OOD 11: Describe the Professional Practice Model(s) and the Care Delivery System(s) in use in the organization. The Professional Practice Model is a schematic description of a theory, phenomenon, or system that depicts how nurses practice, collaborate, communicate, and develop professionally. A Care Delivery System delineates nurses’ authority and accountability for clinical decision-making and outcomes. If possible, provide a depiction of each model.

**Professional Practice Model**

The Massachusetts General Hospital Patient Care Services Professional Practice Model (PPM) is the framework that guides professional practice across multiple disciplines including the profession of nursing. Crafted and launched in 1996 (attachment OOD 11.a) and revised in 2007 (attachment OOD 11.b), the PPM is comprised of nine interlocking components which facilitate the interdependent relationships between staff nurses and members of the health professions within the context of their own practice provided to MGH patients and families.

The intent of the model is to provide clinicians the opportunity to explore, develop, learn, and articulate their contributions to patient care. The MGH PCS PPM is driven by the commitment of everyone to provide the highest quality care to patients and families. The PPM is grounded in values and beliefs that embrace patient-centered care in partnership with the nurse and other clinicians within the environment of care. In total, the PPM symbolizes the delivery of seamless, knowledge-based patient care and demonstrates the importance of each component as part of a greater whole.

These components include:
- Patient Centeredness
- Vision and Values
- Standards of Practice
- Narrative Culture
Professional Development
Clinical Recognition and Advancement
Collaborative Decision-Making
Research, and
Innovation and Entrepreneurial Teamwork.

In our organization, the nurse continuously seeks to promote the health of the person while recognizing their uniqueness (e.g., age, culture, race, ethnicity, gender, health status, religion/spirituality, sexual orientation, ability level, socioeconomic status, and opinion) and the complexity of the patient situation. The goal is to provide holistic care to patients, families, and groups in the numerous communities we serve. The model is predicated on the availability of fiscal and human resources within the context of MGH’s institutional commitment to the provision of safe, timely, efficient, effective, equitable and patient-centered care.

The PPM promotes the use of discipline-specific knowledge to guide the delivery of care, extend existing knowledge and transform practice. Research is seen as a vehicle for generating, testing and evaluating knowledge. Information obtained from research, as well as information yielded from clinical investigations, is translated into practice to improve care. Evidence gained from clinical evaluation of current practice serves to inform care and link nursing contributions to patient outcomes.

The collaborative relationship between the nurse, patients, families and other clinicians promotes dialogue, reflection and problem-solving. Each individual plan of care is continuously revised to respond to the changing needs of the patient and family. Desired outcomes for patients are achieved in mutual partnerships, with the nurse and patient developing and implementing a plan that best responds to each individual situation.

The internal health care environment fosters the autonomy of the clinician through multiple initiatives designed to enhance clinicians’ competence and overall quality of care. As the central piece of the PPM, Patient-Centeredness guides the Patient Care Delivery Model, which embraces provider attributes (doing for and being with the patient) and seeks to teach, evaluate and transfer new competencies that enhance professional practice and foster personal and professional growth. Continued support for professional development within and external to the MGH is encouraged and resourced, when appropriate, to enhance the professional practice environment (e.g., The Norman Knight Nursing Center for Clinical & Professional Development and The Yvonne L. Munn Center for Nursing Research).

Multiple initiatives within the internal health care environment are designed to promote quality care and strengthen professional practice. Evaluation of the Professional Practice Environment through the administration of the Staff Perceptions of the Professional Practice Environment Survey occurs every 12-18 months. All direct care clinicians in Patient Care Services are invited to participate, with nurses comprising the largest group of respondents. The data provides nursing leadership with a report on the clinician’s perception of the professional practice environment around eight organizational characteristics (e.g., autonomy, control over practice, clinician/physician relations, communication, conflict management, teamwork, internal work motivation and cultural sensitivity). This survey, as an evaluation of the PPM, is discussed more fully in EP 1.

Significant survey findings guide changes in both the institutional and unit-based practice environment. Data from subsequent surveys provide continuous evaluation of the professional practice environment of care and measure the impact of organizational change. Evidence documenting changes, made in response to findings, are used as measures of effectiveness reported
to support the quality of patient care outcomes. The PPM is also evaluated on a regular basis and revised to reflect changes in health care nationally.

A detailed explanation of the revised PPM and each of the nine components follows in the April 5, 2007, special issue of Caring Headlines (Attachment OOD 11.b).

Philosophical Underpinnings for Patient- and Family-Centeredness

Our most important value is Patient- and Family-Centered Care. Patient Care Service’s vision and values statement states that, “We believe that care delivery is driven by compassion” (OOD 1). As clinicians, we demonstrate empathy for the patient’s well-being, we utilize our expertise to alleviate suffering and to address patient and family needs. The diagram above depicts the patient and family at the center of the work. Involvement with the patient and family is central to professional practice at MGH. Value is placed on the dynamic and therapeutic interactions that occur between the nurse, the patient, and the family. Patient- and Family Centered Care is reflected in the 2012-2013 PCS Strategic Plan (Attachment OOD 11.c and OOD 3.i, p. 6).

As previously stated, the core component of the MGH PCS PPM, Patient Centeredness, defines the Patient Care Delivery Model, which is patient- and family-centered and interdisciplinary in nature. Patient-centeredness articulates a care-delivery system that is responsive to the patient and family and supported by a philosophy of care and a practice environment that enhances patient outcomes. These elements include knowing the patient, mutual development of goals that reflect patient choices and decisions, evidence-driven practice, staffing patterns, strategies for aggregating patient populations, reimbursement methods, and effective communication systems that report and document outcomes of patients’ hospitalizations.

Patient care is expected to be of the highest quality, comprehensive, accessible, supportive, and personalized. The vision statement for Patient Care Services (OOD 1) says, “Patients are our primary focus, and the way we deliver care reflects that focus every day.” Patient- and family-centered care optimizes this relationship by placing the care-delivery system around the patient.
Patient Care Delivery Model (1999 – 2012)

Decisions about care and the environment of care are made at the practice level by clinical staff and unit leadership through the patient care delivery model (as depicted in the figure below). Authority, responsibility, and accountability for the nursing care of patients and families ultimately rest with Registered Nurses. Nursing care is prescribed by a Registered Nurse and delivered by a Registered Nurse (or delegated to other licensed or unlicensed personnel, as appropriate). Accountability for nursing care and outcomes of nursing interventions are always assumed by the Registered Nurse assigned to the patient. Patient care is influenced by the patient’s overall health status and a variety of contributing biophysical, psychosocial and cultural influences. Within the nurse-patient relationship, the nurse creates a therapeutic environment that ensures mutual trust, safety, privacy, and respect. As a Staff Nurse comes to know a patient and the patient’s unique response to certain situations, he/she designs a care plan based on that knowledge and best practices. The nurse’s practice has two components: doing for and being with. Doing for includes assessment, diagnosis, planning, intervention, and evaluation of outcomes; being with refers to behaviors that create an environment where patients can heal. The nurse-patient relationship occurs within and across each dimension of the patient experience including coming to know the patient and family, their changing health responses and the dynamic and interactive response of the nurse to the patient experience. Nursing care requires nurses to be present to patients and families — to listen, to come to know responses to illness and life style, choices and preferences and to advocate throughout the healthcare experience. The MGH culture encourages professional autonomy and clinical decision-making and supports interventions that promote optimal patient care and achievement of outcomes across a variety of healthcare settings.

Nurses are creative in their approach to care and use knowledge to improve outcomes. They optimize patient strengths and provide support for human limitations. Staff Nurses at MGH are afforded an environment that optimizes professional practice and enhances patient care. The nurse-
patient relationship, central to the work of nursing, is based on mutual trust and respect and is therapeutic in nature. The partnership forged between a nurse and patient, as well as family and community, is essential to promoting health, managing illness, and negotiating changes in lifestyle patterns. Nurses identify concerns related to the human experience (i.e., birth, health, illness, and death) and engage in clinical reasoning processes to identify problems, define outcomes, and generate interventions and evaluate responses based on goals developed by the nurse, the patient, and the family.

Within the Patient Care Delivery Model, the nurse is depicted as leading a variety of initiatives within the delivery of patient care. Multiple elements contained within a nursing role (e.g., accountability, autonomy, authority, advocacy, cultural competency) are implemented in creative ways responsive to the practice setting, thus promoting the optimization of professional practice across settings. The nurse’s practice is guided by scope of practice and professional standards of practice and adherence to appropriate role preparation, credentialing regulations and academic qualifications. This professional self-regulation supports the societal contract outlined in the American Nurses Association’s Nursing Social Policy Statement (2010) and certifies to the consumer the nurse’s role in the provision of quality and competent care.

Evaluation of staff performance within the patient care setting is ongoing and occurs formally on an annual basis during the performance appraisal process. In concert with leadership, areas for improvement and further development are identified and support strategies isolated to enhance provider performance. Through continued mentoring, guidance and peer review, the professional’s competence and overall performance is monitored and promoted (OOD 17 and EP 20).

An Evolving Model: 2012 and Beyond

In March 2012, twelve “Innovation Units” were launched to test a new care delivery model which includes a new Attending Nurse role, daily interdisciplinary rounds, the philosophy of relationship-based care and additional interventions designed to improve communication and promote efficiencies across the continuum of care. The Innovation Units are described in detail in evidence TL 4 EO.

The current delivery model, developed in 1999, was a result of careful reflection of many factors: the local and national labor market, the changing profile of patients served, the nature of the workforce, and the systems or infrastructure that supports practice. The delivery model was derived after careful development of vision, values and long-range goals. A similar approach is being taken to develop the next model that will allow us to be more responsive to the changing health care environment. The figure in Attachment OOD 11.d represents Nursing’s and Patient Care Services’ evolving Patient Care Delivery Model.

The evolving model is comprised of four key components:

- IOM Six Aims of Quality Improvement
- Philosophy of Relationship-Based Care
- Domains of Practice (across all disciplines)
- Empirical Outcomes

Dohmen’s “structure, process, and outcomes” cycle circles the model. The emerging delivery model on the Innovation Units is currently being evaluated. It is our aspiration to have this more fully implemented at the time of our site visit.
Our professional practice model

... revolutionizing patient care!

