

# Caring

Headlines

May 8, 2014

## Pierce-Chana receives this year's Pamela J. Ellis Memorial Secretarial Award

*The Pamela J. Ellis Award was first presented in 1997, in memory of Pam Ellis, who served as an executive secretary at MGH for four years beginning in 1992. The award was established to honor secretarial staff who, "exhibit similar, remarkable qualities in their work."*

*Ellis died of melanoma at the age of 31.*



*See story on  
page 4*

Susan 'Susie' Pierce-Chana, Lunder 9 operations associate, accepts bouquet of flowers after being named the 2014 recipient of the Pamela J. Ellis Memorial Secretarial Award at this year's April 23rd Secretary's Day celebration.

# When it comes to nurse-patient staffing ratios, California's Dreamin'

Meeting the needs of acutely ill patients in real time requires flexibility and clinical judgment. As MGH staff nurse, Meg Soriano, RN, told the Massachusetts Joint Committee on Health Care Financing recently, "Please leave the decisions of nurse staffing where they belong—with nurses."

Since my column appeared in the April 3, 2014, issue of *Caring Headlines* ("Fixed nurse-patient staffing ratios: when it comes to patient safety, one size definitely does not fit all"), many of you have asked why I oppose government-mandated, nurse-patient staffing ratios. For me, the answer is simple: I believe in nurses and our ability to determine the staffing needs of patients and families. Being able to meet the needs of critically ill patients versus patients in non-academic medical centers requires very different staffing strategies. At MGH, for example, we care for seriously ill, medically complex patients, many of who come to us from community hospitals unable to meet their care needs. So why would we want our staffing strategies to be the same as hospitals that can only handle minimally ill patients? Answer: We don't.

Meeting the needs of acutely ill patients in real time requires flexibility and clinical judgment. As MGH staff nurse, Meg Soriano, RN, told the Massachusetts Joint Committee on Health Care Financing recently, "Please leave the decisions of nurse staffing where they belong—with nurses."

Staff nurse, Sabianca Delva, RN, associate chief nurse, Kevin Whitney, RN, and nursing director, Tara Tehan, RN, also addressed the Committee. Tara made the point that, "Nurses understand that one-size-fits-all solutions are not the answer. Yes, we need staffing plans that protect patients. And yes, hospitals should be required to develop and evaluate staffing plans." Hospitals. Not legislators.

That's why MGH and all hospitals throughout the Commonwealth report nurse staffing on the publicly available website, *Patient Care Link*. This site provides information about each hospital's staffing



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

and other key nurse-sensitive indicators. In Massachusetts, our focus is on quality and safety, not numbers.

California is the first and only state to mandate fixed nurse-patient staffing ratios. In my opinion, this was a failed experiment. There are no research studies to support the claim that mandated nurse-patient ratios have improved patient outcomes in that state. Study after study finds that the more educated the nursing workforce and the better the practice environment, the better patient outcomes are.

In the recent article, "California's Nurse-to-Patient Ratio: Eight Years Later, What do we Know?" the author shared that out of eight research studies, three demonstrated a mix of positive and negative outcomes, while five showed no change whatsoever in patient outcomes. The number of studies is limited, but after eight years of mandated ratios, you'd think California would have more to show for their efforts, given that quality of care was the issue that spurred the debate in the first place.

In the study, "Mandatory Nurse-Patient Ratios," again, the author points to the fact that there are no appreciable improvements in outcomes due to mandated nurse-patient staffing ratios.

*continued on next page*

Government-mandated staffing has been debated in Massachusetts for 15 years, and each year it has been summarily rejected. With no government intervention, Massachusetts has managed to significantly improve patient outcomes, as the graphic on this page clearly demonstrates.

