Celebrating Occupational Therapy Month

Outpatient occupational therapist, Katie Swy, OTR/L, works with patient, Peter Etzel, to restore functional hand strength and increase range of motion.

See articles on pages 4 and 5 and clinical narrative on page 10
A salute to MGH marathoners
running to raise awareness, support patient care, and fund critical research

I want to give a shout-out to the scores of MGH staff who participated in this year’s Boston Marathon to raise awareness and money for MGH. And a big thank-you to John Hancock for sponsoring our Pediatric Cancer Team (for the past 21 years) and our Emergency Response Team (for the past five).

In addition to those who ran under John Hancock’s corporate sponsorship, many staff members qualified for the race on their own and committed to raising money for MGH programs like:
- the Cancer Center
- Caring for a Cure
- Cystic Fibrosis
- Down Syndrome
- BOTSOGO (the BOTSswana Oncology Global Outreach program)
- the Lutie Center
- Mootha Lab

It’s truly inspiring that staff make this kind of effort on behalf of our patients and families.

Whether you finished the race or not, you have my greatest respect and admiration. Speaking for the entire MGH community, thank-you, and well done!

Debbie Burke, RN
senior vice president for Nursing & Patient Care Services and chief nurse

At left: the Caring for a Cure team, founded by MGH hematology/oncology nurses to ease the journey for patients and families of the MGH Cancer Center.

Debbie Burke

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Occupational Therapy

OT implements ‘Triage Task Force’ improving the standard of care
— by clinical specialists, Stephanie Smith, OT, and Leslie McLaughlin, OT

Occupational Therapy (OT) is defined as the therapeutic use of everyday activities (occupations) for the purpose of enhancing or enabling participation in roles, habits, and routines. Acute care clinicians apply this framework to the fast-paced, medically complex, hospital environment to assist patients in improving their function, optimizing their medical course, and facilitating discharge to the most appropriate setting.

Occupational Therapy Department tuned to the optimal time in their hospital course.

With the rapidly changing healthcare system, decreasing lengths of stay, the need to reduce re-admissions, and enterprise-wide efforts to make care more coordinated, it’s all the more important to ensure that OT is facilitating safe and efficient discharges, as well as meeting the rehab needs of an increasingly complex patient population.

Toward that end, the inpatient Occupational Therapy Department developed the Triage Task Force to improve consult response time and treatment planning.

Indicators show that not only has consult response time improved, but clinician satisfaction and transparency of practice have also increased. These positive outcomes have resulted in greater standardization of care across patient populations. The OT Triage Task Force will continue to study and improve the system to better accommodate the patients we serve.

Assessing functional cognition ensuring safe discharge and minimizing the potential for re-admission
— by Jessica Ranford, OT, clinical specialist

Given the changing healthcare landscape, the role of inpatient occupational therapists in assessing functional cognition is integral to discharge-planning and key to containing hospital costs. Functional cognition is how an individual utilizes and integrates thinking and processing skills to accomplish everyday activities (self-care, household chores, child care, workplace tasks, driving, etc.). Recognizing the importance of cognitive functioning on resource utilization, length of stay, and long-term outcomes, the inpatient OT department established standards of practice for basic to advanced assessment and treatment of functional cognition. Through a review of the literature, the department outlined how medical diagnoses, co-morbidities, and medical interventions (such as pain medications) affect cognitive functioning in the acute phase of illness.

Occupational therapists measure functional cognition as they identify performance-based, cognitive impairments from subtle to overt. Assessing functional cognition is necessary to identify cognitive impairments that challenge a patient’s ability to perform real-world tasks, such as managing medications, ensuring home safety, cooking, maintaining healthy lifestyle behaviors, and engaging in positive social interactions.

In the acute-care setting, the goal is a safe discharge to the home environment. It’s critical for occupational therapists to utilize the hospital environment to engage patients in the everyday tasks they need to perform at home. Occupational therapists identify and treat cognitive impairments to ensure a safe discharge plan that minimizes the potential for hospital re-admission.

The inpatient OT department consists of therapists at all levels of practice. They have developed a clinical algorithm for establishing optimal, safe discharge recommendations across clinical practice levels and service areas throughout the hospital.