Driven by our commitment to provide the highest-quality care to our patients and their families, every element of our model “interlocks” to ensure the delivery of seamless, knowledge-based patient care.
Our professional practice model

It is a privilege to introduce this issue of Caring Headlines, which is dedicated to describing key elements of our emerging professional practice model. Now, in the crucial, formative stages, it is important for all of us to understand exactly what this model is, and invest our interest and energy into making it a viable, working reality.

The past seven months have seen tremendous change, both organizationally and in the mindset of individuals helping to mold a new culture during this very turbulent time in health care. I have seen it at staff meetings, forums, luncheons, and committee meetings—there is renewed understanding around the importance of having a practice model and its intrinsic connection to the delivery of high-quality care.

Though the fruits of our efforts may not fully be evident until all aspects of the model are understood and embraced by clinicians and others in our community, the challenge now is to define the concepts in a way that brings significance to our daily practice. Each “piece” of the model represents a component of practice. Since each component is inherently related to all of the others, we have chosen an “interlocking” puzzle to represent our model.

If the model is to work, each of us needs to understand, embrace, and master the skills involved; participate in the whole process; and be willing to learn—continuously—because the environment in which we work is rapidly changing. This is a journey we must take together.

For this special issue of Caring Headlines, I enlisted the aid of several professionals to describe the various components of our model. When these authors first began their work, they were skeptical of their ability to write about this model. Each was excited about the journey, but hesitant to take the first step. The feelings they experienced are similar to the ones I hear voiced every day: “Can we really do this?” I assure you, this hesitation does not stem from inability. It stems from the unprecedented complexity surrounding health care in the 90s.

You may recall that when we began this work, I had been newly appointed interim leader for Patient Care Services. There were many issues we wanted to address; each day brought new challenges and exciting opportunities to work together. The competitive marketplace rising out of the world of managed-care, the drive for cost-effective care, and the shift from inpatient to outpatient and alternative settings made us reach into our collective wisdom for new ways to provide excellent care. All of our discussions have centered on the need to truly understand the patient experience and ways to improve the patient-care process . . . with each discipline bringing the richness of its expertise to the interdisciplinary table.

This professional practice model will give every MGH clinician the tools they need to explore, to develop, and to learn. Nurses, physical therapists, occupational therapists, speech language pathologists, reading specialists, orthotics technicians, chaplains, and social workers will all share a common language and understanding in addressing the issues and challenges of the new age.

Many of you have been generous enough to share your wisdom and experience with me. I would like to share with you now the wisdom of some of your colleagues in describing the elements of our model. They, like me, take great pride in this work. Through this effort of redefining our practice, it will become clear that there are no boundaries to limit the contributions, opportunities, and accomplishments in our future. We are leaders in building a stronger, more human, patient-care delivery system.

Our journey to the future is framed by a well-articulated, patient-and-employee-oriented vision. The vision is grounded in our understanding of the richness of our practice. The unique contributions of each of the professional disciplines and support staff bring special meaning to the relationships we have with patients, their families, and the interdisciplinary team as a whole. Each of these unique contributions has a place in our vision for the future.

Our vision encompasses aspects of current reality and looks ahead to a future we can all embrace. It acknowledges that our primary focus is the patient, and it stresses the importance of preserving the integrity of the relationship between patient and clinician. Our vision clearly demonstrates the need for action in creating a practice environment that has no barriers, that is built on a spirit of inquiry, and that reflects a culturally-competent workforce supportive of the family-focused values of this institution.

Guided by this vision, we are called to action. Inspired by this vision, we will launch new committees and new efforts to publicly describe and articulate our practice. As you can see, we do have a master plan . . . a plan that focuses on practice, organizational effectiveness, and collaborative decision-making.

As you read the articles in this issue of Caring Headlines, I think you will agree that we are ready to take on the challenges of the next century. I invite you to share in what we have already learned, and to join us in completing our journey!
Our vision...

As nurses, health professionals, and Patient Care Services support staff, our every action is guided by knowledge, enabled by skill, and motivated by compassion. Patients are our primary focus, and the way we deliver care reflects that focus every day.

- We are ever-alert for opportunities to improve patient care; we provide care based on the latest research findings.
- We recognize the importance of encouraging patients and families to participate in the decisions affecting their care.
- We are most effective as a team; we continually strengthen our relationships with each other and actively promote diversity within our staff.
- We enhance patient care and the systems supporting that care as we work with others; we eagerly enter new partnerships with people inside and outside of the Massachusetts General Hospital.
- We never lose sight of the needs and expectations of our patients and their families as we make clinical decisions based on the most effective use of internal and external resources.
- We view learning as a lifelong process essential to the growth and development of clinicians striving to deliver quality patient-care.
- We acknowledge that maintaining the highest standards of patient care delivery is a never-ending process that involves the patient, family, nurse, all healthcare providers, and the community at large.

Our promise...

... is to make each of these statements a demonstrable truth every day by letting our thoughts, decisions, and actions be guided by our values; to ensure that our practice is caring, innovative, scientific, and empowering, and is based on a foundation of leadership and entrepreneurial teamwork.
Philosophy

A philosophy statement is derived from the values, principles, and beliefs that support the individualized work of each discipline. At MGH each clinical discipline is guided by its own philosophy which synthesizes the beliefs of its practice. Two examples of philosophies within Patient Care Services include:

Nursing
We believe that the essence of nursing practice is caring. Caring which is ...
... a science and an art ...
... deliverable, teachable, researchable ...
... accomplished with wisdom, knowledge, compassion, and competence.

We believe that ...
... the clinical practice of nursing is built on a scientific base ...
... evaluation of nursing practice is a professional responsibility ...
... critical thinking and scientific inquiry are essential to the improvement of practice

We believe that we have the responsibility to ...
... educate ourselves and educate others ...
... expand our knowledge and expertise ...
... share this growing body of knowledge ...
... provide such opportunities to the greater healthcare community

Occupational Therapy

Occupational Therapy is the art and science of directing an individual’s participation in purposeful activity to restore, reinforce, and enhance performance.

Using their capacity for intrinsic motivation, human beings are able to maximize their physical and mental health and their social and physical environment through purposeful activity. Human development includes a process of continuous adaptation. Adaptation is a change in function that promotes survival and self-actualization. Biological, psychological, and environmental factors may interrupt the adaptation process at any time throughout the life cycle. Dysfunction may occur when adaptation is impaired. Purposeful activity facilitates the adaptive process. Occupational therapy is based on the belief that purposeful activity may be used to prevent and mediate dysfunction, and to elicit maximum adaptation. Activity as used by the occupational therapist includes both an intrinsic and a therapeutic purpose.

Values

Supporting our vision is a clearly-articulated set of values which pervade our decision-making process and find daily expression in our policies, practices and norms of behavior. Our values combined with our vision provide both an affirmation of work which already exists and a foundation on which to bring about ideas not yet realized. Each of us makes decisions every day driven by personal and institutional values. The values we have chosen to be of primary importance to us as we move forward are: leadership, entrepreneurial teamwork, caring, innovation, and scientific practice.

In addition, as described in our vision statement, we value accountability, responsibility, diversity, resource effectiveness, and our core value—patient-focused care. During the course of the development of our professional practice model, our journey will be guided by these values and by a shared belief in our vision for the future.
It is very important to understand that while serving the essential role of guiding the novice, standards of practice also guide the behavior of more experienced professionals. Standards of practice are the conduits of the institution’s culture of care, and therefore, the very essence of that care. By serving as a teaching tool, they establish a level of expectation about care-delivery within an organization.

Universal adherence to standards of practice also provides an added measure of safety by extending the knowledge of clinical expertise when real experts may not be available. With the guidance of practice standards, clinicians can step into situations and perform effectively even when more experienced providers are not present.

It is important to note that standards of practice are geared toward the “typical” situation, and are not intended to supersede the individual, specific needs of the patient at any given time. Healthcare professionals face many complex situations every day. Understanding the unique clinical needs of each situation and the latitude in applying standards is imperative to providing effective, high-quality care. Strictly adhering to standards does not, in and of itself, constitute best care. It is up to the individual professional to recognize and interpret situations, and to know what standards of practice apply and in what ways they apply. The integration of clinical knowledge and standards of practice reflects a more proficient, or expert, professional.

As Patient Care Services develops its professional practice model, there will be opportunities to update our standards of practice to better reflect the decision-making process and clinical knowledge of our expert professionals. This will be an exciting opportunity for many expert clinicians to become involved with this work, to share their knowledge, and articulate their practice.
all, of the context for this is provided by the patient-care delivery model, which is a detailed plan for an infrastructure to support the professional practice of caring for patients at MGH.

Several key ideas are fundamental to understanding the patient-care delivery model. They are briefly described in the following paragraphs:

**Role redesign and decentralization of work** are probably most visible to you now as we begin to implement the new unit-based roles of patient care associate, unit service associate, and enhancing the role of nurses on inpatient units. The intent here is to have the right person doing the right work at the right time.

Some work that was formerly done by staff in central departments such as Phlebotomy, Environmental Services, and IV Therapy will now be done by staff working on the unit under the nurse manager. This decentralization of work makes it easier for staff on units to provide care in a more timely, co-ordinated way during the course of a patient’s stay. In addition, having unit-based staff to perform this work (such as phlebotomy and peripheral IV starts) means providing more integrated care in a less fragmented process.

As a result of the work sampling analysis (the beeper study), we also discovered that patients and registered nurses benefit from having more assistance from patient care associates with some direct-care activities. This role redesign enables nurses to spend their time more productively with patients providing professional care. The intent is to promote the patient/family-nurse relationship by supporting and enhancing the nurse’s presence at the bedside.

**Work simplification** means improving and streamlining systems in order to save time. This is explained in more detail on page 8 as it is a very important aspect of the model. Several work-simplification ideas are being implemented now, with others in various stages of development. Time saved from these ideas will also contribute to nurses being able to spend time more productively with patients.

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*Patient-care delivery model* - by Barbara Bauman, RN  
*Introduction by Jeanette Ives Erickson:* Our patient-care delivery system is based on the premise that clinicians’ involvement with patients and families is central to our work. As changes occur in the healthcare environment (the growth of managed care, increased patient acuity and decreased lengths of stay) and the needs of our patients and their families increase, we have a catalyst to build a new system. The delivery system is the infrastructure that supports clinical and organizational outcomes. Barbara Bauman, RN, who was intimately involved in our operations improvement effort, was asked to write this overview. From her writings you should see that incorporated into our thinking are interdisciplinary pathways, the integration of research into practice, quality-assessment activities that study variation as a way of improving care, and systems improvement as a way of enhancing direct patient-care delivery time.