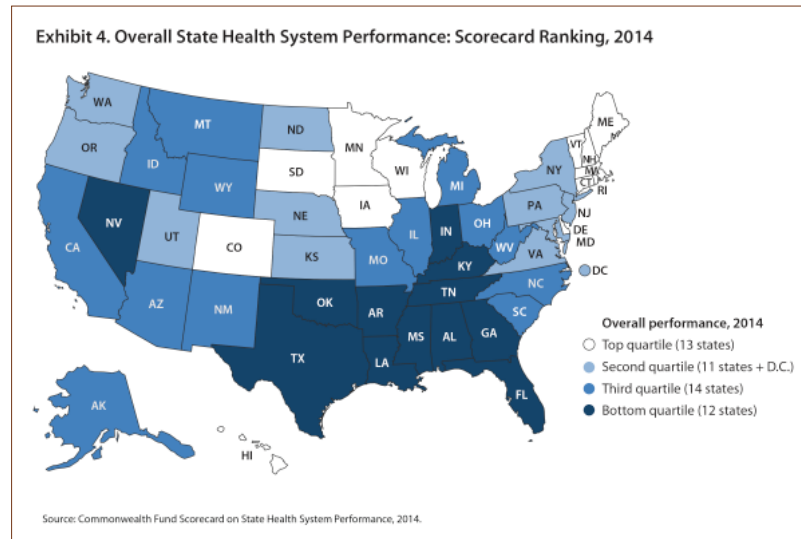
Research findings published in 2005 (Donaldson, Bolton, Aydin, Elashoff, and Sandhu); 2007 (Bolton, Aydin, Donaldson, Brown, Sandhu, Fridman, and Aronow); and 2009 (Spetz, Chapman, Herrera, Kaiser, Seago, and Dower) indicate that no significant improvement in patient-care quality has been achieved in connection with mandated nurse staffing ratios.

Linda Aiken, RN, acclaimed nurse researcher from the University of Pennsylvania, evaluated California-mandated ratios (2010 and 2013) and found that lower ratios were associated with lower mortality, and that nurse outcomes were predictive of better nurse retention. That may be true, but no evidence exists that definitively supports specific nurse-to-patient ratios. While hospitals imposing mandated ratios may have shown an increase in

nurse staffing levels and/or nurse satisfaction regarding the work environment, nurse-sensitive quality indicators such as the incidence of falls and pressure ulcers have not been significantly affected. Aiken's latest research points to two factors that positively impact patient outcomes: the education of the nurse and the work environment in which nurses practice. This is not at all surprising. Our own Staff Perceptions of the Professional Practice Environment Survey tells us that clinicians want to work on high-performing teams where the patient and family are the focus of care.

Government-mandated staffing has been debated in Massachusetts for 15 years, and each year it has been summarily rejected. With no government intervention, Massachusetts has managed to significantly improve patient outcomes, as the graphic to the left

clearly demonstrates. I oppose government-mandated, staffing ratios for all these reasons. But mostly, I oppose them because if I were a patient, I'd want the best team of qualified nurses to care for me, not an arbitrary number of nurses determined by my state legislators.



This year, the Commonwealth Fund reviewed 42 aspects of states' healthcare performance and ranked Massachusetts 2nd overall and best in the nation for access and affordability, prevention and treatment, and equity.

## In this Issue

Pamela J. Ellis Memorial Secretarial Award.....	1	The Mary C Forshay Scholarship.....	8
Jeanette Ives Erickson.....	2	Fielding the Issues.....	9
● Fixed Nurse-Patient Staffing Ratios		● Hourly Rounding	
Pamela J. Ellis Memorial Secretarial Award.....	4	Announcements.....	10
National Women's Health Week.....	5	Comfort Zone Camp.....	11
Clinical Narrative.....	6	HCAHPS.....	12
● Julie MacPherson-Clements, RRT			

(Cover photo by Paul Batista)

# Pierce-Chana receives 2014 Pamela J. Ellis Memorial Secretarial Award

**O**n Wednesday, April 23, 2014, at this year's Secretary's Day celebration, Lunder 9 operations associate, Susie Pierce-Chana, became the 19th recipient of the Pamela J. Ellis Memorial Secretarial Award, joining an elite

group of support staff who've been recognized for this prestigious honor. Nominated by many of her colleagues, Pierce-Chana was described as, "diligent, cool-headed, empathetic, detail-oriented, and a pleasure to work with."

Nurse practitioner, Katherine Runey, RN, wrote, "Susie is the calm in the eye of the storm... Even on the busiest of days, she has a positive attitude and maintains a sunny disposition, which in turn helps her colleagues keep their cool."

Staff nurse, Kathryn Aguilar, RN, said, "Susie is always on time and completely present... She gives

one hundred percent, every day, every shift, no matter the situation... We would be lost without her."

Said staff nurse, Denise Pimentel, RN, "It's not unusual for us to be short-staffed at the front desk, but Susie does her job with no complaints and a smile on her face. She really deserves this award."