For more information about the work of occupational therapists, call Jane Evans, OT, clinical director, at 617-724-0147.
Clinical Recognition

CRP event answers the question: ‘What is influence on practice?’

— by Christine Joyce, RN, and Vanessa McKenna, RN

On Thursday, March 22, 2018, the Clinical Recognition Program (CRP) presented, “Meet the Board,” an event intended to dispel myths about the CRP program, demystify the interview process, and encourage eligible candidates to apply for recognition. Led by CRP Review Board co-chairs, Ann Jampel, PT, and Alexa O’Toole, RN, (a clinical scholar), the presentation focused on the themes: Clinician-Patient Relationship, Clinical Knowledge and Decision-Making, and Teamwork and Collaboration.

Jampel and O’Toole stressed that portfolios must highlight the applicant’s influence on practice. Influence on practice can be thought of as the clinician’s ‘footprint’ on practice on their unit or within their department (for advanced clinicians) or across units or even hospital-wide (for clinical scholars).

Influence on practice could be a special project the applicant initiated and made a significant contribution to, or an influential practice change that was made based on his or her efforts. Examples of influence on practice were given by recently recognized advanced clinicians, Kelly Mulane, RN, staff nurse; Trupti Tanna, PT, physical therapist; and clinical scholars, Cathy Cuack, RN, staff nurse; and Stacey Sullivan, SLP, speech-language pathologist. Attendees were encouraged to ask questions of the 15-member multi-disciplinary Review Board and panelists.

Isn’t it time you got recognized! The CRP is open to clinicians in direct-care Nursing, Respiratory Care, Occupational Therapy, Social Work, Physical Therapy, and Speech-Language Pathology.

Information on how to apply is available from unit leadership or go to the CRP website at: www.mgh.org/ipc/programs/Recognition/. For more information, contact review board co-chairs, Ann Jampel, PT, at 617-724-0128, or Alexa O’Toole, RN, at 617-724-4831.

Privacy

Looking at family and friends’ medical records

is it a violation of HIPAA privacy policy?

— submitted by the Privacy Office

Has a friend or family member ever asked you to review his or her medical record for personal reasons—to get advice about their care or help them navigate the system? If you don’t have a clinician-patient relationship with that friend or family member or any other business reason to access their health information, that person must sign a written authorization form before you can access the record. Verbal consent is not sufficient.

Accessing a friend or family member’s medical record before submitting a signed authorization form (and receiving Health Information Management’s approval) is a HIPAA privacy violation and subject to corrective action.

The next time a friend or family member asks you to access their medical record, have them complete the appropriate form:

For ongoing electronic access to a health record:

• For pediatrics, see policy: https://hospitalpolicies.elucid.com/documents/view/2096/11891
• For one-time paper copies of health records:
  • go to: http://apollo.massgeneral.org/hipaa/forms/ to find the Authorization for Release of Protected or Privileged Health Information form in English or Spanish. This is a Partners-wide form and can be used for patients at any site

For more information, go to the MOH Privacy and Security intranet website: http://apollo.massgeneral.org/hipaa/forms/ or call the Privacy Hotline at 617-726-1098.

For staff or patients of other Partners hospitals, follow that site’s policy, which may differ from ours.
Recognition

The Molly Catherine Tramontana Award

On March 16, 2018, obstetrics staff nurse, Dana Allison, RN, became this year’s recipient of the Molly Catherine Tramontana Award that recognizes compassionate care delivered by labor and delivery nurses. Suzanne Stanton, RN, and Susan Ahern, RN, were also nominated.

In their letter of nomination, Andrea Hennigan, RN, and colleagues wrote of Allison, “We have worked with Dana on Blake 14 for many years. We’ve always known Dana to be an outstanding nurse. She has the clinical knowledge, technical skill, and nursing intuition that make her one of the finest nurses we’ve ever worked with. In addition to being extremely proficient at her job, Dana truly has a heart of gold.”

The Tramontana family has generously supported this award for more than ten years, enabling nurses to attend educational conferences and advance their professional development. This year’s award will allow labor and delivery nurses to attend the annual Partners in Perinatal Health program and other educational programs. For more information about the award, call Michele O’Hara, RN, nursing director, at 617-724-1878.

