Celebrating Speech Language Pathology

May is Better Speech & Hearing Month

Speech-language pathologist, Erin Vuijk, CCC-SLP, works with patient, Dottie Runnals, on the Lunder 9 Oncology Unit, to ensure use of safe swallowing techniques.
Continuous virtual monitoring

introducing electronic patient observer technology

With the ever-changing healthcare landscape, we are continuously challenged to ensure that the care we provide is safe, effective, and efficient. You may recall that as part of Partners 2.0, the Partners Chief Nurse Council created the Patient Observer Tiger Team to explore the feasibility of implementing a system-wide, electronic, patient observer program, or continuous virtual monitoring (CVM).

In the past, patient observation usually consisted of direct, physical observation by a designated staff member. The observer would intervene if the patient was perceived to be at risk in any way (such as pulling out tubes or lines). Direct observation is resource-intensive, and in light of recent technological advancements, may not be the most effective way to monitor patients at risk. At MGH, we have a history of leadership in finding innovative ways to keep patients safe. Over the past few years, despite increasing acuity and a decrease in restraint utilization, we’ve seen a significant reduction in the use of direct observers. This is partly due to the targeted interventions we’ve developed for patients with delirium and those at risk for falling. Many of the same nurses who worked to create those interventions are leading our efforts to implement a continuous virtual monitoring program.

I’m sure you’re curious about how it works. With continuous virtual monitoring, patients requiring observation can be monitored remotely by specially trained staff using a live-feed camera and two-way audio equipment. As many as eight patients can be monitored at one time by two remote observers stationed at a central location. These specially trained observers have the ability to alert unit-based staff to immediately respond to patients if/when the need arises. Patient privacy is protected with the use of special screens (that block both audio and visual monitoring); these screens can be activated as needed for patient care or sensitive discussions. When continuous virtual monitoring is initiated, signs are posted in the patient’s room to alert everyone that CVM is in use.

Continuous virtual monitoring was successfully piloted on four units at MGH (White 7, White 10, Ellison 7, and Ellison 16). The monitoring station is located on Bigelow 10 and is staffed by two trained observers at all times. The program is now available throughout the entire hospital and can be initiated by following the usual procedure for requesting a patient observer.

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Continuous virtual monitoring was successfully piloted on four units at MGH. The monitoring station is located on Bigelow 10 and is staffed by two trained observers at all times. The program is now available throughout the entire hospital and can be initiated by following the usual procedure for requesting a patient observer.

The Patient Observer Tiger Team has refined the criteria for determining whether patients would be better served by direct observation or CVM. The new criteria and re-assessment process will assist nurses in determining the need to initiate, continue, or discontinue observation, and facilitate deployment of observers when patients in need of monitoring are identified. The team has worked to streamline eCare documentation around patient observation and improve hand-off communication between nurses and observers.

The Staff Nurse Advisory Committee provided excellent feedback on many aspects of the program, which we’ve incorporated into the roll-out. As we move forward, we’ll be interested in your comments and suggestions; please send ideas to Ann Marie Dwyer, RN, at 617-724-356, or Patti Shanteler, RN, at 617-643-2995.

### Guidelines for determining type and level of patient observation

<table>
<thead>
<tr>
<th>Observation Level</th>
<th>Patient Behavior Clinical Criteria</th>
<th>Role of Nurse</th>
<th>Role of Observer</th>
<th>MD Ordered Required</th>
<th>Appropriate for Continuous Virtual Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL 1-Suicide Risk</strong></td>
<td>The patient has demonstrated or stated intent to harm him/herself requiring close observation with interventions to maintain safety.</td>
<td>• Initiate Suicide Precautions, including a provider order for Observer • Communicate specific risk and plan of care to assigned observers • Document in patient record</td>
<td>• Remains at a distance that provides unimpeded view (including toilet) and keeps patient and observer safe per nursing assessment • Communicate patient behavior and interventions to nurse</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td><strong>LEVEL 1- All Others</strong></td>
<td>The patient is demonstrating such severe impairment in judgment, high level of impulsivity, or has demonstrated intent to harm others requiring close observation with interventions to maintain safety.</td>
<td>• Assess safety of environment and continued need for Level 1 observation every shift • Communicate plan of care to assigned observers • Document in patient record</td>
<td>• Remains at a distance that provides unimpeded view (including toilet) and keeps patient and observer safe per nursing assessment • Communicate patient behavior and interventions to nurse • PCAs can perform AELs and V5 (per facility)</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td><strong>LEVEL 2</strong></td>
<td>The patient demonstrates severe impairment of judgment and some impulsivity or behavioral dyscontrol. Patient cannot be verbally re-directed.</td>
<td>• Attempt alternative to observation prior to observer request • Assess safety of environment • Re-assess at a minimum every shift for continuation of observer or move to virtual observation (if available) • Communicate plan of care to observer • Document in patient record</td>
<td>• Maintains an unimpeded view of the patient (either in the room or outside the room based on nursing judgment) • May observe multiple patients if cohorted and nursing has assessed situation as safe • Communicate patient behavior and interventions to nurse • PCAs can perform AELs and V5 (per facility)</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td><strong>LEVEL 3</strong></td>
<td>The patient demonstrates impairment in judgment, but is in good control Patient cannot be verbally re-directed. Use virtual observation where available</td>
<td>• Attempt alternatives to observer prior to initiating referral • Assess for capacity for patient to respond to verbal direction • Assess safety of environment and continued need for Level 3 observation every shift • Communicate plan of care to observer • Document in patient record</td>
<td>• May observe more than one patient outside the room with virtual observation where available while maintaining unimpeded view of patient • Communicate patient behavior and interventions to nurse • PCAs can perform AELs and V5 (per facility)</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

