

Caring

Headlines

October 5, 2017



At MGH, diversity means recognizing, accepting, and respecting each person's unique differences in race, ethnicity, gender, sexual orientation, socio-economic status, age, physical ability, religious and political beliefs, and other ideologies.

It's the exploration of those differences in a safe and nurturing environment.

It's moving beyond tolerance to embrace and celebrate the many differences that make us all who we are.

(See Jeanette Ives Erickson's column on page 2)

New MGH Patient-Family Discriminatory Behavior Policy

In short, the policy states that requests for a specific type of provider based on race, ethnicity, religious creed, gender, sexual orientation, gender identity, age, disability, veteran/military status, or immigration status, will not be accommodated.

Who among us has not witnessed or been the recipient of a discriminatory remark or behavior? Sadly, it happens more frequently than we'd like to admit. It can be subtle—a casual remark about someone's upbringing, accent, or education. It can be more overt, such as an openly racist remark or epithet. Our values, mission statement, and guiding principles speak very clearly of our commitment to treat people with respect; foster a spirit of inclusiveness; and create an environment where everyone, patients, staff, and visitors, feel safe and welcome. But sometimes that's not enough to keep bigotry and prejudice from filtering into our workplace.

So what do you do when someone behaves in a way that is obviously discriminatory in nature?

"I don't want a Muslim doctor."

"I won't share a room with a gay person."

"If she's not white, I don't want her caring for me."

Historically, when situations like these have arisen, they've been dealt with as diplomatically as possible by the staff and caregivers involved—with varying degrees of success. Hospital leadership recognized the need for more formal guidance in responding to these situations. I'm happy to report that the *PatientFamily Discriminatory Requests or Demands for a Specific Type of Provider or Workforce Member Policy* has been added to the MGH/MGPO Clinical Policy & Procedure Manual, and goes into effect immediately.



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

In short, the policy states that requests for a specific type of provider based on race, ethnicity, religious creed, gender, sexual orientation, gender identity, age, disability, veteran/military status, or immigration status, will not be accommodated.

The policy recognizes that there are situations where requests for caregivers of a certain gender are not made because of prejudice but are the result of cultural beliefs, modesty, or cases involving sexual assault. All requests should be viewed through a lens of trauma-informed care. We need to consider the unique context of each situation to ensure patients' needs are fully understood and met within the parameters of a mutually respectful interaction.

The Patient-Family Discriminatory Behavior Policy applies to every area of MGH (and the MGPO) and encompasses every member of the MGH community, including providers, employees, volunteers, and students. As with all interactions

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The policy applies to every area of MGH (and the MGPO) and encompasses every member of the MGH community, including providers, employees, volunteers, and students. As with all interactions in the workplace, policies don't solve problems—people do. Which is why, when dealing with discriminatory behavior, the new policy recommends a team approach.

in the workplace, policies don't solve problems—people do. Which is why, when dealing with discriminatory behavior, the new policy recommends a team approach. I urge you to consult the policy for specific details, but briefly, if you witness or become involved in a patient or family member's discriminatory request, you should:

- calmly clarify what's motivating the request
- remind the person making the request of our commitment to a non-discriminatory environment
- remind the person making the request of the qualifications and talent of the healthcare team and the implications of refusing care or services
- support and engage other members of the team
- when necessary, involve the next level of leadership, up to and including the chief nurse and/or chief medical officer
- consider transferring the patient's care to another unit or hospital
- document the encounter in the patient's record, and file a safety report, if warranted

It's helpful to be equipped with strategies for dealing with discriminatory requests or demands before you actually find yourself in that situation. The Patient-Family Discriminatory Behavior Policy suggests:

- trying to establish a therapeutic relationship with the individual making the request by asking, "Help me understand why you don't want

this clinician to care for you?" or, "Tell me what you're afraid of."

- agreeing in principle with the request, saying, "You're right, we're different. But what's important is that you need high-quality care, and I'm here to help you."
- re-directing the conversation by saying, "All MGH team members are highly qualified, and our top priority is ensuring you receive the best possible care."
- ensuring a safe environment for MGH workforce members by saying something like, "We're here to help you. We don't assign nurses, doctors, or any caregivers based on their race, ethnicity, religion, etc."
- educating and reinforcing behavioral expectations with statements like, "We won't tolerate your speaking to our colleague that way. If you can't treat your caregivers with respect, we'll have to make other arrangements for your care."