The description of the patient-care delivery system includes discussions on delegation and systems improvement. Tim Quigley, RN, and Sally Millar, RN, were asked to write the article on systems improvement as they worked closely on many of the system-improvement activities we will implement in the next few months.

Any discussion in the 90s of patient-care delivery systems must address the issue of delegation. We believe our model differs as we have taken a stand that the decision to delegate is clearly driven by the registered nurse’s assessment of the patient. As long as the decision is consistent and within the boundaries of the Nurse Practice Act, the decision rests with the nurse.

Our core value of patient-focused care and our belief that the patient/family-nurse relationship is essential, are critical to the development of our professional practice model. We also believe that these values are reflected in the way we deliver care every day.

The art and science of caring for patients includes a vast array of clinical and organizational activities, behaviors, and processes. Much, but by no means the description of the patient-care delivery system includes discussions on delegation and systems improvement. Tim Quigley, RN, and Sally Millar, RN, were asked to write the article on systems improvement as they worked closely on many of the system-improvement activities we will implement in the next few months.

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Patient aggregation refers to the grouping of patients with similar resource needs in close or adjacent areas. This is especially challenging at MGH because of the complexity of the physical layout and because there are many important priorities competing for space. In addition, as health care and clinical practice continue to evolve, the ability to project volume and type of patient aggregation becomes even more difficult. As patient populations shift and change on inpatient units, the resources required to care for them must constantly be re-assessed.

Integration of clinical practice changes among all health professionals (including nurses, therapists, and physicians) is one of the most important aspects of the patient-care delivery model. As we confront the challenges presented by decreasing lengths of stay and increasing patient acuity, innovation and caring, research-based practice will be critical. Clinical, service, and financial outcomes will have to be closely monitored as we develop interdisciplinary care paths. MGH has long been recognized for its innovative practice based on cutting-edge research. Maintaining that reputation in the expanding managed-care environment may well be the greatest challenge we face as we move forward in developing our professional practice model.

Delegation
—by Barbara Bauman, RN

Understanding the patient-care delivery model requires thinking about the nature of the work of patient care (especially the work associated with direct care) as well as the nature of the team who provides that care. We must be especially thoughtful about how decisions are made regarding who does what work, and when.

The work of patient care can be separated into two types. Type-one work is highly specific; those who perform type-one work must be licensed or have highly-specialized training and education. It cannot be delegated. For example, in baseball . . . a pitcher pitches, and a catcher catches. On a patient-care unit, only the registered nurse administers medications.

Type-two work is shareable work. Two or more people from different roles may perform this work equally well. Continuing with our baseball analogy, a center fielder and a right fielder would be equally competent to catch a fly ball. On a patient-care unit, both an RN and a patient care associate are equally competent to take vital signs. The question in this case will always be: should the RN delegate this task to the patient care associate in a particular patient-care situation? The answer will always be guided by the nurse’s judgement and knowledge of the patient at that point in time.

Nursing practice involves clinical decision-making that is the application of judgement to dynamic changes in the clinical condition of the patient. When we talk about nurses delegating work to others, we emphasize that there are never any clinical tasks which are always or completely delegated to unlicensed personnel. Certain tasks have been identified as being type-two work, and are therefore able to be delegated to appropriately-trained assistive staff. The clinical decision and judgement to delegate must always be driven by the patient’s requirements for care. It is the nurse’s knowledge of the patient’s care requirements, along with her or his critical thinking skills, that determine which work and tasks are delegatable to unlicensed personnel.

Language from the Board of Registration Rules and Regulations also provides clear direction regarding delegation, and this language has been incorporated into the job descriptions and training programs of the patient-care delivery model.
Systems improvement

A foundational premise during the design of the patient-care delivery model was that “three rights” be adhered to. This means that the delivery model was crafted so that the patient receives the care they need from “the right person, performing the right intervention, at the right time.” In order to support all members of the care-delivery team, significant resources were directed at streamlining and simplifying the hundreds of interventions and tasks which collectively comprise this patient-care experience. Particular emphasis was placed on reducing the time that professional nursing staff spent on redundant tasks, so that their time could be more appropriately directed toward providing and planning direct patient care. Consistent with the role of the registered nurse within a professional practice model, efforts were further directed at improving communication and patient-care planning with other members of the healthcare team.

The following improvements specifically associated with the patient-care delivery model have been made, or are currently in process:

1) Upgrading of fax machines on all units to improve communication (complete).
2) Implementation of an “all-on” policy for patient televisions, eliminating long waits for TVs to be turned on and improving patient satisfaction (complete).
3) Introduction of real-time census which allows Admitting to know where available beds are on a “real-time” basis, decreasing the number of phone calls to and from patient-care units (complete).
4) Consolidation of multiple, discipline-specific patient discharge forms into a single form (in process).
5) Creation of standard medication administration instructions for the Micromedex computer system, eliminating the need to hand-write or copy discharge instructions (in process).

6) Introduction of automated medication dispensing machines across all patient-care areas, eliminating every-shift narcotic counts (planned for FY 1998).

Many other system improvements are in various stages of planning and implementation, and while not directly linked to the patient-care delivery model, they will have significant impact on the amount of time registered nurses spend on direct patient care, and on how that care is managed with other members of the healthcare team. Examples of these system improvements include:

1) A computerized order entry system, connected directly to support departments such as Radiology, Pharmacy, Dietetics, Physical Therapy, Occupational Therapy, and Speech-Language Pathology. This will allow requests for patient services provided from these areas to be sent on a “real-time” basis in a clear and legible format.
2) An electronic medical-record system to allow multiple disciplines and providers to more effectively communicate, and simultaneously provide data to meet quality monitoring and regulatory needs.

The work of improving the systems by which we deliver patient-focused care never ends. There are always opportunities to critically examine, question, and re-design the systems which support our work as we transform the “three rights” from vision to reality. Because these system improvements ultimately support our core value of patient-focused care, they are enablers for the development and application of a professional practice model.
Descriptive theory models

—by Mandi Coakley, RN, staff specialist
Carolyn Hayes, RN, clinical nurse
Julie Basque, RN, clinical nurse
Lynne Griffin, RN, clinical nurse

Introduction by Jeanette Ives Erickson: While many staff could have been selected to write about a favorite theorist and the applicability of a particular theory to our model, these four nurses were chosen because they are recent students who studied the importance of theory. While they encourage us to apply one theorist to our model, I continue to challenge that thinking. **We must always learn more!**

Theory is a term we all use regularly. However, putting theory into practice is not an idea we often discuss. The challenges of our current practice environment present us with an opportunity to reflect on our practice—to articulate the “whys” of what we do. Understanding the philosophical and theoretical foundation of our practice is an important part of professional development and the overall change processes we are undertaking.

Theory provides a vision of the central concepts of any discipline. Theory construction is essential in all disciplines as it helps to describe, explain, predict, and prescribe phenomena and situations. Clinicians use theories as a means of guiding their practice and influencing their interventions. Other models have demonstrated that practice which is guided by theory is consistent because clinicians are given a framework by which to view situations and plan care. When clinicians interact with patients and other members of the healthcare team, they are giving life to the assumptions, beliefs, and concepts that make up a theory.

Theories exist to explain critical concepts and to describe the relationships that connect those concepts. For example, a theory would guide how a practitioner connects pieces of a puzzle. First, theory helps to identify which piece(s) of the puzzle a practitioner is accountable for connecting. Then, it may help to determine which pieces the practitioner is to start with. It is a guide that helps us to get to the clearest picture in the shortest amount of time. The strength and direction of those connections are constantly shaped and challenged by ongoing practice and research. If pieces that appear to fit together are moved and you get a clearer picture, then the theory is adjusted, or a new theory emerges altogether.

Nursing, for example, has four concepts which are the building blocks of any nursing theory. They are **person**, **environment**, **health**, and **nursing**. Various nursing theories describe different relationships among those four concepts. The variety of relationships reflects the broad scope of the nursing profession. The practitioner (in this case, the **nurse**) defines his or her relationship with the patient (the **person**) in matters concerning wellness, illness, and disease (**health**) within a family, work setting, community setting, or other patient-defined reality (**environment**).

Physical Therapy uses different concepts to define the boundaries of its discipline. Andrew Guccione, PhD, PT, director, Physical Therapy, explains that the Model of Disablement presented by Nagi, is one theory that can guide a physical therapist through the evaluation of examination data. Nagi offers four categories: **disease**, **impairment**, **functional limitation**, and **disability**. These categories provide physical therapists with a framework for addressing the factors that influence a patient’s functionality and quality of life.

Phyllis Meisel, director, Reading Disabilities, reports that her discipline relies upon theories related to how people learn—particularly, how people with dyslexia learn. As a result, treatment for dyslexic patients involves a very structured, multi-sensory, sequential, phonetic approach. This is an example of how theory helps to determine process as well as desired outcomes.
John Snowden, director, Orthotics and Prosthetics, explains that physics-based theories are the cornerstone of his discipline. The manufacture of braces and prosthetics relies heavily on calculations around and relationships between force, velocity, momentum, and acceleration.

Respiratory Care is also a largely physics-based discipline. Robert Kacmarek, RRT, director, Respiratory Care, reports that theoretical principles are woven into the curriculum of Respiratory Care’s educational inservices, including: fluid mechanics, the mechanics of gas, etiology of pulmonary disease, natural course of diseases, and approaches to the assessment of severity in illness.

Trina Oswald, OTR/L, director, Occupational Therapy, describes her discipline as the art and science of directing an individual’s participation in selected tasks to restore, reinforce, and enhance performance. It is based on the theory that purposeful activity may be used to prevent and mediate dysfunction, and elicit maximum adaptation.

As we develop as individual practitioners and as collaborative colleagues, it is exciting to share, explore, and challenge the theoretical perspectives we utilize in the delivery of patient care. Together, we connect all the pieces of the puzzle. The integration and continued growth of our theoretical perspectives is an essential element of our professional practice model.

The possession of a body of knowledge from research is the hallmark of a profession. Research is the bridge that translates academic knowledge and constructed theories into direct clinical practice. The challenge in the current era of health care is to generate knowledge that is clinically relevant and scientifically vigorous in order to contribute to the health care of the public. Therefore, the priority of healthcare professionals is to identify the major clinical phenomena of unique concern to their discipline and to develop substantial bodies of information in relation to these clinical phenomena.

