

# Caring

Headlines

October 1, 2015

## Celebrating Accessible MGH



Clockwise from top left: Representative from the Brewer Company demonstrates power exam table; MGH president, Peter Slavin, MD, addresses the gathering; Terry Malcolm (left) and Julie Proud Ray of the Deaf Survivors Center communicate in sign language; Zary Amirhosseini, disability program manager (right), shares remarks.



*See story on page 4*



# The 2015 Staff Perceptions of the Professional Practice Environment Survey

The survey seeks to gauge staff's level of satisfaction with their work environment while at the same time providing a report card of sorts highlighting the strengths and weaknesses of our environment of care.

The Staff Perceptions of the Professional Practice Environment Survey (SPPPE) has been a valuable and instructive tool since its inception in 1999. It was originally created to evaluate the effectiveness of our then newly developed Professional Practice Model, which was revised last year and can be seen on the opposite page. The survey seeks to gauge staff's level of satisfaction with their work environment while at the same time providing a report card of sorts highlighting the strengths and weaknesses of our environment of care.

Over the years, the SPPPE survey has undergone changes and revisions to ensure it continues to be an effective and meaningful measure of staff satisfaction in a constantly evolving healthcare environment. The 2015 survey sought to measure staff's perceptions of:

- Autonomy and Control over Practice
- Communication about Patients
- Cultural Sensitivity
- Handling Disagreement and Conflict
- Sufficient Staff, Time, and Resources for Quality Patient Care
- Staff Relations with Physicians, Other Staff, and Hospital Groups
- Supportive Leadership
- Teamwork
- Work Motivation
- Job Enjoyment
- Overall Work Satisfaction
- Knowing Participation in Change



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

All survey responses are completely confidential. The survey is administered by staff of the Yvonne L. Munn Center for Nursing Research; surveys are distributed and collected electronically with no link to the respondents' names or e-mail addresses. All professional staff within Patient Care Services who provide direct care to patients were invited to participate. Of the 4,885 eligible staff members, 1,650 actually completed the survey, which translates to a 34% response rate.

The survey measures used a 6-point Likert scale for responses (Strongly Disagree; Moderately Disagree; Disagree; Agree; Moderately Agree; and Strongly Agree), versus the 4-point Likert scale used in past years. Qualitative data was derived from a single, open-ended question that simply said, "Please feel free to write any comments you have about the topics in this survey or other topics that pertain to the professional practice environment." And of the 1,650 respondents, 521 (or 32%) provided written comments.

*continued on next page*

The real power of the survey lies in how staff and leadership use these findings. I urge you to review the report for your area, engage in conversations with your colleagues and leaders, and use this information to identify ways to make the environment of care better for patients, families, and staff.

I'm happy to say that, overall, staff continue to report a high level of agreement with the organizational characteristics listed on the previous page. There was, of course, some variability among disciplines and patient care units, but overall, clinicians reported 84% satisfaction working in their respective disciplines and/or units.

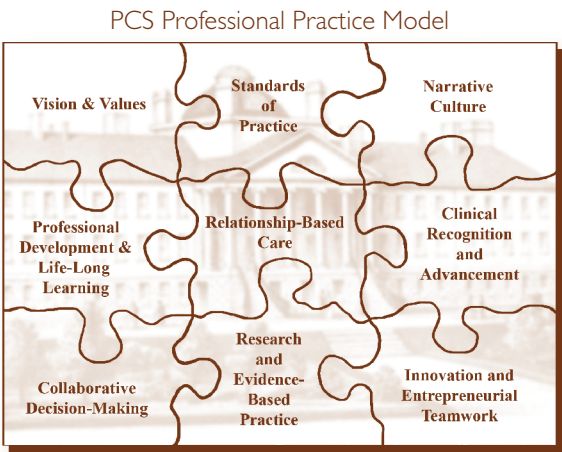
In the qualitative portion of the survey, analysis of written comments revealed a number of recurring themes:

- The importance of effective leadership in engendering satisfaction, teamwork, and professional growth and development
- An awareness that we're in a state of heightened demand with increased patient acuity, increased focus on hospital stays, documentation, and unprecedented change
- A perception that morale suffers when staff's participation in decision-making is limited or access to leadership is inhibited
- A perception that workload and time spent with patients and families is impacted in times of peak demand and/or because of limited space or resources

- A sense of pride at feeling part of a network of talented, creative, highly motivated professionals working together to provide optimal patient care in a safe, high-quality, cost-effective environment

Results of the SPPPE survey are reported out at three levels: an overview of all of Patient Care Services, by discipline, and by patient-care unit. Each report provides insight into what's working well, where there are opportunities for improvement, and how staff feel about their practice environment. The real power of the survey lies in how staff and leadership use these findings. We couldn't ask for a better barometer of our professional practice environment than the results of this survey. I urge you to review the report for your area, engage in conversations with your colleagues and leaders, and use the information to identify ways to make the environment of care better for patients, families, and staff.

I'd like to thank everyone who took the time to participate in the SPPPE survey. It truly is one of the most valuable and informative tools at our disposal in creating a functional, effective, and enjoyable professional practice environment.



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(Cover photos by Paul Batista)



# Celebrating Accessible MGH

—by Ellen Forman, LICSW, manager, Social Service's Community Resource Center

**O**n September 10, 2015, the MGH community came together under the Bulfinch tent to celebrate 'Accessible MGH.' The event was held to recognize the success of the MGH Disabilities Initiative and those who've worked so hard over the years to ensure MGH patients with disabilities receive the highest quality care and employees with disabilities are able to contribute fully in the workplace. This year marks the 25th anniversary of the passage of the Americans with Dis-

Staffing booth at Accessible MGH event are Mandi Coakley RN, staff specialist (left); and Ann Giauque, administrative director, Lurie Center for Autism.



(Photos by Paul Batista)

abilities Act (ADA), which requires businesses to be accessible to all.

The MGH Council on Disabilities Awareness was created in 2003. In 2009, MGH and BWH entered into an agreement with the Boston Center for Independent Living (BCIL) to work together to ensure our facilities were accessible and welcoming for all. In his remarks, MGH president, Peter Slavin, MD, spoke about the progress we've made remediating architectural barriers; acquiring accessible medical equipment; amending and introducing policies and procedures to improve access; and training hospital staff and volunteers. Said Slavin, "We committed ourselves to these efforts through the time and talents of many employees and financial resources. There is still work to be done, but we've implemented an impressive number of improvements of which we can be very proud."

Among efforts to mitigate architectural barriers, automatic doors have been installed in public and practice locations, ground-floor bathrooms have been renovated, accessible parking spaces and curbs cuts have been added, ramps have been widened, and reception counters at the main entrance, outpatient Pharmacy, and newly-renovated nursing stations have been lowered.

The disabilities portal and MGH Accessibility Resource Site (MARS), provide a one-stop, on-line site where staff can access resources and equipment for patients and families with disabilities. And HealthStream now has modules tailored to specific role groups to support our efforts to make MGH a welcoming environment for all.

Five years ago the hospital hired full-time, disabilities program manager, Zary Amirhosseini, who

*continued on next page*

serves as a liaison to patients with disabilities, offers assistance navigating the hospital, fields concerns about care, and solicits ideas for service improvement. The Employee Disability Resource Group (EDRG) was created to provide a forum for discussion, mentoring, collaboration, and networking for employees with disabilities and friends and relatives of those with disabilities.

Other accomplishments include:

- Becoming the first hospital in the nation to 'flag' the medical records of patients with disabilities so we can better anticipate and accommodate their needs
- Becoming the first hospital in New England to provide deaf and hard-of-hearing inpatients with access to mobile video phones, allowing users to communicate with American Sign Language
- Becoming one of the first hospitals in the country to launch an accessibility web page to provide information to patients with disabilities and their families
- Measuring HCAHPS results specific to patients with self-reported disabilities and soliciting patient feedback specific to disability services

In his comments, Bill Henning, executive director of the Boston Center for Independent Living, said, "MGH has done a terrific job investing time, capital, and brainpower to improve access for peo-

ple with disabilities. Leadership has recognized that this is a long-term effort. We're thrilled to partner with you in this work as MGH is ahead of almost every hospital in the country in these efforts."