It's unfortunate that a community dedicated to delivering compassionate, patient-centered care has to deal with discriminatory behavior. But hopefully this new policy will give us the tools to help keep these potentially volatile situations from escalating.

For more information, contact Brian French, RN, director of the Blum Patient & Family Learning Center and co-chair of the MGH Clinical Policy and Record Committee, at 617-724-7843.

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Health literacy awareness

bringing health information into sharper focus for patients and families

—by Susan Croteau RN; Christina Murphy, RN; and Tracy Waterhouse, RN, of the PCS Patient Education Committee

The US Department of Health and Human Services defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services necessary to make the appropriate health decisions.

Autumn in New England is a kaleidoscope of beautiful, fall colors. Unfortunately, for many patients and families, accessing health information is like looking through a kaleidoscope of jumbled words and images—it makes no sense.

The US Department of Health and Human Services (2000) defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services necessary to make the appropriate health decisions. Health literacy requires reading, listening, analytical and decision-making skills, and the ability to apply those skills to health situations. Patients are expected to understand instructions, read prescription drug labels, schedule and keep appointments, and read and understand patient-education mate-

rials. All these skills are necessary to navigate the complex healthcare system.

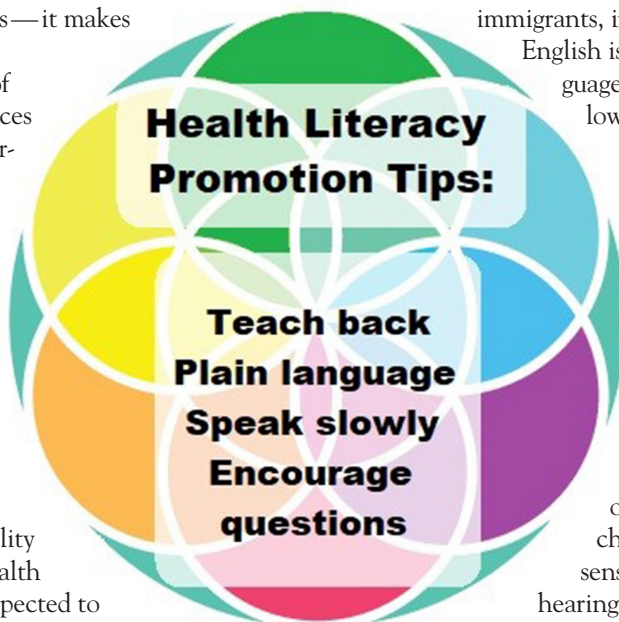
According to the National Assessment of Adult Literacy (US Department of Education, 2003), nine out of ten adults lack the skills necessary to manage their health care and prevent disease. The most vulnerable populations include older adults,

immigrants, individuals for whom English is their second language, minorities, and low-income populations.

Some factors that contribute to low health literacy include low educational attainment and reading levels, learning disabilities, and cultural or language barriers.

Adults, 65 and older, are vulnerable because of potential cognitive changes or a decline in sensory abilities (such as hearing or vision). And a patient's ability to comprehend health

issues or understand health information can be compromised by stress and illness.



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Low health literacy is associated with riskier behaviors, more frequent emergency-room visits and hospital admissions, and poorer health outcomes, including mortality.

According to the report, *Low Health Literacy: Implications for National Policy* (2002), “Low health literacy is a major source of economic inefficiency in the US healthcare system.” The report estimates that the cost of low health literacy to the US economy is between \$106 and \$238 billion annually. That represents 7-17% of all personal healthcare expenditures.

Improving health communication and health literacy reduces healthcare costs and increases quality of care. That doesn’t mean that clinicians need to tailor educational communications to a specific patient’s literacy level. A good guideline is to remember that all patients appreciate clear, plain-language communication and an opportunity to ask questions.

What materials are available to help healthcare providers communicate with and educate patients?