Translating the questions generated at the bedside into formal scientific hypotheses is a part of the continuum of professional development. Research must become an integral aspect of clinical practice as healthcare professionals proceed from novice to expert. These research efforts define a systematic body of knowledge that guides professional clinical practice.

Healthcare professionals must weave experience as well as knowledge derived from research into their clinical practice. Application of research findings to clinical practice enhances the professional practice environment, and is critical to the improvement in patient outcomes. In the current era of change, there are unlimited opportunities available to nurses and health professionals to study and define the quality and cost-effectiveness of our professional clinical practice.

Introduction by Jeanette Ives Erickson: Research-based practice creates a spirit of inquiry that consistently challenges critical thinking. By folding research into our framework we continuously improve the patient experience and strengthen our professional identities. Diane Carroll and Bob Kacmarek were asked to write this article as two clinicians who integrate research into their practice each day. Both have numerous grants and publications to their credit. As a department, we will seek these opportunities for all clinicians.

Special thanks... to Jeff Wdow, Development and Public Affairs, for creating the graphics that appear in this issue of Caring Headlines.
Privileging, credentialing, and peer review
—by Deborah Burke, RN, nurse manager
Jan Duffy, RN, staff specialist
Andrew Guccione, PhD, PT, director, Physical Therapy

Privileging and credentialing are important parts of our professional practice model as we are accountable for ensuring that our patients and their families receive quality care from competent providers. Each discipline within Patient Care Services is bounded and governed by both external mechanisms (e.g., Code of Ethics, Practice Act, Board of Registration Rules and Regulations, Standards of Practice) and internal mechanisms (e.g., MGH mission, values, position description, practice standards, etc.) which define competent practice. Establishing systems for assessing and affirming the competency of all providers is required of organizations accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), by the Conditions of Participation for hospitals that receive Medicare reimbursement, and increasingly by other third-party payors.

There are two common ways for an organization to fulfill this responsibility:
- Position description and performance appraisal
- Credentialing and privileging

We are all familiar with position descriptions and performance appraisals, but may be less so with privileging and credentialing. This process, which is traditionally associated with physician practice, increasingly is the trend for other healthcare providers because it is based on professional accountability for practice. Privileging and credentialing are two distinct but complementary activities. Credentialing is an administrative procedure to examine information about a practitioner’s education, certification, training, continuing education, and experience, as well as any malpractice claims or actions by the Board of Registration. Privileging is a process of granting authorization to provide specific patient-care treatments and procedures within defined limits based on the review of credentials.

It may be helpful to think of privileging and credentialing as separate procedures with overlapping interests as depicted in the diagram below. The “credentials” circle relates to the qualifications of the individual to practice in Massachusetts within the scope of practice for that individual’s profession. This continued...
is generic to the profession and open to anyone who is credentialed in that discipline. The “privileges” circle delineates those professional activities which a practitioner could perform under Commonwealth law, but which require specific internal authorization to perform in a particular work setting. In this way, privileging may restrict practice to certain individuals. The intersection of credentialing and privileging identifies the discipline-specific scope of practice as it exists for each discipline at MGH. Although credentials are distinct between professions, several professions may share some of the same privileges while others remain the domain of only one profession. Taken together, credentials and privileges define the potential scope of practice of each discipline, while individual credentials and privileges define the scope of practice for each practitioner.

Peer review is an important component of privileging. This process, which is currently being used in some departments and units, reinforces staff autonomy and accountability for their practice. Criteria related to current licensure, relevant training and/or experience, and current competence are determined by the staff of each discipline and are uniformly applied during the peer review process. Quality data related to patient outcomes is included when available. Through peer review staff have the opportunity as well as the responsibility to support each team member in improving both individual and organizational performance.

It is essential that we develop effective systems to assess staff competency and to assure that patient needs are carefully matched with provider skills. The concepts of privileging and credentialing engage the full circle of accountability to patients, peers, our professions, and the MGH. We all need to play an integral part in deciding the best methods for ensuring that our patients and their families receive excellent care from competent providers.

Introduction by Jeanette Ives Erickson:
Decision-making that empowers professionals involves collaboration with me and a concerted effort to improve communication. A key factor for success is the creation of a model that places the responsibility, authority, and accountability for delivering patient care clearly with clinicians. Our committee structure is the vehicle for incorporating our philosophy and values into our daily practice. This effort will require significant support from me and key leadership. Marianne Ditomassi, RN, has been appointed to facilitate the launching of this important work.

In addition to asking my administrative support to keep this effort moving forward, I have appointed a facilitator (or coach) to work with committees. Wherever possible, committees will be chaired by clinical staff and it will be the role of the coach to assist clinicians with behind-the-scenes work.

Collaborative decision-making
—by Marianne Ditomassi, RN
executive assistant

Collaborative decision-making is built on the premise of “team-ness” and team learning. As a team we refer to a collective “we,” meaning the network of important relationships between people who come together to develop and implement actions or strategies toward a desired outcome. The team is driven by a shared vision. Team-ness is based on trust and mutual respect for the talents and competencies each person brings to the process. A group or team that has achieved team-ness has matured to a point where they share collaborative and interdependent relationships. Members of such teams often describe a sense of “feeling like we’re making a difference.”

Team learning starts with “dialoguing,” including the ability of team members to suspend assumptions and enter into a genuine mode of “thinking together.” Team learning is vital because teams, not individuals, are continued...
the fundamental learning units of modern organizations.

In Patient Care Services, a clearly-defined decision-making structure creates an environment of collaborative governance. This structure recognizes and relies upon the knowledge, creativity, and talent of our clinical staff, and is a mechanism for translating our vision into reality. Committee charters clearly articulate the decision-making scope of each respective committee.

Collaborative governance is . . .

- A communication and decision-making model
- The placement of authority, responsibility, and accountability for patient care with the practicing clinician
- Achieved through belief in a shared vision
- Implemented through committees, councils, quality programs
- Based on the beliefs that knowledge with participation is empowering
- people make appropriate decisions with sufficient information
- personal and organizational congruency in goals leads to productivity and commitment
- individuals are accountable for their own practice

From The Business of Nursing, AONE Leadership Series, printed by the American Hospital Association, 1996.

The following pages contain a list of existing and soon-to-be launched committees which represent the structure of shared governance within Patient Care Services. Listings include the name, charges, meeting schedule, chairperson(s), and description of membership for each committee. Staff interested in becoming involved should discuss these opportunities with their managers or directors. Committee membership forms are available.

### Quality Committee

**Charges:**
- Review quality issues based on high-volume, high-risk, and problem-prone clinical activities.
- Identify strategies to improve quality.
- Review findings and recommend departmental actions.

**Meetings:** Bi-monthly

**Co-Chairpersons:** Staff nurse, Health Professions therapist

**Coach:** Jan Duffy, RN

**Membership:** Multi-disciplinary clinicians from nursing and therapy departments representing various levels and types of clinical practice. Primary requirement for membership is passion for quality.

### Professional Development Committee

**Charges:**
- Design a clinical advancement program for clinicians within Patient Care Services:
  - Define program objectives
  - Identify levels of performance for the clinician
  - Describe behaviors that define each level of performance
  - Establish advancement process
  - Develop implementation strategies
  - Identify criteria for program evaluation

**Meetings:** Bi-monthly

**Co-Chairpersons:** Staff nurse, Health Professions therapist

**Coach:** Carolyn Hayes, RN

**Membership:** Consists of staff nurses from nursing and therapy departments representing various levels and types of clinical expertise, nurse managers, an advanced practice nurse, and a representative from Human Resources.

### Ethics in Clinical Practice Committee

**Charges:**
- Design and implement activities/programs for the development and articulation of ethical aspects of care and judgements.
- Identify strategies to improve integration and articulation of ethical aspects of care and judgements in professional practice.
- Identify impediments to sound ethical practice and identify strategies to eliminate them.
- Provide consultation regarding policies, procedures, and/or programs with explicit ethical implications.
- Respond to ethical issues identified by other Patient Care Services Committees, patient care groups, and individual clinical staff.

**Meetings:** Monthly two-hour meetings

**Co-Chairpersons:** Staff nurse, Health Professions therapist

**Coach:** Carolyn Hayes, RN

**Membership:** Consists of nurses from each patient care center population, chaplain, social worker, physical therapist, occupational therapist, respiratory therapist, dietitian, physician, clinical nurse specialist, nurse manager, patient care representative, and the director of Diversity (or designee).

### Patient Education Committee

**Charges:**
- Develop strategies to assist staff in patient education activities.
- Develop process for inter-disciplinary education across the continuum.
- Recommend systems and technology to support the cataloging, dissemination, documentation, and evaluation of patient education activities and materials.
- Ensure activities and materials reflect diversity of the population served.

**Meetings:** Monthly

**Co-Chairpersons:** Staff nurse, Health Professions therapist

**Coach:** Laura Mylott, RN

**Membership:** Staff nurses, therapists, advanced practice nurses, nurse managers, librarian (for cataloging), and Information Systems support for database development. Focus groups of patients and families will be used to evaluate patient education materials as needed.

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**Work groups and role-group committees**

In addition to the committees listed on these pages, the following work groups and role-group committees participate in the shared-governance structure:

- **Work groups**
  - Patient Care Services Of Oversight Group
  - Management Systems Advisory Committee
  - Nursing Order-Entry Task Force

- **Role-group Committees**
  - Nursing Directors
  - Therapy Department Directors
  - Nurse managers
  - Advanced Practice Nurses
  - Clinical Nurse Supervisors
  - Operations Coordinators
Department of Nursing Practice Committee

Charges:
- Determine and communicate standards and directions for professional nursing practice at MGH.
- Consult and approve standards of practice including clinical care and documentation guidelines.
- Approve clinical product selections.
- Approve clinical practice recommendations (including integration of new patient care delivery model).
- Communicate committee outcomes throughout Patient Care Services and to others as appropriate.
- Communicate changes and additions to clinical pathways.

Meetings: Bi-monthly (Goal is monthly)
Chairperson: Staff nurse
Coach: Lori Clark, RN
Membership: Consists of clinical nurse supervisors, nurse managers, clinical nurses, advanced practice nurses, and case managers representing patient-care populations/specialties/community health/ambulatory care.