Observances

Celebrating the life and legacy of Martin Luther King, Jr.

“Dr. King’s remembrance was jaw-dropping, heart-breaking, and inspirational all at the same time. The life, the struggle, the man, his dream, and the world he would never see were all brought to life. The videos, recordings, and songs gave me pause and an opportunity to reflect on how I’m carrying on his dream.”
— Esther Dupie, manager, Leased Parking & Commuter Services

“It was exhilarating to hear attendees share the ways they hope to carry on Dr. King’s legacy. As a person of color, it gave me a chance to feel seen and heard.”
— Reverend Alice Cabotaje, director, Spiritual Care and Education

“It was a safe place for people to share their remembrances of Dr. King’s work and the progress that has been made. It was energizing to hear from a diverse crowd. I look forward to continuing to reach for Dr. King’s dream of equality.”
— Antron Watson, AARP community engagement partner
Clinical Narrative (continued)

Challenging case helps OT re-define her approach to acute care

My name is Sarah Basiliere, and the past five months have challenged, changed, and strengthened my approach as an occupational therapist. Coming from a rehabilitation setting, firm guidelines and strategies framed my treatment interventions and care plans. Working on an inpatient unit, I quickly realized that acute care didn’t, and couldn’t, have the same structured expectations. I was seeing patients who had experienced acute events in the context of extremely complex medical and social circumstances. I was forced to reconsider my approach to care and maximize my therapeutic influence. While every patient experience contributes to my professional development, David provided an invaluable perspective in this novel work environment.

Upon admission, David was diagnosed with neurosyphilis. We had very little information about his prior level of function or medical history. His impairments had both cognitive and physical presentations. David demonstrated deficits in executive functioning, attention, organization, safety awareness, insight, orientation, processing, and balance. But his most limiting impairment was chronic and of unknown origin: David was blind.

Our initial sessions focused heavily on safety. David was agitated, CAM+ and, and only inconsistently following direction from staff. David lacked anticipatory awareness, judgment, and insight into his limitations. I began each encounter with an introduction and re-orientation by telling him our location, the date, my role, and his reason for being in the hospital. Because of his visual deficits, he needed clear, verbal explanations before engaging in treatment. Insight into where he was and why he was here was essential for functional progression.

I first observed the scope of David’s deficits in the context of his basic activities of daily living. One of the first tasks we attempted was a multi-step, multi-tool sequence because of his visual deficits.

With the assistance of my clinical supervisor, I introduced the clock technique. The clock technique applied David’s basic knowledge of a clock face to the location of items on the table. Using hand-over-hand assistance, I showed David the 12:00, 3:00, 6:00, and 9:00 locations in relation to his body. Later, I added tactile cues to the table for multi-sensory identification of those locations.

We started with the focus on these four primary locations then slowly introduced secondary locations at intervals in between. We applied the clock technique to oral care and locating food on his plate at meal time. I created visual aides for nurses and verbalized my movements prior to execution. I down-graded the tooth-brushing activity to a two-step task using simple, verbal commands, and sensory exploration. Together, we verbally sequenced each step before and during execution. Over time, this paved the way for more complex activities. But I continued to struggle with orienting David to multi-step, multi-tool sequences because of his visual deficits.

While the clock technique facilitated independence during some daily activities, it was only helpful when he was seated in his recliner or walking to the sink. He continued to require hands-on assistance and cueing during transfers and ambulation. I worked closely with the physical therapist to ensure our cueing was consistent and to create a streamlined language of mobility for David.

After trials several adaptive devices, David progressed to using a white cane. Based on extensive research and consultation with the American Association for the Blind, we began teaching David the preliminary strategies of white-cane utilization, including tap techniques, sweeping, positioning, rhythm, and proprioceptive/sensory feedback. David’s occupational and physical therapists and nurses collaborated in assisting with proper cane utilization in his room and on the unit.