The MGH Patient and Family Education Materials and Resources website, accessible through Partners Applications, provides patient-education materials and links to other resources. Many of these resources are produced by MGH experts to ensure standardized information and best practice. Also included are links to preferred websites like CAPE for Oncology, CARMA for Pediatrics, and links to medication sites and materials in multiple languages, such as CareNotes and Drugnotes.

Part of choosing the right patient-education resource is considering the language used to convey health information. The Blum Patient & Family Learning Center offers a plain-language consulta-

tion and material-development process for departments that produce educational materials to ensure the information provided is clear, easy to understand, and appropriate for all patient populations. The Medical Interpreters Office offers translation services so that materials can be presented in the patient’s primary language.

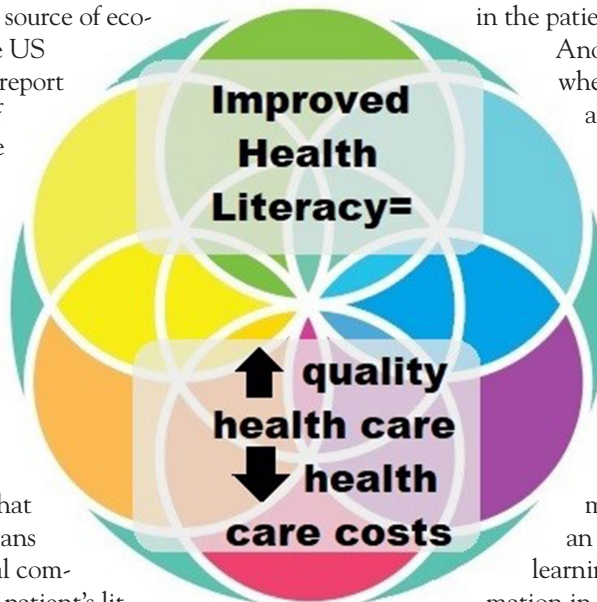
Another important tool when educating patients of all literacy levels is the teach-back method. Studies show that 40-80% of medical information presented to patients is forgotten, and almost half of what is retained is inaccurate. The teach-back method is one way to ensure patients understand health information, and it gives them an opportunity to reinforce learning by repeating the information in their own words.

If you’d like to brush up on your teach-back skills, check out the HealthStream course: *Improving Your Patient/Family Teaching Skills through the Teach Back/Show Back Method*.

As members of the healthcare team, it’s incumbent on us to assist patients and families in locating, understanding, and navigating healthcare information. Patients’ understanding of information guides their decisions and impacts their outcomes no matter where they are in the continuum of care.

For the purposes of this article, we compared the process of accessing health information to looking through a muddled kaleidoscope. Hopefully, the resources and strategies discussed here will help bring health information into sharper focus for patients and families.

For more information about health literacy or any of the resources included in this article, contact Tracy Waterhouse, RN, at 617-724-8189, or the Blum Patient & Family Learning Center at 617-724-7352.



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Nurse reflects on the ‘delicate’ balance of the art and science of nursing

‘Chris’ had run back into a downed plane to try to save his best friend when it suddenly exploded... As his family talked, I began to learn more about who Chris was as a person—a brave, athletic, outgoing, family-oriented man.

My name is James Ehrlich, and I’m a staff nurse in the Burn ICU. As nurses, we encounter challenging clinical situations and complex patients that stimulate analytical thinking and build on our ability to care for others. The art and science of nursing are delicate concepts that enter into every nurse-patient relationship. In the past five years, I’ve been challenged, rewarded, and brought to tears while caring for vulnerable patients who are dealing with life-altering injuries. One experience in particular thrust me into the role of patient advocate in a way that made me re-examine my role as a bedside nurse. It left me with a fortified sense of nursing values and heightened awareness of my patient as a person.

We’d heard about ‘Chris’ for the past three days—a 31-year-old man who’d suffered third-degree burns over his entire body, the result of a plane crash. Injuries of that magnitude require a burn center capable of employing laboratory-grown, cultured, epithelial autografts. Chris’s local hospital didn’t have the technology, so they were eager to transfer Chris to MGH. Chris had been too unstable to travel for the first few days after his injury as he’d been under-resuscitated with fluids and delayed from being excised in the operating room.