Nursing Research Committee

Charges:
- Foster spirit of inquiry into questions around clinical practice.
- Support and mentor the nurse in the research process from questions, design, implementation, analysis to dissemination.
- Interpret and report current research that supports clinical practice changes.
- Identify and target funding sources that support MGH nursing research activities.
- Communicate institutional research activities through a variety of forums (e.g., grand rounds, roving poster presentations).
- Review research proposals as they relate to policy and procedures and Institutional Review Board (IRB) requirements.

Meetings: Monthly (with ad-hoc assistance and support to nurses conducting research)
Chairperson: Staff nurse
Coach: TBA
Membership: Consists of clinical nurse specialists, doctoral-prepared MGH nurses and liaisons to provide various expertise as needed.

Patient Care Services Diversity Steering Committee

Charges:
- Develop operational strategic goals with action steps for implementation for Patient Care Services which will create opportunities to support a diverse workforce, address the issues presented in the development of that workforce so that we may better meet the needs of the department and the patients for whom we care.
- Support career-development in order to have a competitive advantage in the development/retention of a culturally diverse staff with the goal of internal promotion of staff.
- Increase interest in and access to MGH by culturally-diverse students/potential employees.
- Enhance visibility of MGH in community and create an exchange of expertise with communities in area to increase our contact with and knowledge of culturally-diverse groups.
- Design and deliver learning and development opportunities on cultural diversity and culturally-competent care.
- Develop patient-education materials that can be used by clinicians with a diverse patient population.

Meetings: Monthly (or bi-monthly depending on status of committee initiatives)
Chairperson: director of Diversity, Patient Care Services

Patient Care Services Executive Committee (PCSEC)

Charges:
- Consider and, on behalf of Patient Care Services, adopt policies and procedures relating to 1) patient care; 2) education for nursing and allied health professions; and 3) at the request of the senior vice president for Patient Care Services and chief nurse executive, other matters affecting the optimal operation of Patient Care Services.
- Act in an advisory capacity to the senior vice president for Patient Care Services and chief nurse executive on all matters affecting the optimal operations of Patient Care Services.
- Serve as a liaison between the Nursing and Allied Health Professions staff and the administration of the hospital.

Meetings: Monthly two-hour meetings
Chairperson: Senior vice president for Patient Care Services and chief nurse executive
Membership: Consists of associate chief for Nursing Practice, directors reporting to the senior vice president for Patient Care Services, representatives from Human Resources for Nursing and the Allied Health Professions, and the editor of Caring Headlines (non-voting member).

Patient Care Services Committee Leaders

Charges:
- Prepare business plans, project proposals, and operational plans for review if funding is needed, and ensure adequate resources are available for implementing recommendations.
- Provide updates and track status of committee work.
- Serve as network for ensuring committee’s efforts are complementary and aligned with department’s strategic direction.
- Function as reactor panel for the development of business plans and project proposals.
- Coordinate review and revision of committee charges, membership, and staff support.

Meetings: Ad-hoc
Chairperson: Executive assistant to senior vice president for Patient Care Services and chief nurse executive
Membership: Comprised of chairpersons of Patient Care Services collaborative governance committees.
Professional development

—by Carol Camooso, RN
staff specialist, Patient Care Services

Introduction by Jeanette Ives Erickson: Professional development includes empowerment through knowledge and reward/recognition-systems for acknowledging variations in practice. Professional development activities allow us to describe skill acquisition and provide us with an opportunity to create an environment for learning. We now have a structure, the Professional Development Committee, which will work diligently to define strategies that encourage and celebrate professional development, including activities to celebrate clinical expertise.

Carol Camooso, RN, was selected to write this column and to serve as a coach to the Professional Development committee because of her dedication and proven track record in resolving impediments to clinical practice and her passion for excellence.

Health professionals place a high value on continuing professional development; we view it as essential to our ability to provide quality care, to achieve personal and professional satisfaction, and to advance our careers. These activities include orientation, inservice training, formal and continuing education, and clinical advancement activities.

Of great interest within Patient Care Services are developmental and promotional opportunities which are currently being explored through the introduction of a clinical advancement program. Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care Services, has asked me to coordinate a committee to design such a program. This program will strive to reward and recognize practice and provide promotional opportunities which help keep the professional with the patient. In addition to a clinical advancement track, other organizations have introduced opportunities for development on administrative and research tracks as well. Though our focus at this time is advancement of clinical practice, the consideration of other tracks for professional development will continue to be explored.

The clinical advancement program will enhance already-existing professional development activities important to the organization such as orientation, inservice training, and continuing and formal education. Professional development begins with new-employee orientation, at which time employees are introduced to the MGH values and environment. At this time, orientation includes information on the Service MGH Program, the MGH philosophy and policies, and other technical and safety-oriented content. New-employee orientation will continue to evolve with our changing environment.

Once introduced to the system, continuing inservice training and educational programs are key to maintaining quality. As the pace of technological and scientific developments accelerates, one of our greatest challenges will be to maintain and advance our technical competence. We need to continually explore efficient, flexible methods to assist employees with enhancing their technical skills.

The quest to keep pace with the latest technological developments cannot overshadow other ongoing efforts to enhance professional development. These efforts include the sharing of narratives or exemplars, attendance at conferences or seminars, and formal educational advancement.

- **Narratives**—Within Patient Care Services, we recently introduced the use of narratives as a way to articulate clinical knowledge acquired over time. This technique helps us to “tap into” the “know-how” of expert clinicians as well as provide recognition and reward.

- **Professional conferences**—Attending professional conferences provides exposure to other health professionals and new ideas. One initiative recently implemented to promote this area is the creation of the Expertise in Clinical Practice Award which provides funding for conference and seminar attendance. A committee is working closely with Ives Erickson to continue to develop these approaches.

- **Formal education**—MGH continues to provide $1,500 per year in tuition reimbursement to those individuals who qualify. Managers provide flexibility in scheduling when possible to promote class attendance.

continued . . .
Technical excellence and a more complete understanding of the art and science of professional practice are, and will continue to be, critical as new models of patient-care delivery evolve. We are currently implementing a new patient-care delivery model with the support of a new Education Center. This center, which has various training sites, is preparing employees, through skill-building, to practice within the model.

As the healthcare environment evolves and changes, professional development activities will take on increasing importance in assuring that we provide quality care, attract and retain excellent practitioners, and promote professional satisfaction.

December 12, 1996

The Dreyfus Model of Skill Acquisition, which was first developed by Dreyfus and Dreyfus in 1980, is one way of looking at theory application. The model can be applied to the learning of any new skill; it suggests that those who master specific skills must pass through five levels of proficiency in the process: novice, advanced beginner, competent, proficient, and expert.

According to the Dreyfus Model, the novice is governed by rules and is unable to rely on previous experience to recognize relevant aspects within a situation. This person is like a new driver who starts and stops the car in a jerking fashion in an attempt to understand how much gas to give the car.

The learner in the next stage, advanced beginner, is still rule-focused, but has begun to rely on previous experience. This person will need guidelines in order to perform at an acceptable level.

Competent performers are more organized; they have a plan and have become more efficient.

Proficient performers are able to learn from previous experiences and can modify their responses in a given situation.

Experts, with their extensive experience and ability to see the significance and meaning within a contextual whole, are fluid and flexible in performing their skills. They are the chess player who develops a sixth sense for strategy, the athlete who develops a feel for the ball, the older child who rides as if his bicycle is an extension of himself, or the airline pilot who self-corrects during a difficult landing without having to think through each step of the process.

While Dreyfus applied this model to airline pilots and chess players, the model has also been applied by various nursing departments around the country to describe how care givers advance from novice to expert clinicians. As a department, we believe that knowledge is gained, not just through theory and principles, but also through the embodiment of those principles in daily practice. Through the use of narratives or exemplars, one begins the process of sharing positive clinical experiences with others. As expert practitioners write about their practice, their stories demonstrate both sound knowledge and a highly-developed sense of intuition. Experts “know” when a clinical situation is changing even when some common indicators may remain unchanged. Colleagues come to rely on these experts as teams of providers come together to provide care that is truly exemplary.

In Patient Care Services we are applying the Dreyfus Model to all clinical disciplines. Carmen Vega-Barachowitz, MS, CCC, supervisor, Speech-Language Pathology, sees a correlation between Dreyfus’ stages of development and the stages that practitioners in her department pass through. According to Vega-Barachowitz, the novice period is the clinical fellowship year following completion of the master’s program. Advanced beginners have completed their fellowships, but are still relatively new to the practice setting. Competency within many generalized areas is the natural progression. Because Speech-Language Pathology is such a broad discipline, proficiency and expertise tend to occur within specialized areas. For example, Tessa Goldsmith, MS, CCC, is an expert in adult swallowing disorders, while Susan Gray, MEd, MS, CCC, is consulted for her expertise in oral and written language disorders.

Robert Kacmarek, PhD, RRT, director, Respiratory Care, agrees that expert respiratory therapists pass through stages similar to those described by Dreyfus. Kacmarek observes that the usual time-frame for experts to fully develop is between four and five years, though some practitioners are able to advance more rapidly. According to Kacmarek, experts in his field have refined information-processing skills and highly-advanced decision-making capabilities that allow for rapid assimilation of information in making decisions about how to best manage a patient’s respiratory care. These experts tend to be more inquisitive in the early stages, and Kacmarek believes this inquisitiveness helps practitioners to integrate academic and professionally-based knowledge more quickly into their practice.

Vega-Barachowitz and Kacmarek’s comments support the idea that the Dreyfus model is applicable to other disciplines within Patient Care Services. By sharing clinical exemplars we have an opportunity to learn much about ourselves, about each other, and about our patients, as we describe the richness of our individual and collective practices. Let us continue to applaud each other’s accomplishments and grow into teams which are truly collaborative and exemplary.
Driven by a commitment to provide the highest quality care to our patients and their families, the elements of our model ‘interlock’ to ensure seamless, inter-disciplinary, knowledge-based care.
Articulating our professional practice model: a framework for knowledge-based practice

—by Jeanette Ives Erickson, RN, senior vice president for Patient Care

A little more than ten years ago, we published a special issue of Caring Headlines in which we articulated the elements of an emerging professional practice model. With a strong vision and unparalleled commitment to provide the highest quality care to our patients and families, today that professional practice model is a working reality. In the years since that special issue of Caring Headlines, significant contributions have been made to patients, families, our hospital, the communities we serve, and our respective professions because of an interdisciplinary practice that is supported by a strong vision, values, and guiding principles.