Due to complex social and legal circumstances, David had been hospitalized for an extended period of time. Case managers and social workers worked tirelessly to gain a sense of David’s prior level of function, social supports, and home environment while working toward an appropriate discharge plan. As he progressed, I decreased the frequency of my visits, focusing on continuation and carry-over of care from an inter-disciplinary perspective.

Because of my rehab background, I was inclined to continue interventions as long as David remained on the unit. But my newly developing score-care mindset identified that my role in David’s care had limits. I could, hypothetically, continue to intervene, and teach David how to independently perform certain tasks and activities. But I had to ask what the benefit would be to David upon discharge. How would it generalize to his life after MGH? After discussions with other team members and my clinical specialist, I determined that my interventions had fulfilled David’s acute needs, and he was taken off the acute OT service.

While I was no longer providing direct care to David, I did continue to see him on the unit. Whether observing him eating lunch as he reached for a cup at 2:00 and a fork at 9:00, or making small talk in the hallway as he walked with his white cane, I could see my therapeutic influence on his progress and plan of care.

I hope that, ultimately, I was able to provide David with a sense of independence in this life-altering experience. David’s case, and others, have taught me how to match deficits with task demands, progress the plan of care with graded challenges, and determine where and when my intervention is most appropriate.

David had a significant impact on my practice and therapeutic approach. Beyond the scope of occupational therapy, his case showed me how an enormous, academic institution can successfully work as a cohesive, collaborative unit to go above and beyond to address the individual needs of a single patient.

Sarah Basiliere, OT Rtu, occupational therapist

Clinical Narrative (continued)

Beyond the scope of occupational therapy

David’s case showed me how an enormous, academic institution can successfully work as a cohesive, collaborative unit to go above and beyond to address the individual needs of a single patient.
Recognition/Appreciation

Celebrating our GI nurses and associates
— by June Guarante, RN, and Deborah Meade, RN

Some endoscopic procedures:
- Colonoscopy
- Esophageal-gastroendoscopy
- Endoscopic retrograde cholangiopancreatography
- Endoscopic ultrasound
- Esophageal ablation
- Cryotherapy
- Dilatation
- Endoscopic mucosal resection
- Percutaneous gastrostomy tube
- Fetal transplant
- Esophageal motility
- Impedance
- pH probe
- Anorectal manometry
- Video capsule endoscopy
- Bravo pH

During the week of March 26, 2018, along with the rest of the country, MGH celebrated GI Nurses and Associates Week. The GI unit at MGH has steps on Blake 4, Gray 4 (pediatric), and 165 Cambridge Street. Approximately 150 staff members, including nurses, patient care associates, surgical technicians, scope processing technicians, and operations associates perform more than 30,000 procedures every year. March is also Colon Cancer Awareness Month. The GI Week Planning Committee (Janet King, RN; Ellen Goepel, RN; Deborah Meade, RN; Elizabeth Delamore, RN; Ellen Fern, RN; Evelyn Shakes, RN; Barbara Brien, RN; and Tiffany Torres, ST) arranged several events to mark the occasion, including an information booth in the Main Corridor. The booth provided educational materials to staff and visitors about colon cancer screening and colonoscopies. New this year was a video created by Kyle Staller, MD, and his team talking about the importance of colonoscopies. This video is available on-line at www.videcrip.com/mghcolonoscopy.

For more information about screening exams, call 617-726-2426. For information about the Colorectal Center, call 617-643-5166.

Education/Support

Workforce Development Program yields big return on investment
education, motivation, and support open doors
for medical assistant in the ED

The College for America Certificate Program is a partnership between Partners HealthCare and Southern New Hampshire University. The innovative, on-line, competency-based program is offered to Partners employees.

Yuthnita ‘Nita’ Men came to the United States from Cambodia in 2007. Today, she works as a medical assistant in the Emergency Department after having worked at the MGH Revere Health Center for seven years. In her role as medical assistant, Men assists with various aspects of patient care and contributes to a timely, efficient patient experience in the ED.

Men’s path to her role in the ED was paved with encouragement and support. She first heard about the College for America Certificate Program several years ago from her manager in Revere and became interested in applying. She completed the Partners on-line College Preparation Program, which is a prerequisite for the certificate program.