Lisa Iezzoni, MD, director of the Mongan Institute for Health Policy, has experienced MGH as both a caregiver and a patient. She and patient, Tom Perry, shared stories highlighting our journey to provide equitable care to patients with disabilities.

Attendees had an opportunity to visit booths, learn about community resources, and try adaptive equipment currently in use at MGH, including wheelchair scales and exercise equipment available at the MGH Clubs at Charles River Park.

The celebration marked the end of our formal agreement with BCIL and recognized the strides we've made toward achieving our goals. But Slavin, Amirhosseini, and others pledged to continue this work through the MGH Council on Disabilities Awareness.

For more information about services, resources, or the MGH Council on Disabilities Awareness, call Zary Amirhosseini at 617-643-7148; go to the MGH Accessibility Resource Site (MARS), under Partners Applications, Clinical References; or visit the Disabilities EED Portal at [www.mghpcs.org/eed\\_portal/EED\\_disabilities.asp](http://www.mghpcs.org/eed_portal/EED_disabilities.asp).

Below: key stakeholders, members of the MGH Council on Disabilities Awareness, and others, attend Celebrating Accessible MGH event. Below right: Colleen Snyderman, RN, director of the PCS Office of Quality & Safety, peruses educational booths.



# Primary nursing and relationship-based care go hand-in-hand

I started treating 'Johnny' four years ago when he was diagnosed with tongue cancer. I cared for him during a grueling regimen of weekly chemotherapy coupled with daily radiation for seven consecutive weeks.

**M**y name is Sara Hunter, and I've been a nurse at MGH for nearly a decade, most recently in the Infusion Unit in the Yawkey Cancer Center. Acclimating to an outpatient environment after years on an inpatient neuro-oncology unit was a challenge. In the outpatient setting, patients have a 30- to 60-minute clinic visit before going into the infusion unit for treatment, which can last anywhere from 30 minutes to 12 hours. As an infusion nurse, I care for many patients, all of who require assessment, education, chemotherapy, and general care. I'm proud to say we use a primary nursing model in our unit, which allows practitioners to foster strong relationships with patients and families during and after their treatment.

Along with the opportunity to build personal relationships with patients, often comes the challenge of seeing those families cope with the decline of a loved one. It takes a special skill to adapt your care during those difficult times.

I started treating 'Johnny' four years ago when he was diagnosed with tongue cancer. I cared for him during a grueling regimen of weekly chemotherapy coupled with daily radiation for seven consecutive weeks. This is an extremely tough, but typically effective treatment where patients often experience acute pain, increased oral secretions, radiation burns, and mouth sores, all of which contribute to difficulty swallowing. Johnny was no exception.

After working as a Boston police officer for 35 years, Johnny had just retired. When we first met, he was 65 years old and pursuing a degree in law. He was a hard-working, highly educated, strong-willed man



Sara Hunter, RN  
staff nurse, Yawkey 8 Infusion Unit

who was used to directing his life. It was difficult for Johnny to cope with his new vulnerability. Johnny and I were engaged in a perpetual dance with me trying to administer care he was comfortable accepting, and him pulling away if I pushed too hard. By the end of those first seven weeks, Johnny and I had built a solid rapport where I knew his tolerances and he valued my expertise as a seasoned head-and-neck oncology nurse.

Usually head and neck cancer is very curable. Though the treatment is challenging, most people are able to beat the disease. Unfortunately, Johnny was one of the people for whom standard treatment did not produce a cure. Three years later, after passing the bar exam and opening his own law practice, Johnny presented with progression of his cancer. He returned ready to resume weekly chemotherapy in hopes of slowing the tumor and improving his quality of life. This time, however, a new medical issue accompanied his treatment. Johnny had undergone a tongue dissection, which garbled his speech and made it difficult to understand what he was saying. Initially, Johnny had to write things down to communicate with me. But the more Johnny and I spoke, the better I got at understanding his new

*continued on next page*



way of speaking, which was a big relief to him, allowing him to regain some normalcy.

