamphlets provided tips for improving communication with caregivers, such as writing down questions prior to appointments. Notebooks were given out to encourage this practice. Other pamphlets provided a place for patients to record their medications and allergies, another great communication tool for when they meet with caregivers.

For more information about health literacy, go to: <http://www.healthliteracymonth.org>.

For information about patient-education materials available at MGH, e-mail the Blum Center at [PFLC@patners.org](mailto:PFLC@patners.org), or visit the Excellence Every Day portal page at: [http://www.mghpcs.org/eed\\_portal](http://www.mghpcs.org/eed_portal).

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Blum visiting scholar, Nancy S. Morris, RN, associate professor of Nursing at UMass, Worcester, and nurse scientist in the Yvonne L. Munn Center for Nursing Research





# ESOL program takes a field trip

—by Kristen Schlapp, Manager of the Workplace Education Program

Recently, 50 MGH employees enrolled in Workplace Education’s ESOL (English for Speakers of Other Languages) program had an opportunity to visit the Paul S. Russell Museum and apply their classroom education to a real-life learning situation. For almost all who participated, it was their first visit to the Russell Museum, and for many it was the first experience like this anywhere. Said Liana Teixeira, resource unit service associate, “It was beautiful. I pass by the museum every day, but I’ve never been inside. I’m so happy I had a chance to learn about MGH history.”

The visit began with museum docents describing the harsh realities of health care in the early days of MGH; students shook their heads in disbelief. Olga Chavarriaga, of Environmental Services, couldn’t imagine surgery without anesthesia. Said Chavarriaga, “I realized how difficult it was for people when they got sick back then. It was wonderful to see how technology has improved.”

Taking part in a scavenger hunt designed to challenge their reading skills, students explored the Main Gallery learning about centuries of innovation at MGH. They located artifacts, took pictures, and used interactive exhibits. They watched as the docent produced a replica of a human body in an Anatomage table (a highly advanced anatomical education tool) and explained how medical students use it to learn anatomy and practice surgical techniques.

The context and significance of the words of MGH founders, “When in distress every man becomes our neighbor,” came vividly to life for this ESOL class. Said Sylvia Figueroa of Clinical Pathology, “It shows that everyone makes a difference. We could see how much the hospital has grown over 200 years. It’s not just a place for treating illness, but a place to share compassion with all the people who come here.”

The Workplace Education Program offers English and computer classes for MGH support staff through a long-standing partnership with JVS. For more information about English or computer classes, contact Kristen Schlapp at 617-726-2388.

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At the Paul S. Russell Museum, students in the Workplace Education’s ESOL (English for Speakers of Other Languages) program (left) listen as docent explains how the Anatomage table is used and (right) take ‘selfies’ on the roof-top deck.



(Photos by Brian Wilson)

# The six aims of the IOM and medical interpreters

*Question:* I'm a medical interpreter at MGH. What role do you see interpreters playing in providing equitable care to limited English proficient (LEP) and Deaf and Hard of Hearing (DHH) patients?

*Jeanette:* You and your colleagues play a critical role in providing equitable care, one of the six aims identified by the Institute of Medicine (IOM) to eliminate healthcare disparities. Effective communication between patients and providers is essential regardless of characteristics such as language, ability to hear, or any other differences. Medical interpretation eliminates language barriers and promotes patient safety, another of the six aims of the IOM. LEP and DHH patients, their families, and staff rely on medical interpreters to provide safe, equitable care.

*Question:* I'm a nurse on a busy inpatient unit. I always try to book an interpreter ahead of time, but inevitably, something comes up, and I'm unable to keep the appointment. What do you suggest?

*Jeanette:* We all try to make the most effective use of our time, minimize delays, and avoid waste (two more aims of the IOM: care that is timely and efficient). The situation you describe is why we invested in VPOPs (Video Phones On Poles) and IPOPs (Interpreter Phones On Poles). VPOPs and IPOPs are available on every inpatient unit. I encourage you to use them (VPOPs for Spanish and Portuguese video interpretation; VPOPs and IPOPs for interpretation in other languages by telephone).

*Question:* What's the best kind of interpretation to use? Face-to-face, video (VPOP), or telephone (IPOP)?

*Jeanette:* Whenever you can use face-to-face interpreters, that should be your first choice. As clinicians, we must take all factors into consideration and use our best clinical judgment when it comes to choosing which mode of interpretation to use. For family meetings and team rounds, video might be a challenge be-

cause the interpreter's view of the surroundings is limited, so a face-to-face interpreter would be best, if possible. If an interpreter isn't available or delayed for some reason, you can always use an IPOP or VPOP as a back-up. Regardless of

what mode is used, interpreters ensure that care is patient-centered and allow patients to engage in their own health care.

*Question:* What advice would you give to those who use interpreter services on a daily basis?

*Jeanette:* Evidence shows that working with professional interpreters can shorten the length of stay and reduce re-admissions for non-English-speaking, LEP, and DHH patients. In keeping with the aims of the IOM, I suggest trying to schedule an appointment with an interpreter ahead of time whenever possible. If/when that's not possible, don't delay care; use an IPOP or VPOP to connect to an interpreter by phone or video.

In consideration of our interpreters who are in great demand throughout the hospital, please give sufficient notice when cancelling an appointment or if you decide to use the IPOP or VPOP instead. This will allow interpreters to see other patients and make optimal use of their time.

For more information about services offered by medical interpreters, call 617-726-6966.