Just two months after completing the college prep program, Men started a pilot program that enabled her to obtain her certificate in just nine months.

Says Men, “I love that Partners cares so much about its employees that they helped pay for the cost of this program. I couldn’t have come this far without that support.” Men is currently deciding whether to pursue a degree in Nursing or become a physician assistant.

For more information about the College for America Certificate Program, contact Training & Workforce Development at 617-726-2230.
Respiratory Care at MGH

Q&A

Question: Do I need to call the Respiratory Care Department when patients bring their own respiratory equipment to the hospital?

Bob: Yes, for a number of reasons. Much of this equipment is electrical, so a basic electrical safety check is necessary to ensure there’s no potential for electrical shock or malfunction. Many devices aren’t designated for hospital use and may not have the structural integrity to avoid leaking electrical current—specifically RIBAP and CPAP devices. In addition, respiratory therapists need to assess these patients and ensure the devices are operating appropriately for the duration of their stay.

Question: What about patients who bring in nebulizers specific to certain medications?

Bob: Many of the newer aerosol drugs come with their own nebulizers and should be safe to use around staff. Some nebulizers are more complex, and precaution notices should be placed on patients’ doors whenever they’re used. Always contact the respiratory therapist covering your unit when patients bring in their own equipment. Pharmacy should also be consulted to approve the use of patients’ home medications if they’re not in the MGH formulary.

Question: What if a patient is admitted and I’m not sure of his/her specific respiratory-care needs?

Bob: Every patient care unit has an assigned respiratory therapist. Paper pages for each unit are listed in the MGH On-Call Directory. Please call your unit’s respiratory therapist with any questions you may have regarding the respiratory-care needs of any patient. Respiratory therapists are available 24 hours a day, seven days a week.

For more information, contact the respiratory therapist assigned to your unit or the resource therapist (pager 2-4225).

Today’s Guest: Robert Kacmarek, RRT, director, Respiratory Care Services

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Friday, May 4th
200–300pm, O’Keeffe Auditorium, Blake 1
Chief Nurse Address
Presented by Debbie Burke, RN, chief nurse
Reception immediately following, O’Keeffe Auditorium Foyer

Saturday, May 5th
7:00–9:00am, Trustees Room, Bulfinch 2
Staff Nurse Breakfast

Monday, May 7th
10:00–11:00am, Ether Dome, Bulfinch 4
A compendium of nurse-led initiatives
- Management of Clogged Tubes, Mi Haddad, RN
- Advocacy for Splinting Pillow for Pain Management of Nephrology Patients, Holly Millette, RN
- Preventing Skin Injury with Prophylactic Foam Dressings, Laura Lux, RN, and Brittany Grazio, RN
- Attitudes about Restraint Use in Surgical ICU Patients, Jeanine Delan, RN
- Care of the Postpartum Mother with Substance Use Disorder Trauma Informed Care, Shanna Plavka, RN

1:30–2:30pm, Ether Dome, Bulfinch 4
- “Creating a Culture of Safe Sexual-Health Practices in the Teen Population,” Tricia McCarty RN and Jennifer Spina, RN
- “Successful Strategies for Effectively Addressing Moral Distress Among Nurses,” Brian Cyr, RN
- “Lessons Learned from Leadership Immersion,” Molly Lyttle, RN
- Recycle, Reuse, Reduce: The Impact of Nursing,” Barbara Belanger, RN

Tuesday, May 8th
10:00–11:00am, Ether Dome, Bulfinch 4
Scholarly works: the science behind nursing leadership
- “Girl as a Predictor of Success for Nephrology Nurses,” Claire Selgo, RN
- “Readiness for Practice: Evaluation of a Pilot Project for Nursing Students in the Operating Room,” Patricia O’Gogud, RN
- “Evaluation of Discharge Education: an Educational Intervention to Improve Patient Safety with Opioid Medications,” Il Pedros, RN
- “Addressing Device-Related Pressure Injuries in Trauma/Neurovascular Patients and the Triage Process of the Patient,” Marian Jefferson, RN, and Susan Gage, RN