Soon, Johnny's tumor started to protrude beyond his jaw line causing a continuous slow bleed that required cauterization and other interventions. Unfortunately, nothing worked to stop the blood flow. Johnny came to the Infusion Unit numerous times for blood transfusions, creating a palpable fear in me that Johnny could bleed out at any moment.

On many occasions, Johnny was brought to the Infusion Unit only to be sent to the ED for bleeding control. Often he refused to go. Because of Johnny's trust in me, I'd be called upon to convey the danger of not going to the ED and he'd invariably comply. Because of the relationship we built as a result of primary nursing, I was able to reason with him.

Educating Johnny on safety precautions, dressing-changes, and pain-management was a weekly routine. Johnny was having a hard time coming to grips with an existence where he was no longer able to care for himself independently.

Johnny had recently broken up with a girlfriend and was now living with a woman named Christy he met online. She had recently lost her husband and was dealing with her own issues. Christy thought of herself as Johnny's 'soul mate.' She had strong opinions about his care, and often frustrated Johnny with how she treated staff. This proved trying for me, too. Though Christy was not my patient, managing her grief was now an important part of my job. Only by managing her grief could I give Johnny the care he needed.

In time, I deduced that Christy's rudeness stemmed from a sense of fear and loss. She wanted to approve all changes in Johnny's care, so I tried to anticipate her needs and minimize her angst. I included her, when appropriate, in decision-making. Despite my efforts, Christy needed frequent reminders that Johnny's needs had to come before hers. Setting limits and enforcing boundaries for Christy added another layer to Johnny's care.

I looked for opportunities to speak with Johnny alone to better understand his home life. It seemed Christy was refusing to accept the fact that Johnny's condition was no longer curable. As a result, he wasn't getting the support he needed to cope with his situation. We discussed end-of-life care and his fears about dying. Johnny spoke about how difficult it was to be disfigured and lose his law practice.

Johnny's chemo treatments were no longer helping. After many conversations, he was able to see that there comes a time when acceptance is necessary. I tried to help Johnny focus on quality of life. His chemo treatments were causing more pain than relief. I tried to help

him understand that discontinuing treatment didn't mean he was 'giving up.' This was difficult for him to process. He'd never 'failed' at anything; he initially looked at discontinuing chemo as failure. Johnny and I spoke at length about this. I helped him see that he had fought his disease with dignity, strength, and determination.

One evening, when I was transporting Johnny back to his ride, he stopped me in the hallway. Usually stoic, he had tears in his eyes. He asked me if he was going to die that night. This was not a new topic for us. I allayed his immediate fears, but because of our close relationship I felt obliged to be frank. I told him I believed he had only a few more weeks to live. This is what Johnny expected from me. He reached up and hugged me. He thanked me and told me he loved me. I was so touched by his appreciation during that difficult moment.

When I met this strong, imposing patient years ago, I never would have guessed that we would one day share a hug. Because of the primary nursing model, I was able to forge an amazing relationship with him, and hopefully help him find solace during the most challenging time of his life.

Johnny died not long after that hug. I find comfort in knowing that by discontinuing his chemo treatments, he had more quality time with his family. Prior to his death, he rekindled his relationship with his previously-estranged adult children and grandchildren.

As an oncology nurse, I'm constantly forming new relationships, many of which end in death. Caring for someone like Johnny reminds me why I chose oncology nursing as a career path. There's so much to be learned from every patient. I only hope that during the course of their treatment I'm able to make their journey a more pleasant, comfortable, and meaningful one. Primary nursing allows me to do just that.

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

A 'perpetual dance.' What a perfect description of Sara's relationship with Johnny during the course of his treatment. Knowing when to lead and when to follow; when to come together and when to let there be space between you. This particular dance culminated with a special hug during a delicate moment of honesty between nurse and patient. I'm sure it's a hug Sara will remember for a long, long time.

Thank-you, Sara.