James Ehrlich, RN, staff nurse, Burn ICU

When I arrived to work my night shift, I learned that Chris had arrived only a few hours earlier by med flight. His room was chaos. The resident and attending physician were at his bedside performing escharotomies on his extremities; they were trying to reinstate blood-flow to Chris’s arms and legs, which were experiencing extreme compartment syndrome.

As I assessed Chris, I was unable to palpate or locate a Doppler signal to his distal pulses. Cool extremities coupled with a thick layer of black eschar (dark, dead skin) revealed necrosis of his extremities. Chris struggled to breathe, spontaneously grimaced, and became tense. Peri-orbital edema prevented him from opening his eyes. The attending physician explained that Chris’s arms and legs would need to be amputated, and even so, his prognosis was grave. I couldn’t help wonder whether surgery would be futile and how it would impact Chris’s quality of life.

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For me, the noises, smells, alarms, and tubes are a routine part of my day. For a man like Chris, those surroundings must have evoked a sense of terror. Providing Chris with a dimly-lit room, the sound of soft, classic rock music, and his family at his bedside were all parts of Chris's environment that I could control in an attempt to ease his fear and give him a sense of normalcy and familiarity.

In the next few hours, Chris's family began to arrive. I'll never forget his mother, girlfriend, and 10-year-old daughter collapsing into my arms, sobbing. It was only through listening to Chris's family that I learned how he actually received his injuries. Chris had run back into a downed plane to try to save his best friend when it suddenly exploded. His girlfriend had witnessed the whole thing in horror. As they talked, I began to learn more about who Chris was as a person—a brave, athletic, outgoing, family-oriented man.

Chris's family was not yet aware of the true extent of his prognosis. As Chris's advocate, I explained the gravity of his condition. I told them about the physicians' assessment that his limbs would need to be amputated; that he'd never walk, see, or even be able to hold his daughter again. Gently counseling the family, I explained that even if the amputations were performed, Chris's chances of survival were near impossible.

The next day, after consulting the Catholic chaplain to perform the sacrament of the sick, Chris was made comfort measures only. He passed away shortly thereafter, surrounded by his family.

Chris's story is one of many in my nursing career that have caused me to examine my nursing values and helped me define and understand them more deeply. One belief I hold is that a nurse must be a caring and selfless individual. While the primary goal of the medical team is to cure and heal, it was the nursing interventions (washing him, dressing his burns, placing him on clean sheets) that brought Chris comfort. He may have been unable to communicate verbally, but the physiological effect of those interventions on his blood pressure and heart rate told me he was at ease.

I believe that nurses need to preserve human dignity in every way possible. It was my duty as a nurse to ensure Chris was being respected as a unique individual, despite the circumstances. I helped counsel members of the team and aided the family in coming to the decision they felt was best for Chris—even if he had been able to survive the exponentially high mortality rate, living as a quadriplegic would have been unfulfilling based on who he was as a person. It was pivotal to ensure Chris's wishes were at the forefront of every decision. This is one of my core nursing values.

Every patient is a singular and complex individual with his or her own set of beliefs, wishes, interests, and values. In Chris's case, much of what I learned about who he was as a person came from his family. Objectively, I could see that he was tall, muscular, and had several tattoos. But from his family, I discovered he was a new pilot, he was adventurous, and wasn't afraid of anything. He loved sky-diving, mountain-climbing, and deep-sea fishing. And his love for his daughter was paramount. Hearing this information helped me tailor my approach to every intervention.

A patient's environment, surroundings, and perception of those surroundings are important considerations in delivering patient care. Chris's environment was a hospital bed enclosed in plastic for temperature- and infection-control. For me, the noises, smells, alarms, and tubes are a routine part of my day. For a man like Chris, those surroundings must have evoked a sense of terror. Providing Chris with a dimly-lit room, the sound of soft, classic rock music, and his family at his bedside were all parts of Chris's environment that I could control in an attempt to ease his fear and give him a sense of normalcy and familiarity.

My experience with Chris gave me a heightened understanding that nursing is rooted deeply in the core values that drive the profession. In Chris's case, I tried to bring selflessness, human dignity, autonomy, a calm environment, and caring practice to his bedside.