1:30–2:30pm, Ether Dome, Bulfinch 4
- “Phonemic Perceptions of Fall Prevention Barriers Utilizing the Fall Survey for Clinical Nurses,” Jean Stewart, RN
- “Appraising Staff Nurse Perceptions of Quiet Utilizing Focus Group Methodology to Improve the Patient Experience,” Trisha Zeytoonjian, RN
- “A Multi-Modal Community-of-Care Program to Prevent or Minimize Vaginal Effects of Pelvic Radiation Therapy for Women with Lower Gastro-Intestinal and Gynecologic Cancers,” Lorraine Drapek, RN
- “Assessment of Millennial Nurse Work-Satisfaction with the Professional Practice Environment,” Michele O’Hara, RN

Wednesday, May 9th
200–300pm, O’Keeffe Auditorium, Blake 1
It takes a Village: inter-disciplinary team outcomes
- CLABSI reduction in the MICU, Lilian Assarian, RN
- Autism Collaborative, Robin Lipski-Orlando, RN
- Addiction Consult Team, Christopher Shaw, RN
- Stop Transmission of Pathogens Task Force (STOP), Judith Taner, RN
- Stay Connected Program, Jessica Yang, RN
- Neurology Rounds Improvement Task Force, Carolyn McDonald, RN
- Pediatric Fracture/Bone Patient Education Improvement Team
- Kevin Callan, RN
- General Medicine Pain Management Work Group, Patti Fitzgerald, RN
- Stop, in the Emergency Department, Tracy Zachary, RN

Thursday, May 10th
Interactive Nursing Research Poster Session
10:00–11:00am, O’Keeffe Auditorium Foyer
- Nursing Research Insights into Patient and Family Readiness for Practice: Evaluation of a Pilot Project for Nursing Students
- “Care of Patients with Severe Substance Use Disorder: Trauma Informed Care,” Shanna Plavka, RN
- “Lessons Learned from Leadership Immersion,” Molly Lyttle, RN
- “Recycle, Reuse, Reduce: The Impact of Nursing,” Barbara Belanger, RN

1:30–2:30pm, O’Keeffe Auditorium, Blake 1
- Annual Yvonne L. Munn Nursing Research Lecture and Presentation of the 2018 Yvonne L. Munn Nursing Research Awards: “Nursing Research Insights into Patient and Family Responses to Heart Failure,” presented by Christopher L. Lee, RN
- PHQ, FAPA, FANH, FHPA, professor and associate dean for Research at the Boston College Connell School of Nursing, external faculty member, research scientist, Yvonne L. Munn Center for Nursing Research at MGH
- Reception in O’Keeffe Auditorium Foyer

Friday, May 11th
7:00–9:00am, Thier Conference Room, 1st floor, Thier Building
Staff Nurse Breakfast

- Q&A: Respiratory Care at MGH
- by Robert Kacmarek, RRT, director, Respiratory Care Services
Professional Achievements

Appointments
Jane Flanagan, RN
Co-chair, Theory-Guided Expert Panel
American Academy of Nursing

Jeanette Ives Erickson, RN
Senior nurse scientist
Yvonne L. Munn Center for Nursing Research

Commission on Magnet Recognition,
representing the American Academy of Nursing

American Nurses Credentialing Center

Vice chair, Executive Committee,
Board of Trustees
MGH Institute of Health Professions

Emilia Morison, CCC-SLP
Co-webmaster/social media coordinator
Massachusetts Speech Language Hearing Association

Gayle Peterson, RN
Board of Directors, staff nurse
American Nurses Association

Committee on Appointments, chair
American Nurses Association

PAC Board of Trustees

American Nurses Association

Committee on Budget and Planning

Ellen M. Robinson, RN
Clinical Ethics Consultation Affairs
Committee
American Academy of Nursing

Posters

Presentations

Fellow, American Academy of Nursing
Jane Flanagan, RN
Education, MGH

Inaugural incumbent, Dorothy Ann Nesson Award

Humanities
American Society of Bioethics and Clinical Ethics Consultation Affairs

Committee on Budget and Planning

American Nurses Association

PAC-Board of Trustees

Committee on Appointments, chair
American Nurses Association

Board of Directors, staff nurse
Association

Co-web master/social media coordinator
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Vice chair, Executive Committee,
American Nurses Credentialing Center

