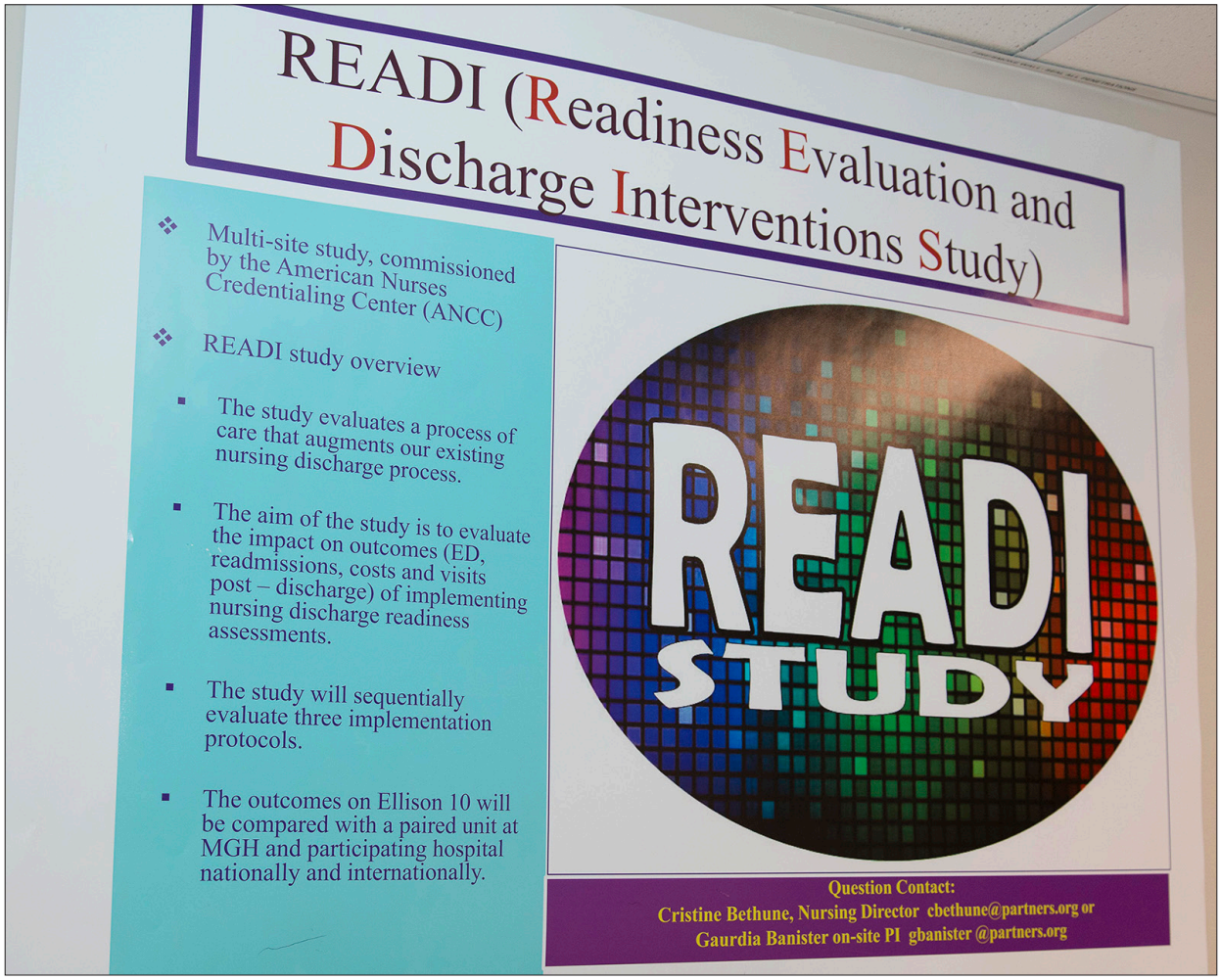
Caring Headlines
March 3, 2016

The READI Study

looking at the impact of a nursing discharge readiness assessment



The Readiness Evaluation and Discharge Intervention Study

(See story on page 4)

Nursing and Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

Always Events

a natural extension of our commitment to relationship-based care and Excellence Every Day

We embrace the idea of Always Events because it's the foundation of our professional practice, the unspoken promise we make to patients and families, and more importantly, because it's the right thing to do.