# Orren Carrere Fox Award for Newborn Intensive Care Unit Caregivers

—by Mary Ellin Smith, RN, professional development manager

It's hard to believe that the tall, good-looking, young man who walked into the Newborn ICU on September 11, 2015, was once a patient there. While 18-year-old, Orren Fox, may not remember his stay in the NICU, his family will never forget; nor will they forget the outstanding care they received from the NICU team during their son's first few days of life. In recognition of that care, the Carrere Fox family established the Orren Carrere Fox Award for Newborn Intensive Care Unit Caregivers, which is given annually to a member of the NICU team who expertly embodies the principles of family-centered care. This year's recipient was staff nurse, Candice Hartford, RN.

In her remarks, NICU nursing director, Peggy Settle, RN, told how Hartford knows that parents worry about their babies when they're away from the hospital,

so she sends them photos of their babies in the middle of the night to assure them that all is well. Settle thanked Hartford for her ability to see 'good' in every person or situation. Said Settle, "That ability is a gift that Candice brings to our unit. We're very lucky to work with her."

Hartford thanked the Fox family for their on-going generosity and her colleagues for, "always showing up for their babies, their families, and each other." Said Hartford, "We're committed to supporting families. They have a say in everything from changing diapers to end-of-life decisions. We never forget that the baby may be our patient, but he or she is their loved one."

Orren's dad, Henry Fox, remembers walking into the NICU and thinking what a foreign world it was. Orren's nurse guided him to understand that his son's progress could be measured by watching the dials on the ventilator

move to the left. "It might not always have been smooth," said Fox. "But that helped me so much as we watched those dials move slowly but surely to the left."

Orren, who will spend the next year doing volunteer work in Nepal, the Caribbean, and Colorado prior to attending Colorado College, told of how he took the care he received at MGH for granted until he saw an infant close to death while volunteering in Nepal. "The kind of care I received wasn't available to that little boy," he said. "Fortunately, he survived. I realized now how lucky my family and I were that we had all of you."

For more information about the Orren Carrere Fox Award for Newborn Intensive Care Unit Caregivers, call professional development manager, Mary Ellin Smith, RN, at 4-5801.



(Photos by Sam Riley)

Top photo: award recipient, Candice Hartford, RN (left), with nursing director, Peggy Settle, RN.  
Above: Hartford, with (l-r): Orren's grandmother; his mom, Libby Delena; Orren; and dad, Henry Fox.



# Re-designing the collaborative governance committee structure

—by Mary Ellin Smith, RN, professional development manager

**O**n May 15, 1997, Jeanette Ives Erickson, RN, senior vice president for Patient Care, told the original members of collaborative governance that their work was about to change. Little did we know how prophetic that statement was going to be. In 2010, collaborative governance was re-designed to be more in line with the work taking place at that time. And now, five years later, collaborative governance is changing again — not because anything is wrong, but because so many things are right.

In 2010, the re-designed structure introduced four new committees under the umbrella of quality and safety—Fall Prevention, Pain Management, Skin Care, and Restraint Solutions in Clinical Practice. The success of these committees as measured by our HCAHPS scores, safety reports, skin-breakdown surveys, and a decrease in the use of restraints, tells us our efforts are working. We will continue to focus on these issues, but we're learning that we make better decisions when we bring clinicians together to share relevant data and information.

Toward that end, Gaurdia Banister, RN, executive director of The Institute for Patient Care, convened a group of key stakeholders to re-structure committees in a way that continues to place authority, responsibility, and accountability for patient care with practicing clinicians but aligns the work in a more meaningful and manageable way. The group recently submitted the following recommendations to the PCS Executive Committee:

*The following committees would end their work December 31, 2015:*

- Fall Prevention
- Pain Management
- Skin Care Committee
- Restraint Solutions in Clinical Practice

*Two new committees would be formed effective January 1, 2016:*

- The Patient Experience Committee: an inter-disciplinary committee charged with improving the patient experience by advancing clinical excellence through the delivery of compassionate, patient-centered care. Champions will focus but not limit their work to identifying opportunities to improve pain-management and creating an environment for healing
- The Quality and Safety Committee: an inter-disciplinary committee charged with identifying actual and potential risks to patients and clinicians through a review of safety reports, quality and safety indicators, and experiential clinical practice. Champions will make recommendations about changes to policies, procedures, and practice to ensure care is safe and evidence-based, and best practices are shared among colleagues

The Ethics in Clinical Practice; Patient Education; Policy, Procedure & Products; Diversity; Research & Evidence-Based Practice; and Staff Advisory committees will not be affected by this re-design.