Every patient experience brings challenges and opportunities to learn new ways to improve my practice. I'm thankful I was able to support Chris through the dying process, and support his family through the grief and trauma of that horrific accident.

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

James gave us a sense of the high-tech care and interventions that were used to try to save Chris's life. But it was the 'low-tech' intervention of expert nursing practice and presence that brought Chris comfort in his final hours. James intrinsically knew where Chris's family was in their grief and deftly guided them through the traumatic, but ultimately peaceful, passing of their loved one.

Thank-you, James.

Nurses describe conditions while serving overseas during the Great War

—submitted by the MGH Nursing History Committee

Some 250 graduates of the MGH School of Nursing (SON) served overseas during World War I, the great majority of them in clinical roles. Many of the day-to-day experiences of those nurses were captured in personal diaries and letters later published in the SON alumnae newsletter, *The Quarterly Record*. Unfortunately for historians, letters during that era were rigorously censored to prevent operational details, troop locations, and other key information from falling into the hands of the enemy. We're fortunate that some documents from that time survived to provide a glimpse into the conditions nurses endured while serving their patients and their country in the Great War.



Helen Jordan, RN
class of 1916

When the MGH Unit was activated, nurses needed to move quickly. Helen Jordan, RN, class of 1916, Harvard Surgical Unit, wrote: "Nov. 9: Telephone from Miss Parsons concerning the Harvard Unit. I phoned to mother for her consent, had my picture taken, went to Hugh Cabot's for typhoid inoculation, had my name crossed off the Central Directory, gave up my room, and went home for my birth certificate.

Nov. 20: Sailed at 5pm."

The conditions nurses would face overseas would be unlike anything they had ever experienced. Their best defense was to be as well prepared as possible. Carrie Hall, RN, class of 1904, chief nurse of Base Hospital #5, Peter Bent Brigham Unit, wrote: "Some of the things that should form the equipment of every nurse: 3 blankets at least and a steamer rug and down puff; 8 uniforms, colored—white is no good and laundry facilities are poor; tan shoes and very heavy boots; a lot of good warm underclothing, storm rubbers big enough to go over her biggest shoes; toilet paper; matches. The cabins or huts are much like the ones in which I have spent vacations in the Maine woods. They are fine for summer but I can imagine a bit chilly in winter. Those who were here last winter tell the wildest stories about hot water bottles freezing in the bed. Each person has an allowance of two tub baths a week."

Nursing History (continued)

Far from the comforts of home, nurses faced extreme cold as they cared for the sick and wounded. Alice Drapeau, RN, class of 1916, Harvard Surgical Unit, wrote: "We live on army rations but will all learn the food plays a very small part in our lives. Our homes are little cubicles in wooden huts, six cubicles to a hut, two nursing sisters in each cubicle. Each morning we draw our ration of coal [to] have a little fire when off duty at night. It did no good the first week for neither my roommate nor I could build a fire. It was the coldest winter since 1885. The tents were cold, dark and cheerless. We kept our heavy woolen gloves and sweaters to work in all day long, making beds, taking temperatures, etc., taking them off just to do the dressings of the wounded lads. For a few days we even wore our gloves in our mess at meals. We had some skating and tobogganing on army tea trays."



To care for the wounded more efficiently, many nurses found themselves closer to the front than they had bargained for. Olga Olsen, RN, class of 1915, MGH Unit, Base Hospital No.6, wrote: "I am up at the American front—as far as the AEF nurses are allowed. In my wildest dreams I had never thought such a thing as this possible. The reserve trenches are a very short distance from us. The CO presented us with our new spring hats—steel helmets which, with gas masks, we are ordered to take along with us when walking. We get no regular time off duty, as we do at the Base, but go off for an hour now and then."

Barton, Maude G.