Recalling her reaction to the news, Pierce-Chana shared, "Jeff Davis came to Lunder 9 and asked to see me! He told me I'd been chosen to receive the Pamela Ellis award, and suddenly I was surrounded at the front desk by this wonderful group of NPs and the happy, smiling faces of the nursing staff. They all congratulated me—it was such an amazing moment. Being appreciated for the work I do and being acknowledged as an important member of the team is the highest compliment I can think of. I want to thank my co-workers and everyone who took the time to nominate me."

On behalf of Patient Care Services and the entire MGH community, Congratulations, Susie!

Below, Pierce-Chana is pictured with (l-r): MGH president, Peter Slavin, MD; Lunder 9 operations manager, Tony Branch; and senior vice president for Human Resources, Jeff Davis.



(Photos by Paul Batista)



# Spring into health and wellness with National Women's Health Week

—by Laura Ferriero, SLP; Mallory A. Hillard; and Mary Stacy, RN,  
for the Patient Education Committee

The primary focus of Women's Health Week is to promote healthy lifestyles by emphasizing the importance of preventative screenings and empowering women to take an active role in their health.

**N**ational Women's Health Week is observed every May to celebrate health and wellness for women of all ages. This year, National Women's Health Week will be observed the week of May 11–17. The primary focus of Women's Health Week is to promote healthy lifestyles by emphasizing the importance of preventative screenings and empowering women to take an active role in their health.

Preventative screenings and open communication with healthcare providers help women maintain good health and reduce the risk of contracting serious diseases. Preventative screenings and open communication with healthcare providers work hand-in-hand to identify risk factors, minimize a woman's chance of exposure to serious conditions, and manage diseases and other co-morbidities if/when they occur.

Early detection is the first line of defense in treating and managing diseases such as diabetes, heart disease, and cancers including, cervical, ovarian, and breast cancer. Talking with patients about family history and personal risk factors can play a vital role in determining which screening tests are required and how often they should be performed.

Patient-education resources are available through MGH and other healthcare agencies. These resources can help patients and families prepare for their appointments and communicate effectively with caregivers about any question or concerns they may have. Of the many on-line resources available

at MGH, the MGH Patient and Family Education Materials and Resources website offers valuable patient-education materials that can be used to teach and motivate patients to learn about their general health and/or any specific conditions they may have.

From the MGH Patient Education website, you can navigate directly to the Maxwell & Eleanor Blum Patient and Family Learning Center. This site can be helpful in locating materials for patient-education, such as preparing for appointments, important questions to ask physicians, and information on specific screening tests. From the MGH Patient Education website, you can also access the site, Ambulatory: PCOI Patient Instructions, which provides links to various materials important to women's health.

In addition to resources available at MGH, agencies such as The Department of Health and Human Services' Office of Women's Health provide materials to foster understanding of risk factors, the importance of knowing and communicating family medical histories, and prevention measures that can be used to reduce the risk of disease.

Celebrate National Women's Health Week by exploring these resources and learning how best to help patients and families lead healthy lifestyles and guard against the possibility of contracting a serious illness.

For more information about patient-education materials available at MGH, e-mail the Blum Center at [PFLC@partners.org](mailto:PFLC@partners.org).

For information about National Women's Health Week, visit The US Department of Health and Human Services' Office on Women's Health website at <http://womenshealth.gov/nwhw/>.

# Respiratory therapist discovers true value of teamwork

'Ellie' had not sought medical care in more than 40 years and was admitted for shortness of breath. It was determined that she had a ruptured ulcer in the context of newly diagnosed chronic obstructive pulmonary disease (COPD).

**M**y name is Julie MacPherson-Clements, and I am a respiratory therapist. My journey as a respiratory therapist began about nine years ago when I was working at a pharmaceutical company doing patient-education for a multiple-sclerosis drug; I realized I wanted more patient interaction. Now, after nine years in the Respiratory Acute Care Unit (RACU), I realize how much I've learned since then. In retrospect, the bulk of my learning has come from practice, not books and lectures.

I immediately loved the RACU—the interdisciplinary collaboration, the motivation to wean patients off ventilators, and the daily learning that comes with every patient assignment. Perhaps most important, I enjoy being able to engage patients in their own care because they're no longer sedated or on medication that would limit their ability to participate in therapy.