Change can be challenging. But this change is a testament to the success and effectiveness of collaborative governance and the champions who work so hard to ensure that every patient receives excellence care, every day.

For more information about the re-design of collaborative governance, contact professional development manager, Mary Ellin Smith, RN, at 4-5801.

# What is MOLST?

*Question:* What is MOLST?

*Jeanette:* MOLST stands for Medical Orders for Life-Sustaining Treatment. It's a written medical order from a physician to other healthcare providers to ensure patients' preferences about certain medical treatments near the end of life are honored. Spurred by the End of Life Expert Panel Report in 2012, all clinical institutions began implementing MOLSTs in 2014. MOLST expands on Massachusetts' Comfort Care/DNR form and is authorized by the Massachusetts Department of Health and Human Services. EMTs are also required to honor MOLST forms.

*Question:* Are MOLSTs and advance directives the same thing?

*Jeanette:* No. A MOLST is a medical order that serves as a standardized method of documenting and communicating a patient's preferences for life-sustaining treatment. An advance directive is a legal document that only takes effect after a patient becomes incapable of making medical decisions. Examples of advance directives are the Massachusetts Health Care Proxy or a living will. Note: Massachusetts law does not recognize a living will as an advance directive. Patients who have only a living will should be encouraged to complete a Massachusetts Health Care Proxy form in order to meet state law requirements. Out-of-state patients should check the laws in their state to ensure their advance directives are legally recognized under the laws in their home states.

*Question:* What is considered a life-sustaining treatment?

*Jeanette:* A life-sustaining treatment is a medical treatment used to keep patients alive. Cardiopulmonary resuscitation is a life-sustaining treatment that healthcare professionals are legally required to perform when a patient's heart stops unless otherwise instructed by a written medical order, such as a MOLST form.

*Question:* Should everyone have a MOLST?

*Jeanette:* MOLSTs are suitable for patients of any age with a life expectancy of 6-12 months and patients with advanced illnesses such as:

- life-threatening diseases
- life-threatening injuries
- chronic progressive diseases
- medical frailty
- or any patient considering a Do Not Resuscitate order

*Question:* Who discusses MOLST with the patient?

*Jeanette:* The physician or licensed independent practitioner caring for the patient should discuss the MOLST form with the patient and family in conjunction with the patient's health condition, values and goals of care, and possible results of treatment. After a discussion of goals of care, the MOLST form is completed and signed by:

- the patient (or the patient's healthcare agent)
- the clinician (physician, nurse practitioner, or physician assistant)

*Question:* Once the form is completed, can it be changed?

*Jeanette:* Yes. Patients may void or request a new MOLST form any time. And patients can opt to receive previously refused, medically indicated treatment despite what the MOLST form indicates.

*Question:* Who gets copies of the MOLST form?

*Jeanette:* The patient keeps the original copy once it's signed. Copies should be given to their healthcare agents, family members, and others, such as their physician, lawyer, or clergy. Patients should keep the MOLST form in a visible location at home.

For more information, contact Cynthia LaSala, RN, nursing practice specialist, at 617-643-0481; or Jeanette Livelo, RN, nursing director, at 617-643-9717.

# Announcements

## Blum Center Events

Please note the different times for each program.

"Infection Prevention is Everyone's Business"

Tuesday, October 20, 2015  
1:00pm–2:00pm  
presented by Dolores Suslak

"Talking to Your Doctor about Pain"

Wednesday, October 21st  
12:00pm–1:00pm  
presented by Paul Arnstein, RN

National Physical Therapy Month  
"We've Got Your Back!"

Thursday, October 29th  
1:00pm–2:00pm  
Learn how to arrange your work environment to best fit you and your body and reduce stress and injury.  
presented by Tara Pai, PT

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.