Sept 24	U. d.	Wed 20-21
" 12 -	U. d.	O. R.
Oct 19-20	Off duty (cold, not well)	
" 28 - Nov 4	" "	Wed 127. Cold
Nov 5 - Nov 8	U. d.	O. R. (Painful)
Nov 9 -	Legion P. Cross Paris	
Dec 20	Ordered detached for P. C. work	
March 1, 1918	U. d.	Wed 4
" 2 "	U. d.	" 45
" 6 "	U. d.	" 8
" 20 "	" "	" 19 (Wed)
Apr 3	U. d.	Wed 25-5
" 9	Detached for op. team	

Surrounded by the realities of war, nurses sought to maintain some semblance of normalcy. Maude Barton, RN, class of 1917, detached from Base Hospital 6 working with an operative team close to the front, wrote: "We have moved again. All that is necessary [to set up housekeeping] is a wooden box to put the suitcase on [to be off the mud] and a board to step on at the bedside. Can you imagine fussy me living for 7 months in a suitcase? This is the realest looking war scenery one could imagine—nothing but a sea of hills barren of trees and most every square inch of ground pitted with shell holes...We went for a walk the other day with the CO (We aren't allowed to go anywhere without one as we are the only women for some distance and there are encampments through all these hills.) Last night was quite exciting as we were operating, and being only in tents, had to turn out all the lights, and I was giving ether, so had to keep on in the dark rather wondering what the patient's condition was. The regular anesthetist has been ill and did not move up with us to this tent life. It is a wonderful experience for me to learn something."



Look for more installments from the MGH Nursing History Committee in future issues of *Caring Headlines*. For more information, contact Georgia Peirce, special projects manager; at 617-724-9865.

Announcements

Collaborative Governance

Applications are now being accepted for collaborative governance, the formal, multi-disciplinary decision-making structure of Patient Care Services.

To learn more about collaborative governance, or to download an application, go to: www.mghpcs.org/IPC/Programs/Governance.asp, or contact Mary Ellin Smith, RN, at 617-724-5801.

Applications are due November 6, 2017.

ACLS classes

Two-day certification program

Day one:

**November 2, 2017
8:00am–3:00pm**

Day two:

**November 3rd
8:00am–1:00pm**

Re-certification (one-day class):

**October 11th
5:30–10:30pm**

Location to be announced.

For information, e-mail: acls@partners.org, or call 617-726-3905

To register, go to:

http://www.mgh.harvard.edu/emergencymedicine/assets/Library/ACLS_registration%20form.pdf.

Make your practice visible: submit a clinical narrative

Caring Headlines is always interested in receiving clinical narratives that highlight the exceptional care provided by clinicians throughout Patient Care Services. Make your practice visible. Submit your narrative for publication in *Caring Headlines*. All submissions should be sent via e-mail to: ssabia@partners.org. For more information, call 4-1746.

Blum Center Events

October is Health Literacy Month.

**Monday, October 23, 2017
1:30–2:30pm
O’Keeffe Auditorium**

“Health Literacy in the Digital Age: Implications for Patient-Centered Care,” presented by Stacy Robison, president and co-founder of CommunicateHealth.

**Tuesday, October 24th
10:30am–1:30pm
Main Corridor**

The PCS Patient Education Committee will host a table in the Main Corridor to showcase resources available to improve health literacy. Medication safety is the theme of this year event. All are welcome.

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

For more information, call 4-3823.

SAFER Fair

**Wednesday, October 11, 2017
12:00–2:00pm
Under the Bulfinch Tent**

Join collaborative governance champions to learn how they’re working to make a SAFER environment for patients, families, and staff. Games, refreshments, and prizes!

For information, call Mary Ellin Smith, RN, at 617-724-5801.

Point-of-Care Ultrasound for Advanced-Practice Providers

**October 21, 2017
7:30am–5:30pm
MGH Institute of Health Professions
2 Constitution Road, Boston**

Learn point-of-care ultrasound techniques through hands-on, case-based scanning on live models in facilitated small groups during this one-day workshop, building from beginner to intermediate skill level.

Participants will achieve a basic understanding of the application of point-of-care ultrasound in ambulatory clinical settings.

8.0 Nursing contact hours
12.0 AAPA category I CME credits

Full Day: \$750
Fee includes: pre-workshop on-line education, course materials, light breakfast, lunch, refreshments, and snacks.

For more information or to register, go to: <http://info.mghihp.edu/ultrasoundcourse>, or call 617-724-6674.

Pharmacology update XII: innovation and evidence

**Saturday, October 14, 2017
O’Keeffe Auditorium
7:50am–3:10pm**

Course will feature sessions on intravenous antibiotics, vaccines, legal intoxication by abuse of prescription drugs, medications for sleep, GI/bowel disorders, and eyes.