'Ellie' had not sought medical care in more than 40 years and was admitted for shortness of breath. It was determined that she had a ruptured ulcer in the context of newly diagnosed chronic obstructive pulmonary disease (COPD). She had been intubated and extubated several times in the Surgical ICU. After long deliberations with her family, the decision was made to have a trach. Ellie's family had told the SICU team that being connected to a machine for



Julie MacPherson-Clements, RRT  
respiratory therapist

the rest of her life would be an 'albatross' to Ellie, who had effectively avoided medical care for the majority of her life. Knowing this, the team was even more determined to wean her off the ventilator.

When she was admitted to the RACU, Ellie's daughter and sister accompanied her. I introduced myself and explained that my role was to help liberate her from the machine and move her toward being able to talk with a trach. This would help her to be able to participate in physical therapy, speech therapy, and occupational therapy. While her family's reaction was hopeful and optimistic at the progress she could make, Ellie's response seemed to be apathy. I imagined that with all she'd been through, hope was in short supply.

The next day, I started to wean Ellie's support after measuring some pulmonary mechanics on the ventilator. According to the numbers, she should have been able to breathe on her own. But she expressed anxiety at the thought of doing any increased 'work' despite insisting she didn't want to be on a

*continued on next page*

This experience taught me a lot about my role as a member of the RACU team. I realized that even though I was disappointed with Ellie's initial response to my treatment interventions, it didn't have to limit her progress. I was able to recruit other members of the team to help work through the challenges.

breathing machine for the rest of her life. Over the course of the next few days, Ellie was able to wean down to minimal settings, and it looked as if she was going to be able to breathe on her own. But once I took away the support of the machine to conduct a spontaneous breathing trial, her breathing pattern changed immediately. She started forcefully exhaling, had mono-phasic wheezing, and became highly anxious. I quickly put her back on the ventilator and stayed with her until her breathing was more comfortable.

Based on my observations, I asked the team to perform a bronchoscopy. I wanted to see if the trach tube was positioned correctly in her airway. If it wasn't, it could have been masked while she was on the ventilator, then once the vent was taken away, her airway could have collapsed against the tube. I explained my theory to the team, and we immediately looked with the bronchoscope. I suggested we visualize the posterior wall of the trachea while Ellie was receiving positive pressure and then again without it. Sure enough, the tube was about 80% occluded, which explained the breathing pattern I had witnessed.

The fellow asked me which tube I thought would be best, and I suggested one with a smaller outer diameter to allow for potential phonation and one that would be long enough to bypass the area of collapse. Ellie was anxious about the procedure, so I recommended we not make any changes until her family arrived later that afternoon and could provide emotional support. As I had anticipated, Ellie's family was very supportive and the tube was changed without incident that afternoon.

My next goal was to evaluate Ellie for a speaking valve. Again, the numbers indicated she should be able to talk, but Ellie resisted. She couldn't give a reason why she didn't want to use the speaking valve, but she flat out refused. In all my years in the RACU, I'd never seen a patient who was *able* to use the speaking valve but simply wouldn't do it. It's usually the opposite—patients feel they have less anxiety when they have a voice to communicate.

During my next shift several days later, I read in the notes that Ellie had not used the speaking valve at all. I started to think about what I could do to help her feel better about using her voice and understand the benefits of using the speaking valve. I contacted Ellie's speech language pathologist (SLP) and asked if she'd meet with Ellie, Ellie's nurse, and me to help Ellie understand how the speaking valve would allow

her to communicate and eat; and to help us understand Ellie's reluctance to use it. I scheduled the meeting for a time when Ellie's family could be present.

It was a wonderful, collaborative discussion. Ellie's family was very supportive and grateful, saying, "Look at all these people who are here to help you; you should take advantage of them."

Once we left the room I spoke with Ellie's nurse, Lauren Vaughn, to try to come up with a solution. We thought it would be a good idea to consult the psychiatric clinical nurse specialist about relaxation techniques for Ellie. Lauren called her and she came by later that day. I was candid with her about my frustration regarding Ellie's resistance to move forward in her treatment. I had worked with a number of COPD patients over the years but had never encountered anyone whose anxiety had halted his/her treatment to this degree. The psychiatric clinical nurse specialist guided Ellie through some relaxation techniques that Ellie found very helpful in managing her anxiety.

Soon, Ellie learned to tolerate the speaking valve and was able to remain off the ventilator. It was a complex situation that required a high level of collaboration among the inter-disciplinary team. It made me realize the value of getting other clinicians involved in a patient's care.