Health care has changed dramatically in the past ten years, and with it our professional practice environment. Advances in research and technology, new knowledge and understanding of disease processes, an increasingly diverse patient population, and fluctuating political climates have all contributed to a dynamic healthcare arena. Without a strong and durable professional practice model, it would be impossible to thrive during times of great change. But a strong and durable practice model is exactly what we have. We are responsible for advancing our mission, vision, values, and guiding principles no matter the prevailing climate. Our professional practice is marked by the contributions we make, the relationships we forge within a growing workforce, and our unwavering commitment to provide the highest quality care to our patients and families. It is through the strength of our professional practice model that we are poised to meet and exceed the expectations of those we serve.

This issue of Caring Headlines documents the progress we’ve made and benchmarks our leadership in the development of a blueprint for the delivery of exceptional, patient-centered care.

As healthcare professionals and support staff, we are driven by a commitment to our patients and families to employ a seamless, interdisciplinary, knowledge-based approach to our work. The challenge for any organization is to define the elements of a professional practice model in a way that brings significance to their daily work. At MGH, since all the elements of our model are inherently related,

continued on next page
we’ve chosen an interlocking puzzle to represent our model.

In order for a professional practice model to work, every clinician and support-staff member must be able to understand, embrace, and master the components described therein. Everyone must be willing to participate in the process, continuously learning and re-learning to keep pace with a constantly changing environment. It is a journey that must be taken together.

The importance of a professional practice model has been well known since the first Magnet Hospital Study in 1983 (McClure, Poulin, Sovie and Wandelt) that articulated the salient elements of professional practice as: autonomy, control over practice, and collaborative relationships with physicians. Our model builds on that foundation and incorporates additional research on organizational behavior, descriptive theory models, teamwork, and the importance of a narrative culture.

Through our own research and our annual Staff Perceptions of the Professional Practice Environment Survey, we understand the organizational concepts that support the activities that advance clinical practice. Our research also tells us which support structures are needed to enhance safety, effectiveness, efficiency, and timeliness of care.

We have found that one of the most effective strategies for aligning clinicians and support staff within Patient Care Services is the articulation of our vision, values, and guiding principles. For that reason, they comprise one of the most basic elements of our practice model. Allowing and enabling all members of the team to fully understand the organizational direction is key. When everyone on the team understands how individual and group efforts impact the whole, there is palpable strength and unity of purpose.

As you can see, the elements of our professional practice model include:

- Vision and Values
- Standards of Practice
- Narrative Culture
- Professional Development
- Clinical Recognition and Advancement
- Collaborative Decision-Making
- Research
- Innovation and Entrepreneurial Teamwork
- Patient-Centeredness

All the pieces of the puzzle surround and support our belief in the importance of patient-centeredness. Every element is critical to professional practice and the delivery of high-quality, knowledge-based care.

The model helps us:

- articulate the work of clinicians across settings and disciplines
- provide a framework to guide clinical practice, education, and research
- promote communication among and between disciplines
- provide a framework for strategic direction
- guide the allocation of resources
- establish a framework by which to evaluate practice

All the pieces of the puzzle surround and support our belief in the importance of patient-centeredness. Every element is critical to professional practice and the delivery of high-quality, knowledge-based care.
Our vision and values: 
the underlying principles that guide our work

Our vision

As nurses, health professionals, and PCS support staff, our every action is guided by knowledge, enabled by skill, and motivated by compassion. Patients are our primary focus, and the way we deliver care reflects that focus every day. We believe in creating a practice environment that has no barriers, is built on a spirit of inquiry, and reflects a culturally competent workforce supportive of the patient-centered values of this institution. It is through our professional practice model that we make our vision a demonstrable truth every day by letting our thoughts, decisions, and actions be guided by our values. As clinicians, we ensure that our practice is caring, innovative, scientific, and empowering, and is based on a foundation of leadership and entrepreneurial teamwork.

Our guiding principles

- We are ever-alert for opportunities to improve patient care; we provide care based on the latest research findings
- We recognize the importance of encouraging patients and families to participate in the decisions affecting their care
- We are most effective as a team; we continually strengthen our relationships with others and actively promote diversity within our staff
- We enhance patient care and the systems supporting that care as we work with others; we eagerly enter new partnerships with people inside and outside of MGH
- We never lose sight of the needs and expectations of our patients and their families as we make clinical decisions based on the most effective use of internal and external resources
- We view learning as a life-long process essential to the growth and development of clinicians striving to deliver quality patient care
- We acknowledge that maintaining the highest standards of patient care is a never-ending process that involves the patient, the family, all members of the healthcare team, and the community at large

Our values

Supporting our vision is a clearly-articulated set of values that drive our decision-making and find daily expression in our policies, practices, and norms of behavior. Our values combined with our vision provide both an affirmation of work that already exists and a foundation on which to bring about ideas not yet realized. Each of us makes decisions every day driven by personal and institutional values. The values we have chosen to be of primary importance to us as we move forward are: leadership, entrepreneurial teamwork, caring, innovation, and scientific practice.

In addition, as described in our vision statement, we value accountability, responsibility, diversity, resource-effectiveness, and our core value—patient-centered care. As our professional practice model continues to evolve, we will be guided by these values and by a shared belief in our vision for the future.
Standards of practice exist to ensure that patients receive the highest quality of care. They provide a detailed description of a particular practice or procedure, along with the scientific rationale supporting the practice.

Standards of practice provide a uniform structure by which to practice by spelling out precisely what to do in situations where providers may have no prior experience. By breaking activities down into basic elements and providing appropriate rules, standards of practice also act as a teaching tool. As a teaching tool, standards of practice establish a level of expectation about care-delivery within an organization.

Universal adherence to standards of practice provides an added measure of safety by extending clinical expertise to situations where actual experts may not be present. With approved standards of practice, clinicians can step into situations and perform with confidence even when more experienced providers are not there for guidance.

It’s important to understand that while serving the essential role of guiding novice practice, standards of practice also guide the behavior of more experienced professionals. Taken together, standards of practice represent an organization’s culture toward care-delivery.

Standards of practice are geared toward ‘typical’ situations, and aren’t intended to supersede the specific, individual needs of any patient. Healthcare professionals face many complex situations every day. Understanding the unique clinical needs of each patient and each situation, and appreciating that latitude in applying standards is imperative to providing effective, high-quality care. Strictly adhering to standards without trusting clinical judgment doesn’t always constitute best care. It’s up to the individual caregiver to recognize and interpret situations, to know what standards of practice apply in various situations and how to apply them. The ability to integrate clinical knowledge and standards of practice is the hallmark of an experienced professional.

With advances in research and technology, it’s important to re-visit standards of practice and adapt them to reflect the most up-to-date clinical knowledge of our learned and expert professionals.
The power of a narrative culture:
sharing knowledge through story-telling

—by Mary Ellin Smith, RN, professional development coordinator

Over the past ten years, clinical narratives have become part of the fabric of professional life within Patient Care Services. Narratives are part of the application process for the Clinical Recognition Program, for awards, and every year clinicians write narratives as an integral component of their annual performance review.

While story-telling has been part of tribal culture from time immemorial, Patricia Benner, RN, noted author and nurse researcher, first introduced clinical narratives as a way to share and reflect on clinical practice. Says Benner, “Narrative accounts of practice reveal the clinical reasoning and knowledge that come from experiential learning. Clinical narratives can become a resource to help practitioners understand their own practice, see and share the clinical knowledge of peers, and reveal strengths and impediments of practice.”

Narratives provide an opportunity for individuals to share stories that have meaning to them and at the same time describe their concerns, intuition, inner dialogues, evolving understanding, feelings of doubt, challenge, and conflict. Narratives reveal what excellent, good, and not-so-good practice look like. Narratives allow clinicians to reflect on past experiences, clarify meaning, gain new insights, discover cues that weren’t known before, and make connections between phenomena that may have been invisible in the moment. Narratives are a vehicle for reflection that can help clinicians see their practice differently.

While putting pen to paper allows clinicians to ‘see’ their practice in a different light, it is also a springboard for dialoguing with colleagues and clinical experts. Through the very important process of dialoguing, clinicians are asked questions that prompt them to probe deeper into their thinking and motivation. They might ask themselves: What were my concerns about this patient in this situation? How was this situation similar to situations I’ve experienced in the past? How was it different? What did I learn? These questions allow clinicians to enter into the clinical situation from a different perspective, to see it in a different way, and perhaps identify different interventions and strategies.

Clinical narratives can be difficult to read when they don’t describe what we consider to be ‘perfect practice.’ But those are the narratives we need to write and read and talk about, because they describe the realities of care and the environment in which care is being provided. We need to be open to all stories and the dialogue that follows in order to create and sustain the highest quality of care.
Clinical recognition and advancement

—by Mary Ellin Smith, RN; Michael Sullivan, PT; and Carmen Vega-Barachowitz, SLP

In 1996, the newly formed Professional Development Committee, comprised of staff from six disciplines within Patient Care Services, was charged with creating a recognition program. At first, there was concern that individual disciplines would lose their identity, but ten years later the voices of all six disciplines are strong, and our recognition program has given us a common language, a deeper understanding, and a genuine respect for each discipline’s unique contributions to the care of patients.

The Clinical Recognition Program took shape as committee members reviewed narratives written by clinicians in the six disciplines and identified themes and criteria applicable to all disciplines. Themes such as clinician-patient relationships; clinical decision-making; and teamwork and collaboration emerged. In their narratives, clinicians spoke of advocacy, clinical risk-taking, and influencing clinical practice. These themes helped establish a set of professional behaviors and attributes that act as developmental milestones.

The theoretical foundation of the Clinical Recognition Program is the Dreyfus Model of Skill Acquisition. Developed by Stuart and Hubert Dreyfus, the model describes how, in the acquisition and development of a particular skill, individuals pass through five stages: novice, advanced beginner, competent, proficient, and expert. The word ‘stage’ is crucial as it relates to our recognition program because it reinforces the idea that clinicians must master each stage or level of development before progressing to the next. You can never practice beyond your experience. Progression through the stages is characterized by:

- movement from reliance on rules to the use of past experience
- perceiving situations as made up of equally relevant parts, to perceiving them as complete, or whole, in which only certain parts are relevant
- movement from being a detached observer to one who acts and influences the situation

Clinical behaviors articulated by the different disciplines represent the milestones to be achieved as clinicians acquire new skills and behaviors. In their entirety, these milestones reflect a trajectory of clinical development showing the evolution of skills and behaviors across the themes of practice. These characteristics serve as a tool to spur clinical reflection and guide mentors as they facilitate the development of clinical practice.