Are you an 'Always Event' person, or a 'Never Event' person? It might seem like a subtle distinction, but I think it's an important one. I'm talking about the philosophical differences between Never Events and Always Events. One revolves around negativity, aversion, and fear of consequences, while the other is based in professionalism, best practice, and a desire to do right by our patients.

The term, Never Events, was first introduced in 2001 by Kenneth Kizer, MD, former CEO of the National Quality Forum, the not-for-profit organization that sets standards for quality-improvement in health care. The term describes the kind of mistakes or medical errors that should never occur; serious, largely preventable, adverse events such as surgery on the wrong body part, hospital-acquired pressure ulcers, or mis-matched blood transfusions. In 2007, the Centers for Medicare and Medicaid Services (CMS) announced that Medicare would no longer pay for costs associated with Never Events, and many states and private insurers followed their lead adopting similar policies.

In 2011, in a much more patient-centered approach to reducing medical errors, the Picker Institute introduced the concept of Always Events (now housed within the Institute for Healthcare Improvement). Always Events refer to aspects of the patient experience that are so important to patients and families, so integral to patient safety, that healthcare providers should *always* get them right.

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

Always Events are positive, affirming behaviors—a natural extension of our commitment to relationship-based care and Excellence Every Day. We embrace the idea of Always Events because it's the foundation of our professional practice, the unspoken promise we make to patients and families, and more importantly, because it's the right thing to do. Some examples of Always Events include:

- using the I-PASS format for patient hand-overs
- checking two sources of patient identification

continued on next page

I think even if we'd never heard of the Picker Institute or the Institute for Healthcare Improvement, we'd still know what Always Events are... We all remember why we were called to the health professions in the first place—to make a positive difference in the lives of patients. Not sometimes. Not whenever the spirit moves us. But *always*.

- performing surgical time-outs
- reading back verbal orders for high-alert medications
- not using unacceptable abbreviations
- ensuring the care environment is quiet at night
- performing hourly rounds

To me, aligning our care-delivery model with our desire to keep patients safe is more reflective of our mission and values than striving to avoid Never Events. Wouldn't you rather celebrate our successful efforts to keep patients safe than our ability to avoid causing them harm? Yes, a 79% Pain-Management score is good, but we *strive* for 100%. A 91% Discharge Information score is good, but we *strive* for 100%.

As I do rounds and visit various settings throughout the hospital, I see evidence of Always Events everywhere I go. I see them whenever a clinician or support staff member offers assistance to a colleague without being asked. I see them when individuals of different races or backgrounds treat each other with respect and compassion. I see them when staff ask patients what they can do for them before leaving their rooms. And I especially see Always Events when employees file safety reports so that systems issues can be identified and fixed to avoid serious safety risks in the future.

Always Events and fostering a culture of safety go hand-in-hand. Both are derived from a desire to provide the highest quality care. Both thrive in an environment of transparency and personal accountability. And both are strengthened when employees feel empowered to report potential hazards, system failures, and near-misses.

We're fortunate to practice in an institution that values a blame-free approach to patient safety and fosters an environment where employees are encouraged to speak up when they see potential risks. Our safety reporting system is among the best in the country. Safety narratives, published in *Caring Headlines* and shared with staff in public forums, bring conversations about errors, system failures, and near-misses out in the open—because there is no higher priority than patient safety.

I think even if we'd never heard of the Picker Institute or the Institute for Healthcare Improvement, we'd still know what Always Events are. We have an intrinsic sense of their value and importance. We all remember why we were called to the health professions in the first place—to make a positive difference in the lives of patients. Not sometimes. Not whenever the spirit moves us. But *always*.