This experience taught me a lot about my role as a member of the RACU team. I realized that even though I was disappointed with Ellie's initial response to my treatment interventions, it didn't have to limit her progress. I was able to recruit other members of the team to help work through the challenges. Having the support of my colleagues helped me gain a better understanding of the resources available to help ensure positive patient outcomes.

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

Julie's expertise as a respiratory therapist is keenly visible in this narrative. She quickly recognized the need to reposition Ellie's trach tube, even before the bronchoscopy confirmed what she suspected. Julie's sensitivity to Ellie's fragile emotional state and need for family support allowed Ellie to move forward, work with other members of the care team, and ultimately free herself from the ventilator. This is a wonderful example of relationship-based care and collaborative practice.

Thank-you, Julie.

# Mary C. Forshay Scholarship

*to advance the care of ALS patients*

—by Julie Goldman, RN, professional development program manager

**O**n April 17, 2014, social worker, Ellen Godena, LCSW, was named this year's recipient of the Mary C. Forshay Scholarship to Advance the Care of ALS Patients. Godena was recognized for her passion, compassion, and advocacy in her care of ALS patients and families in the Neuroscience Unit.

Robert Forshay with scholarship award recipient, Ellen Godena, LCSW, social worker.



(Photo by Paul Batista)

Mary Forshay's husband and family established the scholarship in Mary's memory to recognize compassionate care of ALS patients and promote educational opportunities for staff (including attending the ALS Association's National ALS Advocacy Day and Public Policy Conference in Washington DC). Forshay's career spanned more than 30 years. Forshay was cared for in the Respiratory Acute Care Unit and ALS Clinic. The award was established to enable caregivers to advance their knowledge and care of patients and families with ALS and to honor Forshay's life and work.

Godena began her career with an internship in the Neuro-Oncology Clinic at the Dana Farber Cancer Institute in 2010. Prior to joining the department of Social Service at MGH, she was a clinical social worker at Rhode Island Hospital, where she first cared for ALS patients in the Medical and Respiratory ICUs. As a social worker on the Neuroscience Unit at MGH, Godena provides counseling and support to ALS patients and families coping with and adapting to progressive changes in functioning, communication, and lifestyle. Godena has been deeply touched by the resilience and wisdom of her patients and their families as they progress through the stages of ALS.

Forshay's husband, Robert, noted, "Our family is honored to recognize these staff members who are so committed to caring for ALS patients and families. We're happy to continue Mary's legacy and provide this scholarship so clinicians can attend the national conference and share the knowledge they gain with their colleagues, patients, and families."

For more information, call Julie Goldman, RN, at 617-724-2295.



# Hourly rounding

*an evidence-based, best practice shown to improve safety and patient-satisfaction*

**Question:** I know a lot of units have implemented hourly rounding, or safety rounds. What does that entail, exactly?

**Jeanette:** Hourly rounding is an evidence-based, best practice that's been shown to have a positive impact on safety and patient-satisfaction. Rounding, or checking on patients at frequent, predictable intervals, helps reduce falls and pressure ulcers, which is good for patients and reflects well on our HCAHPS scores. It has been shown to reduce the use of call bells and improve workflow and efficiency. For all these reasons, MGH has committed to implementing hourly rounding on all patient care units throughout the hospital.

**Question:** What does hourly rounding consist of?

**Jeanette:** Our approach to hourly rounding consists of purposeful visits every hour (or every two hours at night) with a focus on the 4 Ps: Presence, Pain, Positioning, and Personal needs. Presence refers to getting to know the patient and family so you can be attuned to their needs. After addressing the 4 Ps, caregivers let the patient know that someone will be back to check on them within the hour.

**Question:** That sounds like what nurses do all the time.

**Jeanette:** It's true that nurses check on patients frequently. Inherent in hourly rounding is patients *knowing* that they can expect someone to check on them every hour, knowing why we employ this practice, and knowing we'll remind them of it every time we conduct hourly rounds. That's why it's important to verify that rounds have occurred in the presence of the patient and family using the white boards in patients' rooms. New erasable templates for

white boards are being distributed to inpatient units to help make the process more second-nature.