Nursing
Commission on Magnet Recognition,
Yvonne L. Munn Center for Nursing Research

Jeanette Ives Erickson, RN
American Academy of Nursing

Professional Achievements (continued)

Practical

Emilia Morison, CCC-SLP
Global Health nursing fellow, Misiona, Uganda

MGH/HIP Interprofessional Dedicated
Education Unit Committee
Award for Excellence in Advancing Inter-
Professional Education and Practice

Samantha Nock

Labrini Nelligan

Lucy, M., Moy, B., Furlani, C., Strand, E.,
Post, K., Ariosto, D., Saine, D., Fang, L., Husch,
Drucker, A., Carroll, D.L., Albert, J., Rafie,
M.D., Call, R., Cameron, C., McDonald, N.,
Maddox, R.R., Garcia-Palm, C., McGuire, J.,
Schnock, K. O., Dykes, P.C., Robertson, E.,
Burke, D., Flanagan, J., Ditomassi, M., Hickey,
P. A., Burke, D., Flanagan, J., Ditomassi, M., Hickey,
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New Leadership

Barbara Cashavelly, RN, has been named the new associate chief nurse for Women and Children, Mental Health, the Cancer Center, and Community Health, filling the position vacated when Debbie Burke, RN, became senior vice president for Patient Care and chief nurse.

Says Burke, “Barbara has been the nursing director of the Lunder 9 Oncology Unit for many years. In addition to assembling a highly skilled team of oncology nurses and support staff, her institutional knowledge and clinical expertise have influenced programs and initiatives throughout the organization. I know Barbara’s passion for patient- and family-centered care and her commitment to excellence will serve her well in her new position.”

Says Cashavelly, “I’m truly grateful and privileged to have been given this opportunity. I look forward to working with this dynamic team and all my MGH colleagues in my new role.”

Cashavelly starts in her new role on May 7, 2018, Patient Care Services and the entire MGH community with her well.
Inpatient HCAHPS

current data

Graph reflects partial data through March. Results will change as sample size increases. MGH is performing well in patient-experience areas, including two of our identified areas of focus: Quiet at Night and Staff Responsiveness.

<table>
<thead>
<tr>
<th>HCAHPS Measure</th>
<th>CY 2017</th>
<th>CY 2018 Year-to-date (as of 3/12/18)</th>
<th>% Point Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Communication Composite</td>
<td>84.3%</td>
<td>84.2%</td>
<td>-0.1</td>
</tr>
<tr>
<td>Doctor Communication Composite</td>
<td>84.5%</td>
<td>85.1%</td>
<td>0.6</td>
</tr>
<tr>
<td>Room Clean</td>
<td>72.0%</td>
<td>70.8%</td>
<td>-1.2</td>
</tr>
<tr>
<td>Quiet at Night</td>
<td>52.7%</td>
<td>53.3%</td>
<td>0.6</td>
</tr>
<tr>
<td>Cleanliness/Quiet Composite</td>
<td>62.3%</td>
<td>62.0%</td>
<td>-0.3</td>
</tr>
<tr>
<td>Staff Responsiveness Composite</td>
<td>67.5%</td>
<td>69.6%</td>
<td>2.1</td>
</tr>
<tr>
<td>Communication about Meds Composite</td>
<td>66.8%</td>
<td>68.1%</td>
<td>1.3</td>
</tr>
<tr>
<td>Care Transitions</td>
<td>62.4%</td>
<td>63.5%</td>
<td>1.1</td>
</tr>
<tr>
<td>Discharge Information Composite</td>
<td>92.7%</td>
<td>92.3%</td>
<td>-0.4</td>
</tr>
<tr>
<td>Overall Hospital Rating</td>
<td>82.9%</td>
<td>85.0%</td>
<td>2.1</td>
</tr>
<tr>
<td>Likelihood to Recommend Hospital</td>
<td>90.7%</td>
<td>91.3%</td>
<td>0.6</td>
</tr>
</tbody>
</table>

All results reflect Top-Box (or ‘Always’ response) percentages.