In this Issue

(Cover photo by Paul Smith)

National READI scholars visit MGH

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care, and Hasna Hakim, RN, IHP student

On June 1, 2015, a three-year, Readiness Evaluation and Discharge Intervention (READI) study began on the Ellison 11 Cardiac Unit and the Ellison 10 Cardiac Step-Down Unit at MGH. The study, that includes 33 other Magnet hospitals, seeks to determine the impact of a nursing discharge readiness assessment on re-admissions, post-discharge visits to the ED, and associated costs.

On February 4, 2016, Marianne Weiss, RN, principle investigator of the READI national team, and Linda Costa, RN, a member of the study team, came to MGH to meet with the MGH project team and nurses interested in advancing the research after the study ends. Weiss and Costa presented, "Readiness for Hospital Discharge: Building a Program of Nursing Research," during Nursing Research Grand Rounds.

Visiting researchers met with Ellison 10 staff and unit leadership. They were impressed by the 97.4% fidelity rate (number of surveys collected based on the number of patients available to participate in the study) of the READI study, an outstanding result and an impressive demonstration of commitment by staff and leadership to this project.

Nurses on Ellison 10 report a positive experience participating in this national study. Says Amy Tramontozzi, RN, "It's really nice that bedside nurses are involved in this change."

Says Bryan Finocchio, RN, "With the READI assessment protocol, I feel I have more concrete tools to advocate for my patients if they're not ready to go home. Participating in a national study and having input into future practice is very empowering. I'm happy to be making a difference."

Attending nurse, Lori Mazzarelli, RN, says, "The READI protocol is becoming standard on Ellison 10. Every nurse fills out the form as a natural part of practice for patients being discharged home. The form becomes a tool that leads to further discussion with patients and families on the day of discharge."

Alison Daley, RN, says, "I feel confident that engaging bedside nurses in this research will help patients and the nursing profession in the future."

Phase II of the four-phase READI study is coming to completion. For more information, contact Gaurdia Banister, RN, executive director of The Institute for Patient Care, at 617-724-1266.

(Photo by Paul Smith)

Marianne Weiss, RN, principle investigator of the READI national team (center), and Linda Costa, RN, team member (center right), meet with staff and leadership of the Ellison 10 READI intervention unit.

What to expect on April 2, 2016, at 5:00am

—by Van Hardison, RN, interim director, PCS Informatics

Command Center Structure

We've been planning, developing, training, and practicing for *e*Care go-live for many months. On April 2, 2016, all our hard work and preparations will pay off. You may be wondering what to expect on the day it all happens. Our *e*Care support model was designed to ensure a smooth and safe transition for patients and staff.

A Command Center comprised of leaders and analysts from Partners *e*Care, MGH, Epic, and Accenture will be set up on the first and second floors of Bartlett Extension. This team will work on any major software issues, manage the service-desk ticket process, and identify themes in issues reported by users.

In addition to the main Command Center, a PCS/Nursing Command Center, part of the Support Coordination Team, will be located on Yawkey 2 and 4 and staffed by MGH leaders, super-users, informatics analysts, and credentialed trainers. This team will field calls about specific issues, help with work-flow problems, and dispatch informatics analysts or super-users to help with urgent situations.

Within PCS, there will be separate command centers for the perioperative areas, the ED, and Nursing and the health professions. These areas have unique work-flows and tools within *e*Care, so separate command centers will be better able to address their respective needs.

The diagram below reflects the Command Center structure and how the components relate to one another.

Reporting and Managing Issues

Super-users and uber-users in each department will serve as primary support. *They* should be your first call if you encounter software issues. They will call the PCS Command Center or log a ticket with the service desk at the Partners *e*Care Command Center for any issues that can't be resolved at the local level.

Cut-Over and Order Conversion

Starting at 7:00am, April 1st, a team of pharmacists, providers, and nurses will begin entering the active orders for all hospital patients into *e*Care. This is a critical part of going live, ensuring that the most accurate and up-to-date orders for each patient will be available.

Our existing systems (POE, LMR, etc.) will go down at 9:00pm; clinicians will use down-time procedures for orders and clinical documentation until *e*Care goes live at 5:00am, April 2nd. At that point, each provider will be responsible for entering down-time orders into *e*Care and completing order reconciliation.