Central to the Clinical Recognition Program is the reflective process, which allows individuals to incorporate the theoretical with the practical, shaping clinical practice over time. This process helps individuals... continued on page 16
The Center for Innovations in Care Delivery is the newest of the four centers comprising Patient Care Services’ Institute for Patient Care. The mission of The Center for Innovations in Care Delivery is to match inter-disciplinary education and research with opportunities to impact care. The intent is to bring teams together to identify opportunities, estimate the impact of change (such as workforce demographics, new technologies, or regulatory changes) and implement meaningful innovations.

Currently, the center is staffed by Ed Coakley, RN, director emeritus, and Barbara Blakeney, RN, innovations specialist. As we move forward, we will introduce a new role to the center: that of site miner. A site miner is an experienced clinician who networks with other clinicians to identify unexplored opportunities to solve problems, enhance professional practice, improve care, and promote patient- and staff-safety.

We will look for site miners who:
- have a proven ability to think outside the box
- have strong communication skills
- embrace change
- are familiar with the complex environment of an academic medical center
- are skilled at developing effective interdisciplinary relationships and alliances
- are comfortable when faced with uncertainty or ambiguity

The inaugural event of the center was a day-long retreat that brought 130 leaders within Patient Care Services together to think, brainstorm, and set in motion the future work of the center. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, set the tone, quoting Sir Leuan Maddoc: “To cherish traditions, old buildings, ancient culture, and graceful lifestyles is a worthy thing; but in a world of technology, to cling to outmoded methods of manufacture, old product lines, old markets, or old attitudes among management and workers is a prescription for suicide.”

Said Ives Erickson, “We need to innovate; to make sure the delivery of patient care and the structures that support it change to meet the changing populations we serve.”

The day was built around six basic assumptions:
- Our employees are our biggest asset
- It takes great leaders
- Imagination is necessary and fun
- Collaborative decision-making is a core value
- A professional practice environment is the foundation on which we will build our future
- Patient-focused care is key

Attendees grappled with questions about beliefs, values, and traditions; what the ideal environment is for innovation; what changes need to occur for us to succeed; and how best to capture insights at the bedside.

The retreat was a coming-together of minds to lay the foundation for important, ground-breaking work around innovations in patient care.
A commitment to life-long professional development

—by Carol Camooso Markus, RN, staff specialist

Clinicians place a high value on professional development. It is essential to our ability to provide quality care, achieve personal and professional satisfaction, and advance our careers. Professional-development activities can include anything from orientation, to inservice training, to formal and continuing education, and clinical advancement opportunities.

Patient Care Services’ Clinical Recognition Program enhances existing professional-development activities, beginning with new-employee orientation where employees are first introduced to the MGH mission, vision, and values. Orientation includes information about the Service MGH Program, our philosophy and policies, important quality and safety information, and an introduction to our diversity program and culturally competent care curriculum. New-employee orientation is constantly evolving to meet the needs of our changing environment.

Ongoing inservice training and educational programs are the mainstay of professional development at MGH. As science and technology advance, one of our greatest challenges is advancing and sustaining our own technical competence. We continually explore efficient, flexible methods to help employees stay current and proficient in their technical skills.

But professional development is not just about technology. Our efforts to support a highly skilled, knowledgeable, and satisfied workforce are multifaceted:

- **Clinical narratives**—Within Patient Care Services, we use clinical narratives as a way to articulate and share clinical knowledge and experience acquired over time. This sharing of stories enables us to tap into the thought processes and best practices of expert clinicians and recognize their contributions to patient care and the organization.

- **Professional conferences**—Attending professional conferences provides exposure to new ideas and best practices outside the institution. Funding is made available to support attendance at professional conferences and seminars.

- **Formal education**—MGH continues to provide financial support in the form of tuition reimbursement to individuals who qualify for our tuition-reimbursement program. Managers provide flexibility in scheduling when possible to support attendance at academic programs.

Technical excellence and an over-arching understanding of the art and science of professional practice are critical elements of our professional practice model. The Institute for Patient Care (which encompasses The Norman Knight Nursing Center for Clinical & Professional Development; The Yvonne L. Munn Center for Nursing Research; The Center for Innovations in Care Delivery; and The Maxwell & Eleanor Blum Patient and Family Learning Center) offers extensive programs and resources to ensure our ability to provide quality care, attract and retain the best practitioners, and support our commitment to life-long professional development.
Within Patient Care Services, a clearly defined decision-making structure exists to help translate our vision and values into reality. This collaborative governance structure brings together clinicians and support staff from all disciplines, recognizing and relying on their knowledge, talent, and creativity. The scope of each committee is clearly articulated in its charter.

The following committees comprise the collaborative governance structure:

- **Professional Development Committee**
  The Professional Development Committee, worked for five years (1997–2002) to launch the Clinical Recognition Program. The committee analyzed clinical narratives from which they derived three themes of practice: clinician-patient relationship; clinical knowledge and decision-making; and teamwork and collaboration. For physical and occupational therapy, a fourth theme, movement, was identified. From this work, the committee defined four levels of clinical practice: entry-level clinician; clinician; advanced clinician; and clinical scholar. As of April, 2007, the Clinical Recognition Program boasts 145 advanced clinicians, and 62 clinical scholars.

- **Staff Nurse Advisory Committee**
  - Provide a forum for dialogue between the chief nurse executive, associate chief nurses, and staff nurses on matters affecting care delivery, clinical development, and quality of work life within the department of Nursing

- **Quality Committee**
  - Review quality issues based on high-volume, high-risk, and problem-prone clinical activities
  - Identify strategies to improve quality
  - Provide increased communication and awareness of systems-improvements
  - Provide an arena to evaluate and promote quality initiatives not specifically initiated by this committee
  - Review findings and recommend departmental actions

- **Ethics in Clinical Practice Committee**
  - Design and implement programs to support the education of staff in the area of healthcare ethics
  - Educate committee members in the area of healthcare ethics
  - Identify and address ethical issues and conflicts faced by clinicians within Patient Care Services
  - Identify impediments to sound ethical practice and identify strategies to eliminate them
  - Provide consultation to the organization regarding policies, procedures, and programs with ethical implications
  - Expand the impact of the committee through collaboration with other collaborative governance committees, links with organizational initiatives, and attendance at professional conferences

- **Nursing Research Committee**
  - Foster a spirit of inquiry around clinical practice
  - Promote awareness of nursing research activities
  - Interpret and report current research that supports clinical practice changes
  - Encourage and provide support for research-based practice
Patient Education Committee
- Develop strategies to assist healthcare providers in patient-education design and implementation
- Encourage joint projects between other collaborative governance committees
- Disseminate patient-education information to the larger MGH community
- Collaborate with The Institute for Patient Care to develop patient-education programs to benefit PCS staff
- Participate in JCAHO task force to promote interdisciplinary education tools
- Recommend systems and technology to support the cataloging, dissemination, documentation, and evaluation of patient-education activities and materials
- Ensure activities and materials reflect diversity of the populations served

Nursing Practice Committee
- Consult and approve standards of practice including clinical care and documentation guidelines
- Approve clinical practice recommendations
- Determine and communicate standards for professional nursing practice at MGH
- Communicate committee outcomes throughout Patient Care Services and to others as appropriate
- Communicate changes and additions to clinical pathways
- Approve the selection of clinical products

Diversity Steering Committee
- Develop strategic goals and action steps to support and develop a diverse workforce so we can better meet the needs of staff and the patients we serve
- Support career-development in order to recruit and retain a culturally diverse staff with the goal of internal promotion
- Enhance visibility of MGH in the community and create an exchange of expertise with communities to increase our contact with and knowledge of culturally-diverse groups
- Increase interest in and access to MGH by culturally diverse students and potential employees
- Design and deliver learning opportunities on cultural diversity and culturally competent care
- Develop patient-education materials that can be used by clinicians with diverse patient populations

Collaborative Governance Leaders Committee
- Prepare business plans, project proposals, and operational plans for review if funding is needed, and ensure adequate resources are available for implementing recommendations
- Provide updates and track status of committee work
- Serve as network for ensuring committees’ efforts are complementary and aligned with the department’s strategic direction
- Function as reactor panel for the development of business plans and project proposals
- Coordinate, review, and revise committee charges, membership, and staff support

Patient Care Services Executive Committee
- Consider and adopt policies and procedures related to patient care; education of nurses and allied health professionals; and address other matters affecting the optimal operation of Patient Care Services
- Act in an advisory capacity to the senior vice president for Patient Care on all matters affecting the optimal operations of Patient Care Services
- Serve as a liaison between Nursing, allied health professions, and hospital administration

This collaborative governance structure brings together clinicians and support staff from all disciplines, recognizing and relying on their knowledge, talent, and creativity.
Research
fostering a spirit of inquiry in the delivery
of patient care
—by Dorothy Jones, RN, and Robert Kacmarek, RRT

Our practice is based on knowledge, experience, tradition, intuition, and research. We believe that evidence-based practice requires a setting that promotes the acquisition and application of knowledge, provides access to new scientific knowledge, and fosters the ability of clinicians to use knowledge to impact patient outcomes. Research is an essential component of our professional practice model and the mission of MGH.

In 2003, MGH was designated the first Magnet hospital in Massachusetts. This is the highest honor bestowed on a hospital for excellence in patient care. A major factor in receiving that recognition was the journey we took to create an environment that embraces evidence-based practice, including the work of the PCS Nursing Research Committee, the opening of the Yvonne L. Munn Center for Nursing Research, and increased funding for scientists within Patient Care Services. Earlier this year, The Center for Innovations in Care Delivery, the newest component of our Institute for Patient Care, was launched to bring clinicians from all disciplines together to think, innovate, and research new ways to enhance patient care. The goal of our research program is to generate new knowledge, help clinicians incorporate scientific findings into practice, and foster a spirit of inquiry.

Research is the bridge that translates academic knowledge and theory into clinical practice. Research dictates that evidence is a necessary prerequisite for the establishment of clinical practice. The challenge is to generate knowledge that is both scientifically vigorous and clinically relevant. The goal of clinical researchers is to identify a major phenomenon of unique concern to their discipline and develop a substantial body of information related to that clinical phenomenon.

