



Patient Care Services, Quality and Safety



Being Ready for Every Patient Every Day

*2012 Regulatory Readiness
Resource Guide*

Excellence Every Day

At Massachusetts General Hospital, Excellence Every Day means striving to provide the best possible care to every patient and family in every moment of every day. It is our philosophy and our commitment. Our efforts to achieve Excellence Every Day include validation by external regulatory agencies in the form of on-site surveys and through our designation as a Magnet hospital. We are all focused upon meeting the needs of patients and creating systems that support the highest level of quality and safety.

During 2012, Massachusetts General Hospital is scheduled to have two surveys by regulatory agencies: ***The Department of Public Health Infection Control Survey***, and ***The Joint Commission Hospital Survey***. Provided our Magnet evidence is approved in late 2012, we anticipate there will be a site visit in 2013 by Magnet appraisers as part of our journey toward redesignation as a Magnet hospital.

Based upon your feedback about the most helpful process for preparing to host regulators, this Resource Guide has been developed for your learning. We hope that it supports your commitment to Excellence Every Day for all our patients and families, those already here and those still to come.

This first section of the resource guide is designed to help you feel ready for the regulatory surveys. For more information about the Magnet Redesignation, close the guide, flip it over, and you'll find what you are looking for!

2012 Joint Commission National Patient Safety Goals

Goal 1: Improve the accuracy of patient identification.

- Use at least two patient identifiers when providing care, treatment and services.
- Eliminate transfusion errors related to patient misidentification.

Goal 2: Improve the effectiveness of communication among caregivers.

- Report critical results of tests and diagnostic procedures on a timely basis.

Goal 3: Improve the safety of using medications.

- Label all medications, medication containers, or other solutions on and off the sterile field in perioperative and other procedural settings.
- Reduce the likelihood of patient harm associated with use of anticoagulant therapy.
- Maintain and communicate accurate patient medication information.

Goal 7: Reduce the risk of health care associated infections.

- Implement evidence-based practices **to prevent**
 - Health care associated infections due to multiple drug-resistant organisms in acute care hospitals
 - Central line-associated bloodstream infections
 - Surgical site infections
 - Indwelling catheter-associated urinary tract infections

Goal 15: The organization identifies safety risks inherent in its patient population

- Identify individuals at risk for suicide.

Universal Protocol

- Conduct a pre-procedure verification process
- Mark the procedure site
- Perform time out

Massachusetts General Hospital Performance Improvement Projects for 2012

- Medication reconciliation: Maintaining and communicating accurate information about a patient's medications
- Universal protocol: Ensuring the correct patient, correct procedure, and correct site for all invasive procedures
- Reducing healthcare associated infections through excellent hand hygiene and use of personal protective equipment
- Care Redesign and Innovation Units: Achieving improved efficiencies and effectiveness by rethinking the processes of care delivery

Regulatory Surveys

When will the regulatory surveys occur?

Regulatory surveys are unannounced; however, there are windows of time within which the surveys will likely occur:

- Department of Public Health (DPH) Infection Control Survey: anytime during **2012**
- Joint Commission (JC) Hospital Survey: Now through August 31, 2012

Department of Public Health Infection Control Survey

What will the DPH Infection Control Survey be like? This survey, which DPH initiated in 2010, is specific to infection control and prevention. Two surveyors will be at MGH for 5 or more days. The surveyors will be accompanied by a staff member from the Infection Control Unit. They will visit as many practice sites as possible; they will especially focus on high-risk areas such as procedural sites, ICU's, emergency department, and dialysis. Surveyors will assess our compliance with infection control standards by observing practice, inspecting the environment, reviewing records and documentation, and interviewing staff.

What will the DPH surveyor look at?

- Food and drink limited to designated areas only
- Hand hygiene and Standard Precautions
- Transmission-based precautions (Contact, Contact Plus, Airborne Droplet etc.)
- Aseptic technique
- Precaution gowns tied minimally at the neck.
- Gloves pulled over cuff of gown
- Gloves and gowns removed before leaving the room
- Needle boxes present and not overfilled
- Equipment cleaned and disinfected between patients with hospital-approved disinfectant
- Clean equipment identified and properly stored

What will the DPH surveyor look at? (continued)

- High-touch surfaces in patient rooms cleaned daily
- Checklist completed during central venous and pulmonary artery catheter insertion
- Patient and family education documented (e.g. hand hygiene, prevention of surgical site and central line infections, isolation precautions)
- Refrigerator temperatures checked and documented
- No expired supplies, no external shipping boxes; no supplies on floor, windowsill or underneath sinks
- Clean supplies/linen on covered cart or in cabinet/container or clean supply room
- Clean and soiled utility rooms doors closed
- Sterile water and sterile saline labeled when opened and replaced every 24 hours

What types of questions will the Infection Control surveyor ask?