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May 4, 2017 — Caring Headlines — Page 3
Many MGH SON alumnae returned to practice at MGH to fill in for nurses who’d enlisted. MGH nursing staff at that time consisted almost entirely of students and SON graduates; the ‘staff nurse’ position wouldn’t be created until 1925.

America had been preparing to enter the Great War for a year before war was actually declared by Congress in 1917. MGH was among the hospitals (coordinated through the American Red Cross) selected to organize and staff the equivalent of a 500-bed hospital in Europe if war was declared. The MGH Unit, Base Hospital No.6, would be located in Talence, France, near Bordeaux. MGH staffing initially consisted of 23 physicians selected by MGH general director, Frederic Washburn, MD; 65 nurses selected by chief nurse, Sara Parsons, RN; and 25 reserves. Shortly before departing from Boston, the entire staff of Base Hospital No. 6 met for the first time at a farewell service at Trinity Church. Bishop Lawrence presided along with the unit’s chaplain, Reverend Henry Knox Sherrill, who described the event as, “the most moving service I ever attended.” Over the course of the war, Base Hospital No.6 increased to 4,000 beds with more than 100 nurses.

All nurses who served were required to be single and between the ages of 25 and 35. They were given physical exams and immunizations against smallpox and typhoid. They were required to provide training-school and alumnae-association credentials prior to signing the muster-in roll (when a military unit is created, it is ‘mustered in,’ when it is disbanded, it is ‘mustered out.’) Signing the roll committed them to service for the duration of the war. Many of these nurses had never left their home towns before.

Initially enrolled as Red Cross nurses, upon taking the oath of allegiance they became part of the Nurse Corps of the US Army. In July, 1918, the Nurse Corps was re-designated the Army Nurse Corps by the Army Reorganization Act. By law, appointments were restricted to female nurses. Although part of the larger US Army, nurses were not given the benefit of military rank, had to provide their own uniforms, and were paid about $50 a month. At the outset of the war, the Army Nurse Corps was comprised of 403 nurses; by the end of the war, in 1918, more than 22,400 nurses had enrolled, 10,000 of them serving overseas.

Half of all nurses employed by MGH volunteered to serve at some point during World War I. In addition to Base Hospital No. 6, MGH personnel served at other base hospitals: Peter Bent Brigham, No.5; Harvard Surgical, No.22; and an Army-run hospital, No. 55. Many MGH School of Nursing alumnae returned to practice at MGH to fill in for nurses who’d enlisted. MGH nursing staff at that time consisted almost entirely of students and School of Nursing graduates; the

**American Red Cross Nursing Service**

**Donna Mary Tarbox**

Mass Gen Hosp Training School Boston Mass

American Red Cross Nurse

Date 5-6-1916

N.6407

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‘staff nurse’ position wouldn’t be created until 1925. And staffing levels were further taxed when a world-wide flu pandemic hit Boston in the fall of 1918.

Throughout the Great War, about 240 School of Nursing graduates served in various settings and capacities—base hospitals, clearing stations near the front lines, hospital trains crossing Europe, mobile surgical units, and hospitals in London and Paris. They filled administrative roles (13 were chief nurses at base hospitals), administered anesthesia, and organized and led educational programs at the newly-created US Army School of Nursing. They cared for soldiers, refugees, prisoners, and one another when they became ill. As prepared as they were by their MGH training, caring for sick and wounded soldiers presented an entirely different kind of challenge. But thanks to their competence and Parsons’ leadership, it was a challenge they met and mastered.