**Question:** Are we learning anything from hourly rounding?

**Jeanette:** As nurse leaders round with patients and families throughout the hospital, we're hearing very positive comments about the practice. Feedback about hourly rounding will be shared with staff on an on-going basis for purposes of improving care and recognizing excellence in care-delivery.

For more information about hourly rounding or the 4 Ps, please call Rick Evans, senior director of Service at 617-724-2838, or Kevin Whitney, RN, associate chief nurse at 617-724-6317.

**Date:**

**Patient Name:**

**Nurse:**

**PCA:**

**Doctor:**

**Anticipated Discharge Date:**

**Goal for the Day:**

\_\_\_\_\_

**Question(s) for your Care Team:**

Hourly Safety Rounding											
AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM	AM

**MASSACHUSETTS GENERAL HOSPITAL**

In-room white boards

# Announcements

## Free one-day bereavement program for children

Saturday, July 19, 2014  
8:30am–4:00pm  
at the MGH Institute  
for Health Professions in the  
Charlestown Navy Yard

For information, call  
617-724-4525

## Senior HealthWISE events

All events are free for  
seniors 60 and older

### “Common Diabetic Foot Problems”

Thursday, May 15th  
11:00am–12:00pm  
Haber Conference Room  
Speaker: Zachary G. Jagmin, DPM  
podiatry resident

### Special Event

### “Getting the Sleep You Need”

Tuesday, June 10th  
11:00am–12:00pm  
O’Keeffe Auditorium  
Speaker: Peg Baim, RN, clinical  
director of the Resiliency Program  
at the Benson-Henry Institute for  
Mind Body Medicine.

Please RSVP: 617-643-6302.

For more information,  
call 4-6756.

## ACLS Classes

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

Day one:  
June 20, 2014  
10:30am–5:00pm

Day two:  
June 23rd  
8:00am–1:00pm

Re-certification (one-day class):  
May 14th  
5:30–10:30pm

For information,  
call 617-726-3905.

Class locations will be announced  
upon registration.  
To register, go to:  
[http://www.massgeneral.org/emergencymedicine/assets/Library/ACLS\\_registration\\_form.pdf](http://www.massgeneral.org/emergencymedicine/assets/Library/ACLS_registration_form.pdf).

## New Fibroid Program at MGH

Radiology and Obstetrics & Gynecology are introducing the new Fibroid Program to provide access to a multi-disciplinary team of specialists, including gynecologists and interventional radiologists, who collaborate to offer a full range of treatments for women with uterine fibroids.

A nurse coordinator helps navigate care throughout the course of treatment, including scheduling appointments and connecting patients to available resources.

Treatments and services include:

- Diagnostic imaging
- Minimally invasive surgery
- Image-guided procedures

Consultations are available on Tuesdays from 8:00am–12:00pm in the the Yawkey 4 OBGYN suite.

For more information go to:  
[massgeneral.org/fibroids](http://massgeneral.org/fibroids).  
For appointments,  
call 857-238-4733 or submit an  
on-line appointment request.

## Steps to Success

Sponsored by Training and  
Workforce Development

Taking the First Step  
Tuesday, May 20, 2014  
12:00–1:00pm

Haber Conference Room

Thinking about enhancing your skills or considering new opportunities? This session will focus on self-assessment, goal-setting, managing priorities, and career-management.

Financing Your Education  
Wednesday, May 21st  
12:00–1:00pm

Haber Conference Room

Thinking about going back to school but unsure of how to pay for it? Financial aid experts from the MGH Institute of Health Professions and the Harvard University Employees Credit Union will share tools and strategies to help finance your education, and MGH tuition coordinator, Christopher Conant, will discuss the tuition reimbursement program and Support Service Employee Grant.

Education Fair  
Thursday, May 22nd  
12:00–3:00pm  
under the Bulfinch Tent

Are you getting the bug to go back to school? Representatives from local institutions will be on hand for the annual MGH Education Fair: Explore certificate, undergraduate, and graduate, clinical and non-clinical programs, including nursing, research administration, inpatient coding, healthcare policy, and administration. Featured schools include Boston University, Bunker Hill Community College, MGH Institute of Health Professions, Simmons College, and UMass Boston.

No registration necessary.  
For more information,  
call 617-726-2230.

## Goodbye Trove, Hello Ellucid

The MGH Compliance Office has announced that MCN Healthcare’s Ellucid program will soon replace Trove as the MGH policy-management system.