## The MGH Blood Donor Center

The MGH Blood Donor Center is located in the lobby of the Gray-Jackson Building. The center is open for whole-blood donations:

Tuesday, Wednesday, Thursday,  
7:30am – 5:30pm

Friday, 8:30am – 4:30pm  
(closed Monday)

Platelet donations:

Monday, Tuesday, Wednesday,  
Thursday,  
7:30am – 5:00pm

Friday, 8:30am – 3:00pm

Appointments are available

Call the MGH Blood Donor Center at 6-8177 to schedule an appointment.

## Office Ergonomic Champion Program

Learn how to make yourself and/or your co-workers more comfortable at the computer. Consider the benefits of a sit-stand workstation. See why using a laptop can be physically challenging.

Friday October 9, 2015  
9:00am–12:00pm  
Schiff Conference Center  
Yawkey 4-910

Presented by Marie Figueroa, PT,  
ergonomics specialist, PHS  
Occupational  
Health Ergonomics Program

Register via HealthStream  
For more information, call 617-726-2926.

## Apply for an Yvonne L. Munn Nursing Research Award

Eligible MGH nurses are invited to apply for a Munn Nursing Research Award to pursue a clinical investigation. Proposals should focus on: original research; advancing evidence-based practice; or performance improvement. Research teams must include a PhD-prepared nurse mentor.

To learn more about the award, e-mail: Kim Francis, RN, at [KFrancis2@partners.org](mailto:KFrancis2@partners.org) or Mary Larkin, RN, at [MLarkin1@partners.org](mailto:MLarkin1@partners.org).

Letters of intent due:  
October 16, 2015  
Proposals due:  
December 11th

For more information, go to the Munn Center website: at [http://www.mghpcs.org/munncenter/Munn\\_Center\\_Research\\_Award.asp](http://www.mghpcs.org/munncenter/Munn_Center_Research_Award.asp).

## Patient Care Associates

### Work Environment Survey

As part of our overall evaluation of staff perceptions of their work environment, the Patient Care Associates – Work Environment Survey (PCA -WES) is being distributed this week (the last week of September).

The survey is being conducted on-line; PCAs can complete the survey in one session or return to it as many times as necessary; all responses are anonymous. PCAs will have one month to complete the survey, which will be used to promote a positive work environment.

For more information, call Gaurdia Banister, RN, executive director of The Institute for Patient Care, at 617-724-1266, or the Munn Center for Nursing Research at 617-643-0431.

## ACLS Classes

Certification:

(Two-day program)

Day one: lecture and review  
Day two: stations and testing)

Day one:  
November 2, 2015  
8:00am–3:00pm

Day two:  
November 3rd  
7:00–11:30am  
(Note early start time)

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

Locations to be announced.  
Some fees apply.

For information, contact Jeff Chambers at [acls@partners.org](mailto:acls@partners.org)

To register, go to:  
[http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS\\_registration%20form.pdf](http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf).

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For more information, call:  
617-724-1746

### Next Publication

October 15, 2015



# Inpatient HCAHPS

## 2015 calendar year, to date

Measure	2014	2015 Year to Date	2014- 2015 Change
Nurse Communication Composite	82.1	83	<b>0.9</b>
Doctor Communication Composite	81.6	83.4	<b>1.8</b>
Room Clean	72.2	73.1	<b>0.9</b>
Quiet at Night	49.7	51.7	<b>2</b>
Cleanliness/Quiet Composite	60.9	62.4	<b>1.5</b>
Staff Responsiveness Composite	63.8	65.8	<b>2</b>
Pain Management Composite	71.7	73.4	<b>1.7</b>
Communication about Meds Composite	65.8	66.6	<b>0.8</b>
Discharge Information Composite	91.6	91.2	<b>-0.4</b>
Overall Rating	79.8	81.4	<b>1.6</b>
Likelihood to Recommend	90	90.6	<b>0.6</b>

Our patient-experience scores continue to reflect exceptional effort by staff. Data is locked through June 2015, but data continues to come in for July, August, and September. We are making excellent strides with our three identified goals; Quiet at Night and Staff Responsiveness up 2.0 above baseline, and Pain Management up 1.7.

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



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