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The six aims of the IOM stress the need for care to be: safe, effective, patient-centered, timely, efficient, and equitable

# Announcements

## On-line Doctor of Nursing Practice Program

The Doctor of Nursing Practice program at the MGH Institute of Health Professions is now available on-line. Pursue your degree full- or part-time with small class sizes, flexible course schedules, and a dedicated academic advisor. Three entry points are available for nurses with RN, master's degree, or executive background.

Vouchers may be used. Discount for Partners employees. For more information, go to: [www.mghihp.edu/dnp](http://www.mghihp.edu/dnp), or call 617-726-3164.

## Second annual Service Excellence Awards

Nominations are now being accepted for MGH Service Excellence Awards.

Awards focus on improving the patient experience. They recognize achievement in improving survey results, and outstanding performance by teams and leaders to provide or inspire outstanding service.

All departments, practices, and units are eligible.

Nominations must be received by Friday, December 19, 2014. Award ceremony will be held in April.

For more information, contact Beth Scott at 617-726-0343.

## Blum Center Events

Shared Decision Making  
"Help for Anxiety: Treatments that Work"

Thursday, December 11, 2014  
12:00pm–1:00pm  
Speaker: Susan Sprich

Programs are free and open to all. No registration required. All sessions held in the Blum Patient & Family Learning Center.

For more information, call 4-3823.

## MGH Back-up Child Care Center

Back-up child care available for holidays and school vacation week programs, providing safe, flexible, playful care for children 2 months to 12 years old.

Monday–Friday, 6:30am–5:45pm  
Cost: \$6 per hour

For more information, go to: [www.partners.org/childcare](http://www.partners.org/childcare), stop by the center located in the Warren Lobby, or call 617-724-7100.

## Ergonomics Train-the-Trainer class

### Calling all computer users

Learn how to help yourself and your co-workers set up computer workstations to promote safety, comfort, and health.

The PHS Office Ergonomics Train-the-Trainer class still has openings:  
Thursday, December 11, 2014  
9:00am–12:00pm  
165 Charles River Park  
Room 210

Register on HealthStream, or call 6-5140 for more information.

## Shearer to present at Grand Rounds

Haji Shearer, LSW, this year's recipient of the Frances J. Bonner, MD, Award, will present at Grand Rounds

December 11, 2014  
12:00pm  
MGH Ether Dome

The Frances J. Bonner, MD award was established in 2010 to promote diversity and inclusion in the psychiatric community. This annual award recognizes an individual who has overcome adversity and made significant contributions to the field of mental health and/or the care of minority communities.

Bonner, a 50-year veteran of MGH Psychiatry, was the first African-American woman physician to train on an MGH service.

For more information, call 617-724-5600.

## Senior HealthWISE events

All events are free for seniors 60 and older

"Cataracts: a Review of Common Symptoms and Recent Treatment Advances"

Thursday, December 4, 2014  
11:00am–12:00pm  
Haber Conference Room

Speaker: Nicolette Flynn-Thompson, MD, Ophthalmic Consultants of Boston

"Understanding Alzheimer's"  
Thursday, December 18th  
11:00am–12:00pm  
Haber Conference Room

Speaker: Fadi Ramadan, MD, Geriatric Medicine

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

## Yvonne L. Munn Post-Doctoral Fellowship in Nursing Research

now accepting applications

The Munn Doctoral Fellowship is now seeking applications from both pre-doctoral nurse candidates (PhD(c)) and post-doctoral, PhD-prepared nurses actively advancing a program of research and related scholarship. Fellowship supports hours of practice time to give fellows the opportunity to achieve a research outcome. At the end of the fellowship, the pre-doctoral fellow is required to have a completed research study that meets the requirements of his/her doctoral studies, a manuscript for publication, and present the study to the MGH nursing community. The post-doctoral fellow will submit a grant application for internal/external funding.

Concept paper is due January 9, 2015;  
final application is due February 6, 2015.

For more information, call:  
Mandi Coakley, RN, at 617-726-5334, or  
Peggy Settle, RN, at 617-726-9340.

# Inpatient HCAHPS Results

## 2013–2014

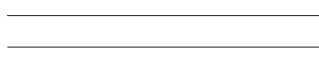
Measure	2013	2014 Year to Date	2013- 2014 Change
Nurse Communication Composite	81.9	82.3	0.4
Doctor Communication Composite	82.5	81.8	-0.7
Room Clean	74.5	73	-1.5
Quiet at Night	50.2	49.6	-0.6
Cleanliness/Quiet Composite	62.4	61.3	-1.1
Staff Responsiveness Composite	64.7	64	-0.7
Pain Management Composite	72.3	72.2	-0.1
Communication about Meds Composite	65.5	66.7	1.2
Discharge Information Composite	91.8	91.7	-0.1
Overall Rating	81.2	80.1	-1.1
Likelihood to Recommend	90.4	89.7	-0.7

Data complete through August, 2014  
 All results reflect Top-Box  
 (or 'Always' response) percentages  
 Pull date: November 3, 2014

Nurse Communication and Communication about Medication continue to outperform our 2013 baseline results. Overall Rating of the Hospital, Likelihood to Recommend MGH, and Discharge Instructions continue to be among the best in the nation. We need to continue to work to improve Pain-Management, Quiet at Night, and Staff Responsiveness.



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**Submissions**  
 All stories should be submitted to: [ssabia@partners.org](mailto:ssabia@partners.org)  
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