MCN Healthcare is a leading provider of regulatory-compliance software and learning solutions.

Ellucid offers advanced search tools and policy-browsing capabilities.

Ellucid provides a list of recently viewed policies and a Favorites folder to save frequently viewed policies.

On-line video-based training is available.

All policies are converted to PDF format for easier viewing and printing.

Please continue to use Trove until implementation of the Ellucid system is complete.

For more information, contact: project coordinators, Kelly Staples at 617-643-5493, or Julia Austin at 617-726-5109; or chief compliance officer, John Belknap at 617-724-9725.

## MGH Institute Alumni Breakfast

Join the MGH Institute of Health Professions for a continental alumni breakfast with School of Nursing dean and Robert Wood Johnson Foundation executive nurse fellow, Laurie Lauzon Clabo, RN. Alumni working at MGH are encouraged to attend.

Tuesday, May 20, 2014  
8:00–9:00am

Thier Conference Room

RSVP by e-mail to  
[sbucciarelli@mghihp.edu](mailto:sbucciarelli@mghihp.edu)

Hosted by the MGH Institute of Health Professions School of Nursing & Office of Development and Alumni Relations.

# Helping kids get inside their 'Comfort Zone'

*a one-day bereavement camp for grieving children*

—by Todd Rinehart, LICSW, social worker

**A**t any given moment, 2.5 million children in the United States are grieving the death of a parent or sibling, one of the most traumatic events a child can experience. Comfort Zone Camp is a program that provides grieving children with a place to heal and a community where they can feel safe, continue to grow, and learn to lead fulfilling lives.

In partnership with Comfort Zone Camp, MGH is offering a free one-day bereavement program for families with children, age 5–17, who have experienced the death of a parent, sibling, or guardian. The program is designed to relieve feelings of isolation; introduce attendees to peers who've experienced similar loss; provide mentorship and professional therapeutic services; and teach kids skills for managing grief in their daily life. Participants and their mentors attend age-based support groups where they have an opportunity to share their experiences and hear about the experiences of other kids their own age. A parent/guardian component of the program helps prepare parents and guardians to support their children in managing their grief in a healthy way.

The one-day program will be held, Saturday, July 19, 2014, from 8:30am–4:00pm, at the MGH Institute for Health Professions in the Charlestown Navy Yard.

To register a child, go to: <http://www.comfortzonecamp.org>, and create an account. A representative will contact you to schedule a telephone interview to discuss your child's loss, current level of grief, personality, and interests. Once the interview is complete, you will be contacted to complete the application process.

Volunteers are still needed to help support the program. Volunteer training will be held, Saturday, June 7th on the main campus.

To register for volunteer training, go to: <http://www.comfortzonecamp.org>, and follow the instructions (a small fee is required). You'll receive a reminder e-mail approximately

one to two weeks prior to training.

All services are free of charge.

The program is supported by the Palliative Care Division of the Pediatric Palliative Care Service, Social Service, and Patient Care Services. For more information, call Todd Rinehart, LICSW, social worker, at 617-724-4525.

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For more information, call:  
617-724-1746

### Next Publication

May 29, 2014

# Inpatient HCAHPS Results

## 2013–2014

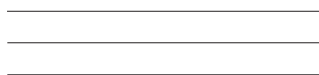
Measure	2013	2014 Year to Date	2013-2014 Change
Nurse Communication Composite	81.9	82.9	+1
Doctor Communication Composite	82.5	81.5	-1
Room Clean	74.5	72.2	- 2.3
Quiet at Night	50.2	50.3	+1
Cleanliness/Quiet Composite	62.4	61.3	- 1.1
Staff Responsiveness Composite	64.7	63.1	-1.6
Pain Management Composite	72.3	73.3	+1
Communication About Meds Composite	65.5	67.1	+1.6
Discharge Information Composite	91.8	92.1	+3
Overall Rating	81.2	80.9	-.3
Likelihood to Recommend	90.4	91.2	+8

Year-to-date HCAHPS results reflect progress in Nursing Communication, Pain-Management, and Communication about Medications. They also show incremental progress in Room Quietness and Discharge Instructions. Overall Rating and Likelihood to Recommend MGH remain among the highest scores in the nation. Continued focus on Staff Responsiveness and Quietness is warranted.

Data complete through February, 2014  
 All results reflect Top-Box (or 'Always' response) percentages  
 Pull date: April 17, 2014



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