Nurses will review orders, medications, plans of care, etc., to be sure they're complete and accurate. Nurses will enter height, weight, recent vitals, etc. into *e*Care to establish a baseline for each patient.

It doesn't get any more exciting than this. It's fair to say that April 2, 2016, will be the beginning of a whole new way of life at MGH. And we're *ready*. For more information, speak with your unit leadership, or call Van Hardison, RN, at 617-726-2696.

Chaplain helps family untangle threads of grief and forgiveness

'Ted' was a 63-year-old man returning from overseas when he collapsed at the airport. After repeated efforts to revive him in the ambulance and in the ED, Ted succumbed to irreversible cardiac arrest.

My name is Thomas Powers, and I have been a per-diem chaplain at MGH for 18 years. I met members of the 'Smith' family one afternoon after being stat paged to the Emergency Department. 'Ted' was a 63-year-old man returning from overseas when he collapsed at the airport. After repeated efforts to revive him in the ambulance and in the ED, Ted succumbed to irreversible cardiac arrest. A nurse ushered me into the treatment bay just as the team was concluding their interventions. Since Ted was Roman Catholic, I provided sacramental care and offered prayers of commendation. I noted that everyone had stopped what they were doing while I offered the prayer. I knew I needed to acknowledge the team for their efforts; to support them through this outcome. I made eye contact with each of them and thanked them for their efforts to save Ted.

The nurse asked if I would speak with Ted's wife, 'Mary,' who was waiting in a consultation room nearby. As we made our way there, the nurse explained that at the time Mary had been called, they had had no knowledge of her husband's status other than that he'd collapsed. She had only just been informed of her husband's death.

When I walked into the room, an attractive, well-dressed, middle-aged woman was seated across

Reverend Thomas Powers, chaplain

from the ED social worker. I approached Mary, calling her by name, and introduced myself. I expressed my condolences and made eye contact with the social worker. Mary immediately stood and began to sob. I stood beside her as she cried and invited her to sit down. I told her I had just come from her husband and had given him the Last Rites. She continued to sob, talking about her need for forgiveness, for herself and her husband. I wasn't sure it was the right time to talk about forgiveness, so I left it open-ended for the moment.

For the next few minutes, Mary spoke haltingly about her shock and disbelief. I offered to help locate other family members. Mary had called one of their sons, 'Bob,' but hadn't told him his father had died. He was on his way to the hospital; she wanted to wait and tell him in person. Her other son, 'Sam' lived out of state. Mary had told him of his father's death, and he was making arrangements to come to Boston.

continued on next page

My goal was to help Mary engage in the theological aspects of forgiveness that are often entangled in the threads of bereavement and help her realize that what she sought from God was also what she could give her husband. In the process of offering forgiveness, she could discover forgiveness from God.

I asked if Mary would like to see her husband. She wanted to wait until Bob arrived. She began to sob again and talk about the need for forgiveness. Since she brought it up again, I invited her to tell me more. Mary told me that she and her husband had been on poor terms; she'd been glad he was on an extended trip but was looking forward to his return. They had a difficult marriage. She wanted God to forgive them both for, "what they had wasted."

At this point, a young man in a semi-military uniform came in and ran to Mary. I assumed it was her son, Bob, but after several minutes of sobbing, I learned it was 'John,' a friend of (son) Sam's who worked nearby. Sam had asked John to come and stay with his mother until Bob could get here. John was almost frantic in his grief. He expressed his incredulity as he paced the room, moaning and sobbing. The social worker and I invited John to sit beside Mary. This seemed to give him something to do—if only to hold Mary's hand as they grieved.

After a while, John and the social worker each excused themselves for a few moments. Mary resumed the story of her ambivalence toward her marriage and how she'd been looking forward to her husband's return. She asked if God would forgive her for not loving her husband. I was about to assure her that God would forgive her, but she seemed to need more than that.

"How did you not love Ted?" I said.

Mary told how they had been, "mad about each other," when they were young but discouragement and disappointment had led them to live largely separate lives. Recently, she'd been hoping to rebuild their relationship because she realized they needed each other.