It’s interesting to note that at this time in US history, the women who served as nurses in The Great War had not yet gained the right to vote. In 1917, at the height of the suffrage movement, hundreds of women were arrested in protests in Washington, DC. Several leaders of the movement went on hunger strikes while in jail and endured force-feedings and beatings. It wasn’t until 1920—two years after the war ended—that the 19th Amendment was passed, and women were granted the right to vote.

Even with that progress in the civilian sector, nurses were still denied official rank in the military. In 1920, Army nurses were given relative, or officer-equivalent rank, but not full rights and privileges—like base pay equal to that of officers of comparable grade. Sara Parsons became actively involved in the struggle to get full military rank for army nurses, taking her case all the way to the United States Senate. Read more about this in the July 6, 2017, issue of Caring Headlines.

This year marks the 100th anniversary of the United States entering World War I. Look for other 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.
I learned my mom had had a stroke and was completely hemiplegic (paralyzed) on the left side. She was conscious, recognized my dad and brother, and was breathing spontaneously.

While she’d had an ischemic stroke, by the time she got to the hospital, she was no longer eligible for tPA. She’s a lawyer, fiercely independent, and prides herself on taking care of everyone else. You can’t share a problem with her without her tirelessly looking for a solution. My mom lives on a small island in Brasil, where she was now hospitalized, too unstable to be transferred to the mainland. It could not have felt worse to be in the best hospital in the world and unable to do anything for her.

I have been practicing in the acute care setting for more than 20 years. Neurology is not my specialty, but I’ve been doing a fellowship at the Neuromodulation Center at Spaulding, so I’ve been exposed to a lot of neuroplasticity and stroke research recently.

Neither my dad nor my brother have any clinical knowledge, but they were able to answer my immediate questions. I learned my mom had had a stroke and was completely hemiplegic (paralyzed) on the left side. She was conscious, recognized them, and was breathing spontaneously. While she’d had an ischemic stroke, by the time she got to the hospital, she was no longer eligible for tPA (the treatment, which when administered early, can reduce the long-term effects of stroke).

I was by my mom’s side 72 hours later. By then, staff there knew I was a speech pathologist and, interestingly, began treating me more as a member of the medical team than a family member.

My mom’s head CT had been saved to the intensivist’s cell phone as a screen saver, which immediately told me her case was severe. I thought they were showing me a picture from a book; my heart sank when I saw my mom’s name beside the image. There was a complete white-out of the right hemisphere. She didn’t recognize me. I knew the next few days would be critical for her survival.

This was the first of many challenges on our journey. How much should I disclose to my bother and dad; how did I tap into my faith and ask for her to survive when science and experience told me that survival could be worse? I was shaken to the core, professionally and personally. This wasn’t one of my patients, this was my mom.

A few days later she started to decline with worsening arousal and inability to clear her secretions due to suspected cerebral edema. I was fully capable and trained to help manage her secretions, but I couldn’t do anything due to a lack of equipment and because at that moment, my role was to be her daughter not her healthcare professional.

I couldn’t eat, sleep, or pray even though staff kept reminding me to. My internal conflict persisted: what do I wish for; do I allow my family to remain hopeful, or do I prepare them for the worst?
Thanks to a fluke of timing, I was spared the discussion on the potential need for a craniectomy, which would have been unbearable to me. With the guidance of the physician, my dad and brother agreed it was best to wait and see what would happen. It took countless medications and a short intubation to start to see some improvement. It was so difficult to see her struggle with her secretions and not have the tools to help. How many times did I see someone use less than optimal technique and have to suppress my urge to step in.

After two long weeks, we were able to move my mom back to the infirmary and into a single room. I spent hours in a chair at her bedside, recognizing her extensive deficits and mourning the loss of her independence. I tried to discuss her preference for code status but she didn’t have the capacity to verbalize her wishes, nor was it appropriate to discuss it at this time given our culture and faith.

Because there was no speech therapist at the hospital, I was allowed to practice as one. But this was worrisome, because to test someone’s ability to swallow, you have to feed them and see if they ‘tolerate’ it. Staff had no understanding of the complexities involved with swallow tests. Gradually, I showed them ways to recognize when it was reasonable for a patient to attempt a swallow test, and when it wasn’t. Within a week, I was seeing other patients in the hospital and training staff on evidence-based, MGH, swallow-screening techniques while still attending to my mom.