Translating questions generated at the bedside into formal scientific hypotheses is a part of the continuum of professional development. Research must be an integral part of clinical practice as healthcare professionals advance from novice to expert. This research defines a systematic body of knowledge that guides professional clinical practice.

Healthcare professionals must weave knowledge derived from research into clinical practice. Application of research findings to clinical practice is critical to the improvement of patient outcomes. Countless opportunities are available to clinicians in all disciplines to study the efficacy, quality, and cost-effectiveness of clinical practice.

Thanks to a generous gift from Yvonne Munn, we are able to advance our research agenda. In developing programs for the Munn Center, one of our guiding principles is to provide opportunities for nurses to participate in research at all levels of practice.

Building on our values and guiding principles, we are committed to:

continued on next page
creating a practice environment that fosters a spirit of inquiry
developing new knowledge and testing that knowledge within the clinical practice environment
translating knowledge into practice to impact patient-care outcomes and the overall patient-care experience
generating and using evidence to inform practice and improve outcomes

We have developed a formal program of nursing research that offers opportunities for nurses prepared at all educational levels (non-master’s and non-doctorally prepared nurses; master’s prepared nurses; doctoral students; and doctorally prepared nurses). Some of the opportunities available for non-doctorally prepared nurses include:

- participating in the Nursing Research Committee
- participating in the Nursing Research Journal Club
- identifying and developing ideas for research studies
- securing research funding through the Munn Nursing Research Awards
- attending and/or presenting at grand rounds

We have formalized a Nurse Scientist Advancement Model for doctorally prepared nurses that delineates three levels of nursing research: associate nurse scientist; nurse scientist; and senior nurse scientist. Our goal is to give all nurses an opportunity to contribute to the development of nursing knowledge. This is a highly adaptable program that can be tailored to meet the needs of every clinician or researcher. We will be funding new nurse researcher positions for seasoned researchers who have an established record of funded research in an area of nursing inquiry.

This is a revolutionary program in the healthcare arena and a milestone in the evolution of The Yvonne L. Munn Center for Nursing Research.

We will continue to look for opportunities to engage in scientific inquiry. We will continue to advance our research agenda to improve patient care. And we will continue to ask ‘Why’ and persevere in our search for answers.

The Institute for Patient Care and The Yvonne L. Munn Center for Nursing Research are still in their infancy. As we move forward, we will actively seek to align our work in research, education, and patient care to ensure our ongoing legacy of excellence and innovation.

We will continue to look for opportunities to engage in scientific inquiry. We will continue to advance our research agenda to improve patient care. And we will continue to ask ‘Why’ and persevere in our search for answers. The possibilities are endless. We’re only limited by the ideas we have and the questions we ask.
The ability to efficiently and effectively care for patients and families requires the support of a vast array of resources, programs, and processes. At MGH, our professional practice model embraces the six pillars of Quality and Safety described by the Institute of Medicine:

- **Safety**: we will work to ensure no needless death, injury, or suffering of patients or staff
- **Effectiveness**: our care will be based on the best science, informed by patient values and preferences
- **Patient-Centeredness**: all care will honor the individual patient, respecting patients’ choices, culture, social context, and specific needs
- **Timeliness**: we will waste no one’s time and will create systems to eliminate unnecessary waiting
- **Efficiency**: we will remove all unnecessary processes or steps in a process; we will streamline all activities
- **Equity**: our work will ensure equal access to all

Several important resources are critical to the support of our patient-care delivery model:

- Implementation of CBEDS capacity-management system
- Upgrading of inpatient beds and furniture
- Implementation of new ‘smart-pump’ technology
- Implementation of the Lean Equipment Management System
- Implementation of new nurse call system and wireless phones
- Relocating of offices and personnel to accommodate patient-care needs

Other initiatives, while not directly linked to the patient-care delivery model, have significant impact on patient care. They include:

- An electronic medication-administration system
- An electronic medical record to promote more effective documentation and communication and provide simultaneous data-entry capabilities

The process of systems-improvement never ends. There are always opportunities to examine, question, and re-design the systems that support our work.

The Norman Knight Nursing Center for Clinical & Professional Development:

Through innovation in research, practice, and education, and in partnership with other groups and disciplines, the mission of The Norman Knight Nursing Center for Clinical & Professional Development is to create a professional environment that supports nurses and other members of the healthcare team in providing high-quality, safe, cost-effective care.

The number of staff served by The Knight Nursing Center grows every year. In 2006, more than 480 hours of continuing education were recorded by the center. More than 400 operations associates, patient care associates, and unit service associates participated in continuing education programs. Relationships have been established with 28 academic institutions, and more than 1,200 nursing students annually have been placed on units either individually or in group preceptorships with MGH nurses.

The future of The Knight Nursing Center is bright. Having recently moved into new space in the Founders Building, the center now has centralized classrooms and a state-of-the-art simulation lab. Future programs will make use of the simulated learning environment and long-distance learning opportunities. Collaborative partnerships within and outside the walls of MGH will remain a cornerstone of The Norman Knight Nursing Center for Clinical & Professional Development.
The Maxwell & Eleanor Blum Patient and Family Learning Center

The Maxwell & Eleanor Blum Patient and Family Learning Center is a patient-education resource, providing health information and services to a diverse community of patients, families, and staff.

Since opening in 1999, the Blum Center has assisted thousands of patrons to understand more about health and illness, make informed treatment choices and healthcare decisions, and improve communication with healthcare providers.

The Blum Center’s services include:
- conducting information searches on any healthcare topic
- sending educational materials to patients at home and on patient care units
- providing information in languages other than English
- maintaining a reference library with more than 500 titles
- managing the patient-education television channel that includes more than 200 videos (available on-demand)
- providing journals and pamphlets on a variety of health topics
- maintaining a website
- copying and faxing services
- providing computer workstations, including a special computer outfitted with assistive-technology software and a Braille printer

The Blum Center provides consultative services to clinicians and staff, and sponsors internships for the University of Massachusetts, Lowell, Health Education degree program, the Boston University Rehabilitation Counseling degree program, the Massachusetts Commission for the Blind, and the MGH-Timilty SummerWorks student partnership programs.

The Blum Center is a valued resource for patients, families, and staff. The Blum Center is open Monday–Friday, 9:30am–6:30pm; Saturday, 11:00am–3:00pm; closed Sundays and all major holidays. To contact the Blum Center, call 4-7352.

Quality & Safety

The Patient Care Services Quality Program has four primary functions:
- to analyze critical events and identify opportunities for improvement
- to improve systems affecting the delivery of care
- to monitor important processes and outcomes
- to ensure compliance with licensing and regulatory requirements

An on-line safety reporting system ensures timely responses, follow-up, and analysis of events. Weekly Quality & Safety rounds offer a chance for staff to express concerns, and a new database allows reports to be disseminated to hospital leadership identifying trends that emerge during rounds.

The PCS Quality Program provides leadership and support in addressing all issues related to quality and safety. It fosters a culture where staff feel compelled to protect patients and families by actively engaging in systems-improvement and prevention processes.

The Office of Patient Advocacy

The Office of Patient Advocacy is designed to help patients, families, visitors, and staff address concerns before they become problems. The Office of Patient Advocacy operates on the basis that:
- patients have the right to control their healthcare decisions
- a patient’s dignity should not be compromised
- caring and compassion are as important as technology
- involvement of family and friends is vital to patients’ well-being
- education, information, and communication are vital components of informed decision-making
- values and ethics are the foundation of our professional practice
- collaboration with other healthcare providers is critical to success

Patient advocates respond to reports by:
- acknowledging the issue
- replying promptly
- apologizing for the experience (if appropriate)
- determining the anticipated resolution
- conducting an investigation
- informing the patient of the results of the investigation

The Office of Patient Advocacy is staffed by four patient advocates and a patient advocacy coordinator, 8:30am–5:00pm, Monday–Friday. The office is located in the Wang Lobby, Room 018, and can be reached by calling 6-3370.
understand their experiences and integrate information in a meaningful way. Clinical practice requires reflection. When we hear the word practice, we may think of the repetitive activity by which an individual tries to achieve proficiency. Clinical practice, however, goes beyond repeating a task to improve accuracy and proficiency. According to Patricia Benner, RN, nurse researcher, experience does not mean a mere passage of time or longevity. Understanding is altered through practical encounters that add shades of nuance to theories. While theories may guide clinicians and enable them to ask useful questions, reflection and mentorship allow clinicians to find meaning in experience. Through these processes individuals learn to see patterns as they think about what has happened, what they could have done differently, and what they might replicate next time.

Though the intent of documenting and describing clinical behaviors was to enable us to describe distinct levels of practice, as the Clinical Recognition Program has evolved and our understanding of reflective practice has grown, we now see additional applications for this work. Reflective practitioners committed to lifelong learning enable us to advance and sustain excellence in patient care. The Clinical Recognition Program promotes a culture of patient-centeredness and supports an environment that nurtures excellence in clinical care.

The Clinical Recognition Program promotes a culture of patient-centeredness and supports an environment that nurtures excellence in clinical care.
Our Most Important Value is Patient Centered Care. We believe that care delivery is driven by Compassion—As clinicians and support staff we demonstrate empathy for the patient’s well-being, we utilize our expertise to alleviate suffering and to address patient and family needs.

- **High Quality Care**
  - Designed with patient at the center
  - Provided through seamless healthcare

- **Comprehensive**
  - Clinical and non clinical care
  - Designed through the eyes, ears, thoughts and emotions of a patient
  - Provided consistently and without redundancy

- **Accessible**
  - Physically convenient
  - Responsive
  - Flexible to patients’ needs

- **Supportive**
  - Reduces anxiety for patients and their families
  - Includes all appropriate staff

- **Personalized**
  - Responsive to individual concerns
  - Private
  - Patient friendly

**Relationship Based Care:**

- Knowing the patient
- Coordination of care
- Consistency of teams
- Building plan of care around the patient
- Clinical support aligned around patient populations rather than transactions
- Learn lessons from the past
- Consistency=Continuity=Coordination=Efficiency/Quality
Our Pillars: Six Aims of Quality Improvement
- Patient-Centered
- Safe
- Efficient
- Effective
- Timely
- Equitable

Empirical Outcomes
- Clinical
- Satisfaction
- Environment
- Workforce

Relationship-Based Care
- Community
- Team
- Self
- Patient-Family

Sources:
- Institute of Medicine
- Donabedian
- Koloroutis + Colleagues
- Barrett

The MGH Patient Care Delivery Model