I asked what it would be like to forgive Ted now. I suggested she could forgive him now and trust that he forgave her. "I believe when you do that, you'll discover that God forgives you, too," I said.

While Mary would likely need more time and support to process her forgiveness, I wanted to validate her feelings to provide some grounding for her to move through the initial shock of bereavement.

The social worker returned with John and some other friends of the family. Each took turns comforting Mary and expressing their own grief. I waited to see if there was anything more I could do to support them or other members of the team.

Finally, the group became less emotionally expressive. Mary began to talk with John and the others about logistics and who needed to be contacted as they waited for Bob to arrive. I offered to return later to accompany the family back to see Ted, and Mary said she'd like that. I completed my visit with a prayer. As I left, I thanked the social worker and asked the nurse to page me when the family was ready to see Ted.

When I returned later, I prayed with what had become a large circle of relatives and friends.

Chaplains regularly support patients, families, and team members in their search for transcendence, affirmation, or meaning in life events. My goal here was to help Mary engage in the theological aspects of forgiveness that are often entangled in the threads of bereavement and help her realize that what she sought from God was also what she could give her husband. In the process of offering forgiveness, she could discover forgiveness from God.

A whole network of individuals played a role in the events that unfolded that late summer afternoon. Nurses, physicians, and other ED staff had been invested in trying to resuscitate Ted. It was important to acknowledge their efforts; especially when the outcome was not what they had hoped it would be. It was important for me to acknowledge my colleagues and affirm their commitment to competent, compassionate care.

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

This is, indeed, a story of exemplary pastoral care. Thomas' compassion extended to every member of the family and the care team. He didn't presume to know what Mary needed. He let her reveal her needs to him in her own time, then gently helped her to realize that divine forgiveness begins with forgiving ourselves and one another. This is a beautiful story of support, empathy, closure, and generosity of spirit.

Thank-you, Thomas.

Construction to renovate 'legacy' ORs

I'm happy to report that we are embarking on a multi-year, multi-phase, multi-million-dollar renovation project to update the 'legacy' ORs... These renovations will be a welcome upgrade to our perioperative services.

Question: What's all the construction on the third floor about?

Jeanette: You may have noticed some construction work taking place on the third floors of the White, Gray, Jackson, and Blake buildings. I'm happy to report that we are embarking on a multi-year, multi-phase, multi-million-dollar renovation project to update the 'legacy' ORs. Our new state-of-the-art operating rooms in the Lunder Building are almost five years old (hard to believe!) The legacy ORs, many of them built in the 1930s, 60s, 70s, and 90s, are no longer able to accommodate the advances in surgery and technology we rely on to support our patients. These renovations will be a welcome upgrade to our perioperative services.

Question: Is there a time frame for completion of the construction?

Jeanette: The White 3 PACU closed in October of 2015. The White Operating Rooms and surrounding support space will close in April of 2016 with demolition set to begin in June. When construction is completed in October of 2017, we'll have three new operating rooms, 18 perioperative bays (pre-op and PACU), a perioperative biomedical engineering space, a satellite sterile-processing area for flexible scopes, and a new pediatric surgical admission area and waiting room.

Question: And the other areas?

Jeanette: Phase II, which includes a new OR pharmacy and anesthesia work rooms, should be completed by May, 2018. And Phase III, which will involve adding five new operating rooms and nine perioperative bays, will be completed by June, 2019.

Question: And then construction will be done?

Jeanette: Actually, there will be five more phases, all of which should be completed by August, 2024. When completed, all 60 operating rooms will have been brought up to current standards and be better able to accommodate current and future technology and space requirements to function as a modern operating room. Patients, families, and staff have been and will continue to be instrumental in the design of this new space. Their input is invaluable as we look not only at the ORs, but the adjacent space required to support this work—Biomedical Engineering, Sterile Processing, Materials Management, Nursing, Anesthesia, Surgery, and the administrative team.

Ongoing construction will increase patient and supply traffic in the Lunder 3 and Ellison 3 hallways; perioperative services request that all non-OR-related traffic seek alternate routes.