Next came discharge. There were no rehabilitation hospitals in the area, no case managers, no information on how to find support services, just a promise that she’d have home care when she got home. There was no patient education, just an ambulance waiting to take us home. (Did I mention my mom lives on an island?)

Home care consisted of a nurse who marked the end of a nasogastric tube in relation to the entrance to my mom’s nostrils, and a physician who wrote down a list of her deficits, based not on a physical exam, but on what I told him they were. My mom was completely dependent on my 76-year-old dad and me to turn her every two hours and tend to all her personal hygiene and toileting needs. After much fighting with the insurance company, we were able to get a physical therapist to come to the house three times a week.

This journey taught me so many things. I realized I knew nothing about the deficits I diagnose every day. Truly understanding what families experience is humbling. I’ve had a skewed perspective of what’s important in terms of making progress. We need to be more attentive to the multi-faceted needs of patients and family members. While effective swallowing is vital, it might not be the highest priority of the day. The entire team, including the patient and family, needs to work together to establish realistic goals and expectations.

One of the biggest lessons I learned is that it’s not just the patient’s life that’s affected but an entire community of family and friends. Fear, frustration, sleep-deprivation, and grief can make even the most rational family behave irrationally. We need to recognize that that behavior may be a cry for help.

I’m blessed to work in health care, I have access to the best professionals, I have extensive clinical experience, and I can still find it overwhelming to prioritize the day’s goals and activities. Imagine what it’s like for those with no clinical background. Behind every patient, there’s a son or daughter, mother or father hoping that everything will be done perfectly. I learned quickly that it’s better to strive for excellence—not perfection. It wasn’t an easy lesson to learn.

While my scientific mind may have temporarily overshadowed my faith during this experience, I’m certain that praying for what was best for my mom played a part in this journey.

My mom is still paralyzed, and her quality of life is not the same. But between the tears and the monumental changes, there has been laughter and love and appreciation. I’m keenly aware that I shouldn’t generalize, and my narrative of events may be colored by my emotional attachment to my mom, but the impact of my personal experience on my professional life is unquestionable. I don’t know what the future holds, but I will continue to be an active participant in this experience and use my knowledge and skills to better serve my patients and families.

I’m proud and honored to be a health professional, as well as a caretaker eager to learn and help.

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

First, Danny, I want to say that the thoughts and prayers of your entire MGH family are with you right now. This narrative is an important reminder of why we say: Treat your patients the way you’d want your loved ones to be treated—with skill, compassion, and kindness. There are so many lessons embedded in this story: being attentive to the multi-faceted needs of patients and families; including the patient and family in decision-making; having empathy for those in crisis; and perhaps most important, remembering that behind every patient is a son or daughter, mother or father, putting their faith in us to do our best for their loved one.

Thank-you, Danny, for sharing this experience, and for the expert care you provide here at MGH, and on that tiny island off the coast of Brasil.
Throughout my pediatric clinical experience, I cared mostly for teenagers who were able to speak and convey their feelings. This was a comfortable place for me, and I felt confident in my care. But ultimately, the time came when I was assigned a 3-month-old baby. I had never held a baby or changed a diaper before, let alone cared for an infant. I was both terrified and excited. Babies seemed so fragile, and the thought of what could happen if I screwed up was very scary.

Once I began taking vital signs and doing my assessment, my nerves started to subside—I was caring for a patient who needed my complete attention. The infant had been admitted for respiratory issues, so monitoring lung sounds and breathing was my primary focus. The mother was very helpful, telling me about his lung sounds prior to arriving at the hospital. She was very comfortable using medical terminology, so I asked what she did for a living. She said she was a Neonatal ICU nurse. My nerves came charging back. I was a student nurse who'd never cared for a child before, and my patient's mother cared for sick babies for a living.

By the end of the day, I had learned some of the most valuable lessons of my nursing-school ‘career.’ Primarily, I learned what it takes to be a nurse and the caregiver you want to be. This mother could very easily have been upset to find her sick baby being cared for by a student nurse. But it was the exact opposite. She showed me how to take vital signs effectively on a restless baby, how to change a diaper, and how to administer oral medication to a baby who doesn’t want to swallow. One of the strongest values of a nurse is the care and help they’re willing to give others. This mother couldn’t help but guide and teach me, and that really made an impression on me.