Free to MGH employees
Partners employees: \$100 per day
Non-Partners employees: \$150 per day

For more information, call the Norman Knight Nursing Center at 617-726-3111.

Pharmacology update: the impact of the opioid epidemic on our patients and our practice

**Tuesday, October 17, 2017
5:00–7:00pm
Partners Healthcare Assembly Row Conference Center**

A two-hour workshop for nursing and physician-assistant professionals who want to learn about the current scope and implications of the opioid crisis on patient care and delivery. Faculty: Jessica Moreno, PharmD, and Samantha Ciarocco, LICSW. Sponsored by the MGH Institute of Health Professions.

For more information, call 617-724-6674.

An update on our diversity agenda

Question: I've really enjoyed the town hall meetings we had that focused on diversity. Will there be more?

Jeanette: I'm glad you attended and enjoyed those sessions. Feedback was very positive. Attendees told us they liked the interactive approach and the use of real-time polling to capture the opinions of participants. Evaluations indicated a desire for more sessions that focus on case studies, role-playing, and 'dos and don'ts' of cross-cultural interactions. We're definitely planning to hold more diversity town halls in the future.

Question: I know we're involved in the Future of Nursing Campaign and the Mass Action Coalition, and both have a strong diversity component. But I haven't heard anything about their efforts recently. What's happening with that?

Jeanette: The Mass Action Coalition is spearheading several initiatives aimed at bringing more diversity to nursing faculty. They are specifically focusing on leadership, the culture of health, and updating nursing core competencies to better reflect cultural sensitivity and diversity. They're also planning their annual summit, so more to come.

Question: I understand our director of Diversity was recently sworn in as a member of the Massachusetts Fall Prevention Commission. What does that mean for our work around fall-prevention?

Jeanette: Yes, I'm happy to report that Deb Washington, our director of PCS Diversity, is now a member of Massachusetts Fall Prevention Commission. The commission pays particular attention to the effect of falls on the elderly. At MGH, we have a long-standing commitment to fall-prevention, and we look forward to collaborating with the commission to advance both our agendas.

Question: There's been a lot in the news lately about racism and hate crimes. I've gotten so much out of our diversity-related forums and events. Do we have anything planned for 2018?

Jeanette: It has been a distressing year. I'm very proud that Dr. Slavin and the leadership of MGH have been quick to remind the MGH community of our values and commitment to diversity and inclusion. We will continue to celebrate the many backgrounds and traditions that make our organization the great cultural 'melting pot' that it is (Latino Heritage Month; Martin Luther King Day; Black History Month, the Jewish holidays; Ramadan; and many other observances).

For more information on any of our diversity events and initiatives, contact Deborah Washington at 617-724-7469.

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For more information, call: 617-724-1746

Next Publication

October 19, 2017

Inpatient HCAHPS

Current data

HCAHPS Measure	CY 2016	CY 2017 Year-to-date (as of 9/19/17)	% Point Change
Nurse Communication Composite	83.0%	84.4%	↑ 1.5
Doctor Communication Composite	82.6%	84.5%	↑ 2.0
Room Clean	71.2%	71.9%	↑ 0.7
Quiet at Night	49.9%	53.4%	↑ 3.5
Cleanliness/Quiet Composite	60.5%	62.6%	↑ 2.1
Staff Responsiveness Composite	64.9%	67.8%	↑ 2.8
Pain Management Composite	72.8%	73.9%	↑ 1.1
Communication about Meds Composite	65.8%	67.2%	↑ 1.4
Care Transitions	61.0%	62.4%	↑ 1.4
Discharge Information Composite	91.9%	93.1%	↑ 1.2
Overall Hospital Rating	81.9%	83.3%	↑ 1.4
Likelihood to Recommend Hospital	89.8%	91.2%	↑ 1.4

Data is complete through the end of July with partial data through September. All scores are higher than 2016 scores. Our goal for 2017 was to improve performance in Quiet at Night and Staff Responsiveness by 1 percentage point over last year's scores. We are ahead of both targets by 3.5 and 2.8 points respectively.

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



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