For more information about this renovation project or its anticipated impact on traffic flow, call 617-724-3855.

Professional Nursing Certification

Professional nursing certification provides tangible recognition of achievement in a defined practice or clinical area of nursing. Nurses who take this extra step demonstrate a commitment to professional growth and a desire to provide the highest quality nursing care.

Question: Why is nursing certification important?

Jeanette: Professional nursing certification provides tangible recognition of achievement in a defined practice or clinical area of nursing. Nurses who take this extra step demonstrate a commitment to professional growth and a desire to provide the highest quality nursing care.

Question: Is the cost of certification reimbursed?

Jeanette: All registered (full- and part-time) nurses in the department of Nursing are reimbursed for the cost of professional and specialty certification and re-certification offered by nationally recognized professional organizations. Reimbursement covers the cost of certification and re-certification in areas related to the nurse's current clinical practice. Reimbursement does not include the cost of preparatory programs, paid time off, or any other activities undertaken in preparation to become certified.

Question: Will I be reimbursed if I don't pass the exam?

Jeanette: Yes. And you'll be eligible for reimbursement again when you re-take the exam.

Question: I don't work in the department of Nursing. Am I still eligible to be reimbursed?

Jeanette: Nurses outside the department of Nursing should consult their managers or supervisors for the reimbursement policy in those areas.

Question: What paperwork do I need to complete for reimbursement?

Jeanette: If you're a member of the department of Nursing and not currently a member of the American Nurses Association (ANA), you qualify for the Success Pays© Program. See your nursing director for information.

If you are a member of the ANA:

- complete the Certification/Re-Certification Reimbursement Request Form (embedded in the policy) at http://intranet.massgeneral.org/pcs/eed/documents/Professional_Certification_9_17_2012.pdf
- obtain the signature of your nursing director
- obtain documentation that you've taken the certification exam or satisfied the requirements for re-certification
- submit the Reimbursement Request Form, the above documentation, and the canceled check or valid receipt to the Nursing Management Support Office on Bigelow 10
- submit all reimbursement requests within 180 days of incurring expenses

Initial certification reimbursement is contingent upon taking the exam, not receiving certification. Each nurse will be scheduled the appropriate time away from the practice setting for the purpose of taking the exam.

For more information about professional nursing certification or reimbursement, call the Knight Nursing Center for Clinical & Professional Development, at 617-643-6530.

Announcements

Patient Safety Awareness Week

"Speak Up for Safety"

Patient Safety Awareness Week
March 8–14, 2016
is a national education and awareness campaign sponsored by the National Patient Safety Foundation.
Activities will include honoring this year's Patient Safety Stars at a special recognition breakfast.

Safety Week keynote speaker, Thor Sundt, MD, chief of Cardiac Surgery, will present:
"Learning from My Mistakes: the Power of Teamwork"
March 17th
12:00–1:00pm
O'Keeffe Auditorium
followed by panel discussion with May Pian-Smith, MD, Anesthesia, Critical Care, and Pain Medicine Quality chair, and Steven Yule, assistant professor of Surgery, BWH.

Safety information tables will be set up in the Main Corridor, Monday and Tuesday, March 14th and 15th from 10:00am to 2:00pm.

For eCare-related safety tips, go to: https://partnersecare.partners.org/hospital-networks/mgh/super-user/.

For more information about Patient Safety Awareness Week activities, call 617-726-8310.

Travel for business? Enroll in TravelSafe

If you travel for hospital business, consider enrolling in Partners TravelSafe, a travel information and emergency-assistance program for employees. TravelSafe offers travel information, alerts, emergency assistance, and a single point of contact should you encounter trouble while traveling domestically or internationally.

TravelSafe's global hotline is: +1 443-965-9242.

When you book travel through a Partners-approved travel agency, your travel details are automatically registered with TravelSafe, or you can manually enter trip details at: www.partners.org/travelsafe.

For more information, e-mail: travelsafe@partners.org.