After this interaction, I was much more relaxed and excited to care for this patient. Based on AWHONN’s virtues of providing care, this day was going to be about engagement. The mother was very knowledgeable and able to engage in discussions about her son’s treatment plan. When it came time for him to be discharged, we had an open dialogue about her thoughts. She was happy with how her baby had progressed and confident that it was time to go home.

The second virtue of this interaction was humility. I went into this situation with such a small understanding of what’s involved in caring for an infant. My instructor had coached me on certain skills. But when I found out the mother was a NICU nurse, I was completely open to the opportunity to learn. I realized the mom wasn’t here in her capacity as a nurse; this was her child, so I needed to keep an unbiased approach. My ability to put aside thinking I knew more than I did allowed me to learn so much more throughout the day. I was able to provide the best care possible for this patient.

This clinical experience allowed me to learn so much more than caring for an infant; I learned about the nursing profession as a community. I saw how open nurses are to teaching one another so the profession can continue to grow and get better. If everyone works together like this with students and new nurses, the profession will be incredibly strong. It energizes me to know that in a few short months this is the community I’ll be part of.
The Massachusetts Health & Hospital Association held its second annual Compass Awards, March 9, 2017, to recognize provider excellence and innovation in the delivery of safe, efficient, high-quality care. Two MGH teams, the Psychiatry Team and the Stay Connected Program, were recognized earning second-place honors. The Inpatient Psychiatry Team was nominated in the Providing Care to Special Populations category, demonstrating a sustained decrease in length of stay (from 11 to 9 days) over several years. The team also showed improvement in pre-noon discharges and admission volume.

The Stay Connected Program was nominated in the category of Reducing Hospital-Acquired Conditions and Re-Admissions. Implemented in 2016, the program is a bundle of services offered to high-risk patients on six general medicine and two cardiology units. Initial results show a decrease in re-admissions compared to a control group with a similar patient population. Special thanks to the multi-disciplinary team, including: Case Management, Nursing, Pharmacy, Social Work, providers, and inpatient administrative coordinators.

For more information, call Maryellen O’Dea at 617-643-0201.
Changes to evaluation process for nursing performance appraisals

Nurses evaluating nurses to elevate practice

**Question:** I understand there are going to be some changes to the nursing performance appraisal. What's changing?

**Jeanette:** As chief nurse, I’m responsible for the practice of all registered nurses at MGH. We want to ensure that nursing practice is reviewed by nurse leaders who meet the minimum educational requirements of BSN or MSN. The objective is to align all nurses with a nurse leader who meets those requirements. This reinforces professional standards and our commitment to provide the highest quality patient care.

**Question:** What’s changing?

**Jeanette:** Performance appraisals of all nurses will now be reviewed by a nurse leader. In working with Human Resources, department managers, staff and leadership, it came to our attention that a number of nurses’ performance evaluations were being reviewed by someone who wasn’t a nurse. Nurses who don’t currently report to a nurse leader will now have a nurse leader assigned to them for participation in their review process. The performance appraisal form has been revised to include a signature line for the newly-identified nurse leader. To access the new performance evaluation document, go to: http://hr.partners.org/mgh/department-of-nursing-performance-evaluation-forms.aspx.

**Question:** Is anything else changing?

**Jeanette:** Current reporting relationships will not change. Nurses will continue to report to their existing managers. Existing managers and evaluators are responsible for the timely completion of nursing performance evaluations.

**Question:** How will I know who my newly-assigned nurse leader is?

**Jeanette:** A nurse leader will be identified in collaboration with your current manager, so you’ll know who will be reviewing your performance.

**Question:** What is the role of the nurse leader?

**Jeanette:** The nurse leader will review the performance evaluation documents to ensure adherence with professional standards of practice and recommend an action plan if practice is not aligned with standards. The nurse leader will co-sign the performance evaluation documents.

**Question:** When will these changes take place?

**Jeanette:** Changes will go into effect the week of May 14, 2017, and affect all registered nurses at all levels of the organization.

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

Blum Center Events

“Stroke: Time is Brain”
Tuesday, May 9, 2017
12:00–1:00pm
Stroke occurs when blood stops flowing to part of your brain. Join Judith Clark, RN, to learn the warning signs of stroke, what to do if you have these warning signs, and the therapies available.

“Managing Asthma”
Tuesday, May 23rd
12:00–1:00pm
Asthma is a chronic disease that causes the airways of the lungs to swell and narrow. Join respiratory therapist, Nancy Davis, RRT, to learn what happens when someone has an asthma attack, common causes of flare-ups, and ways to help manage asthma at home.