Pharmacology Update IX: Innovation and Evidence

Saturday, March 26, 2016
O'Keeffe Auditorium
7:50am–3:00pm
The Pharmacology Update is a semi-annual program that focuses on current evidence-based information about medications. The March program will include medications used to treat thyroid disorders, an update on anticoagulation and antibiotic drugs that enhance and impede wound healing, and the new AHA Guidelines for Emergency Cardiac Care.
Target audience: nurses, pharmacists, and physicians

Pre-registration required
MGH employees: no fee
Partners employees: $100 per day
Non-Partner's employees: $150 per day

Pharmacology contact hours will be awarded
Contact Hours will be awarded
For more information, call 617-726-1651.

ACLS Class

Certification:

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

Day one:
April 1, 2016
8:00am–3:00pm

Day two:
April 15th
8:00am–1:00pm

Re-certification (one-day class):
April 6th
5:30–10:30pm

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

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

The Cyrus Hopkins Leadership in Patient Safety Award

Seeking Nominations

The Cyrus Hopkins Leadership in Patient Safety Award will be given each year to an MGH/MGPO leader who demonstrates outstanding commitment to patient safety. The award, named after Cyrus Hopkins, MD, for his dedication and passion for patient safety during his 50-year tenure at MGH, is the highest patient-safety recognition bestowed by MGH/MGPO.

Nominees must:
- demonstrate long-standing commitment to patient safety
- be a positive role model in the pursuit of patient safety
- have made a significant contribution to creating a culture of safety and/or reducing risk of patient harm

The award will be given each spring during National Patient Safety Awareness Week.

To nominate a colleague, send brief statement to: Elizabeth Mort, MD, by March 4, 2016.

Blum Center Events

"The Importance of Sleep Health"
Tuesday, March 8, 2016
1:00–2:00pm
Haber Conference Room
Join Josna Adusumilli, MD, to learn more about how sleep impacts your overall health.

Shared Decision Making:
"Colon Cancer Screening"
Thursday, March 17th
11:00am–12:00pm
Blum Center,
Join Daniel Chung, MD, for a presentation, short video, and discussion on colon cancer screening.

"Chair Yoga"
Wednesday, March 23rd
11:00am–12:00pm
Blum Center
Join Laura Malloy, LICSW, to learn healthful chair yoga techniques and ways to manage stress at your desk.

"Understanding Your Kidneys"
Monday, March 28th
1:00pm–2:00pm
Blum Center
Join Laurie Biel, RN, to learn more about, common causes and treatment options for kidney disease, and how to keep your kidneys healthy.

Programs are free and open to MGH staff and patients.
No registration required.
Check locations above.

For more information, call 4-3823.

National Patient Safety Awareness Week

March 13–19, 2016

Thursday, March 3, 2016
2:00pm
Tejal Gandhi, MD
"Talking Patient Safety"
webinar sponsored by the Mass Coalition for the Prevention of Medical Errors

Monday and Tuesday,
March 14th and 15th
10:00am–2:00pm
Main Corridor
Patient Safety Booth
Stop by to learn more about how you can:
"Speak Up for Safety"
and bring a friend

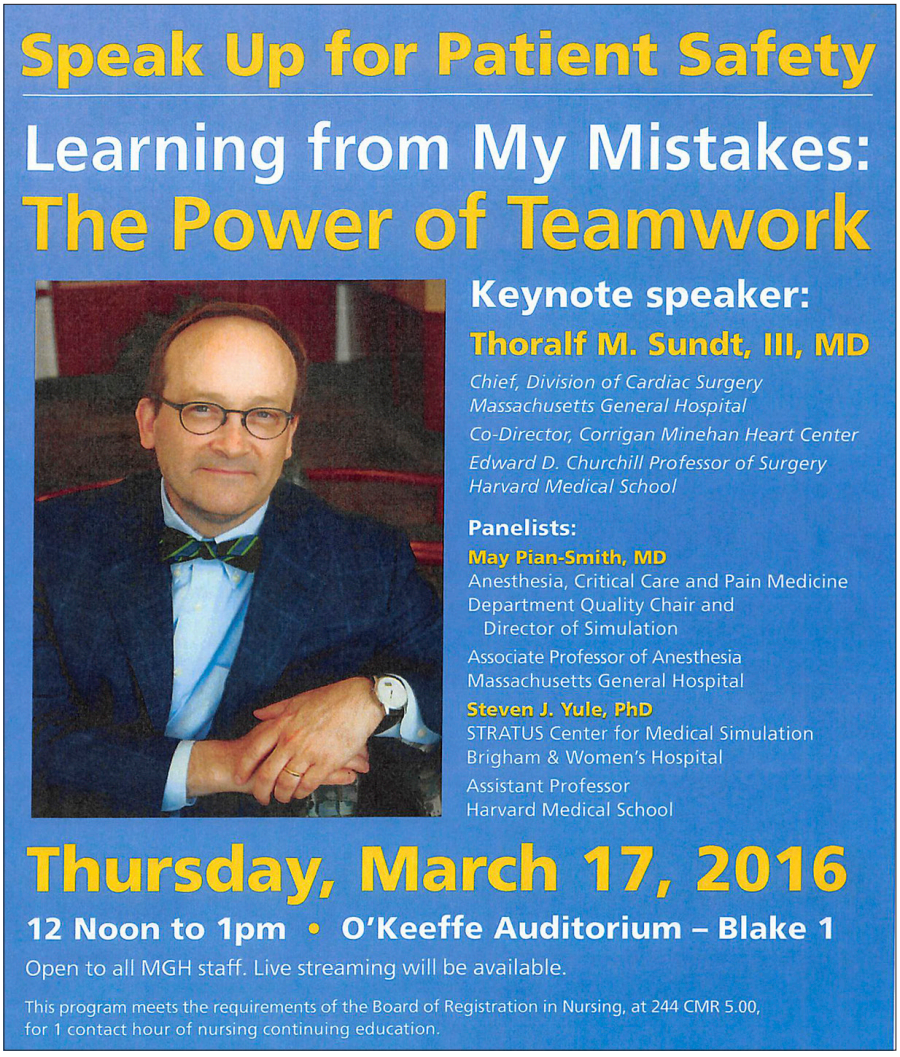
Tuesday, March 15th
8:00–9:00am
O'Keeffe Auditorium
Derek Feeley, CEO, IHI
"Engaging for Improvement"
Sponsored by MGH*f*C

Tuesday, March 15th
2:00pm
Robert Wachter, MD
"Why Transforming the Delivery of Healthcare is No Longer Elective"
a webinar sponsored by the Mass Coalition for the Prevention of Medical Errors

Thursday, March 17th
12:00–1:00pm
O'Keeffe Auditorium
Thoralf Sundt, MD
"Learning from my Mistakes: the Power of Teamwork"

Thursday, March 17th
1:00–2:00pm
National Patient Safety Foundation (NPSF)
"Patient Safety as a Public Health Issue" webcast

For more information,
call 617-643-0140.



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For more information, call:
617-724-1746

Next Publication
March 17, 2016

Inpatient HCAHPS

2015 calendar year

HCAHPS Measure	CY 2014	CY 2015	% Point Change
Nurse Communication Composite	82.1%	83.0%	0.9%
Doctor Communication Composite	81.6%	83.5%	1.9%
Room Clean	72.2%	72.9%	0.7%
Quiet at Night	49.7%	50.8%	1.1%
Cleanliness/Quiet Composite	60.9%	61.8%	0.9%
Staff Responsiveness Composite	63.8%	65.8%	2.0%
Pain Management Composite	71.7%	73.1%	1.4%
Communication about Meds Composite	65.8%	66.6%	0.8%
Care Transitions	59.9%	62.4%	2.5%
Discharge Information Composite	91.6%	91.1%	-0.5%
Overall Hospital Rating	79.8%	81.2%	1.4%
Likelihood to Recommend Hospital	90.0%	90.9%	0.9%

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

MGH continues to perform well on patient-experience measures compared to last year at this time. For our three areas of focus: Quiet at Night, Staff Responsiveness, and Pain Management, we are positioned to achieve our goals. Calendar year 2015 results are complete as of the middle of February.

Caring Headlines
March 3, 2016

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