“Rheumatoid Arthritis: A New Era in Understanding and Treatment”
Thursday, May 25th
12:00–1:00pm
Rheumatoid arthritis (RA) is a form of arthritis that causes pain, swelling, and stiffness in your joints. It is the most common form of autoimmune arthritis. Join Sheila Arvikar, MD, for a talk on understanding, diagnosing, and treating RA.

No registration required.
All sessions held in the Blum Patient & Family Learning Center. For more information, call 4-3823.

MGH Global Health Expo
The MGH Global Health Expo is an opportunity for the MGH community to learn more about the breadth of global-health activities at MGH. Opportunities are available for staff at all levels. The Global Health Expo is a springboard for new collaborations and conversations for those interested in Global Health.
Stop by for refreshments and to learn more about Global Health at MGH.
Wednesday, May 10, 2017
11:00–2:00pm
Under the Bulfinch Tent
For more information, call 617-643-6911.

Healthcare Technology Management Appreciation Week
May 21–May 27, 2017
Every May, Healthcare Technology Management Appreciation Week is celebrated to recognize the people who work in biomedical and clinical engineering. These healthcare professionals service, maintain, manage, and support medical staff in the use of healthcare technology.
Biomedical Engineering is hosting an information table to exhibit some of the equipment they maintain throughout the hospital. Visit the display to meet staff and learn more about the role Biomedical Engineering plays in making MGH a world-class healthcare organization.
Thursday, May 25, 2017
8:00am–3:00pm
Main Corridor
For more information, contact Jean Johanson at 617-726-3239.

Merit Scholarship for Charlestown high-school seniors
The MGH Institute of Health Professions, the MGH Charlestown Community Health Center, and Spaulding Rehabilitation Hospital are offering $6,000 in scholarships to high school seniors from Charlestown. Students entering a two- or four-year college with the intention of becoming healthcare professionals are eligible. Apply at mghihp.edu/merit.
Deadline for applications is Thursday, June 1, 2017.
For more information, call Andrew Criscione at 617-726-0968.

ACLS classes
Two-day certification program
Day one:
June 12, 2017
8:00am–3:00pm
Day two:
June 13, 2017
8:00am–1:00pm
Re-certification (one-day class):
August 9, 2017
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.

AMMP Scholarship
2017 AMMP (Association of Multicultural Members of Partners) Scholarship Opportunity
Are you an AMMP member?
Are you currently in school?
The AMMP scholarship was established as part of AMMP’s mission to support the educational goals of members and assist in their pursuit of degrees and training at colleges and universities.
Applications are now being accepted for the 2017 AMMP scholarship.
Applications are available at the Employee Access Center in Bulfinch 107 or on the AMMP website at: http://AMMP.massgeneral.org
See application for eligibility.
For more information, go to the AMMP website at http://AMMP.massgeneral.org or call AMMP Scholarship chair, Sandra Thomas, at 617-643-0140.
Application deadline is Wednesday July, 12, 2017.

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## Inpatient HCAHPS

### Current data

<table>
<thead>
<tr>
<th>HCAHPS Measure</th>
<th>CY 2016</th>
<th>CY 2017 Year-to-date (as of 4/24/17)</th>
<th>% Point Change</th>
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</thead>
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<tr>
<td>Nurse Communication Composite</td>
<td>83.0%</td>
<td>84.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Doctor Communication Composite</td>
<td>82.6%</td>
<td>84.6%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Room Clean</td>
<td>71.2%</td>
<td>72.1%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Quiet at Night</td>
<td>49.9%</td>
<td>53.0%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Cleanliness/Quiet Composite</td>
<td>60.5%</td>
<td>65.5%</td>
<td>5.0%</td>
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<tr>
<td>Staff Responsiveness Composite</td>
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<td>66.4%</td>
<td>1.5%</td>
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<tr>
<td>Pain Management Composite</td>
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<td>Communication about Meds Composite</td>
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<tr>
<td>Care Transitions</td>
<td>61.0%</td>
<td>62.0%</td>
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<tr>
<td>Discharge Information Composite</td>
<td>91.9%</td>
<td>93.2%</td>
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<tr>
<td>Overall Hospital Rating</td>
<td>81.9%</td>
<td>83.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Likelihood to Recommend Hospital</td>
<td>89.8%</td>
<td>90.7%</td>
<td>0.9%</td>
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</tbody>
</table>

Data is complete through February, with partial data through April. All categories reflect improvement over 2016. Target for 2017 is to improve Quiet at Night and Staff Responsiveness by one percentage point. We are currently on track to achieve those goals.

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