Health Care Associated Infections

Q *What are the most common ways you prevent transmission of infections from one patient to the next?*

A Hand hygiene before and after contact with the patient and the patient's environment (**NPSG**) *and* early identification of patients requiring isolation and timely placement on appropriate precautions.

Q *How do you know if one of your patients has MRSA, VRE, C-difficile or an MDRO? (NPSG)*

A There are several ways that I find out:

- I review laboratory reports; Infection Control or Microbiology laboratory notifies the nursing unit; physicians also inform us.
- Patients identified at MGH by Infection Control are "flagged" in CAS with a red "P" in the corner of the screen. Caregivers can click on the "P" and it opens a window with information on the organism and precautions required.
- When patients are transferred from another hospital, I read the history.

Q *What precautions do you use for patients with MRSA or VRE? (NPSG)*

A Patients with **known or suspected** MRSA or VRE are placed on **Contact Precautions**.

- They're placed in a private room or a semi-private room with another patient infected or colonized with MRSA or VRE.
- Gloves are worn on entry into the room; gowns are worn when there is contact with the patient, surfaces, and equipment.
- Equipment is dedicated to the patient if possible. If equipment is shared it is cleaned and disinfected with hospital-approved disinfectant (Virex or Super Sani Cloth)

Q *What precautions do you use with patients who have C-diff? (NPSG)*

A Patients with **known or suspected** C. diff are placed on Contact Precautions **PLUS**. This is similar to contact precautions with two primary differences. After contact with the patients, hands must be washed with soap and water first then disinfected with Cal Stat. Patient rooms and equipment are cleaned daily with bleach-based disinfectant.

Q *Describe the procedure for donning precaution gown and gloves.*

A Perform hand hygiene, place the gown over the shoulders, tie the neck strings so that the gown overlaps, then tie the waist strings so that the gown ends overlap, put on the gloves, pulling them up to cover the cuffs of the gown.

Q *If a patient on precautions is leaving the unit to go to x-ray, how does the transporter know the patient is on precautions? How does radiology know? (NPSG)*

A The transporter is informed by the sign on the door or by talking with the nurse. The nurse also writes the type of precautions on the "Sticker to Ride" which is placed on the front of the patient record.

Q *What training have you received regarding infection control and what does it include? (NPSG)*

A I've received training about general infection control practices such as hand hygiene, blood borne pathogens and tuberculosis guidelines; and other MGH practices to prevent healthcare-associated infections such as MRSA, VRE, C-diff, central-line associated blood stream infections and surgical site infections.

Q *When did you receive this training? (NPSG)*

A During orientation; it is repeated each year as part of required annual training.

Q *Describe the steps that are taken to prevent infection when inserting a central line. (NPSG)*

A We do the following:

- Perform hand hygiene prior to catheter insertion
- A qualified individual monitors the insertion for breaks in sterile technique and completes the Central Line Infection Prevention Checklist.
- Use a standardized kit and protocol
- Educate patients and families about prevention of infection .

Q *Describes steps that are taken to prevent surgical site infections. (NPSG)*

- A**
- Use aseptic technique during invasive procedures; this includes use of sterile equipment, skin preparation, and managing the environment.
 - Use aseptic technique during dressing changes and closely monitor wounds
 - Educate patients and families about ways to prevent surgical site infections.

Q *Describe a few ways you prevent urinary tract infections.*

A We limit the use of urinary catheters and remove them as soon as possible. We insert using sterile technique and equipment, clean the catheter per procedure, do not disconnect the catheter from the drainage tube unless necessary to irrigate; avoid irrigations, obtain specimens through the specimen port; avoid kinking of the tube, keep the urine bag lower than the bladder and off the floor.

Q *How do you prevent hospital acquired pneumonia?*

A We decrease or prevent aspiration, use hand hygiene and other appropriate measures to prevent cross-contamination. We also ensure that that respiratory equipment is appropriately cleaned. We administer vaccines against influenza, pneumococcal pneumonia. We also educate patients and families about infection control.

- Q** *What do you do if a patient is suspected of having TB?*
- A** The patient is placed on airborne precautions. They're placed in a private room with negative air pressure; the negative air pressure is checked everyday either by looking at the pressure gauge or performing the tissue test.
- Q** *What other precautions do you take when caring for patients on airborne precautions?*
- A** I wear an N-95 respirator when in the room. The respirator has been sized and fitted for me.
- Q** *When must you wash your hands with soap and water?*
- A** When hands are visibly soiled, after using the toilet and before eating. Hands must also be washed with soap and water after caring for a patient on precautions for *C. diff*.
- Q** *When are gloves worn?*
- A** Clean, non-sterile, gloves must be worn when touching blood, body fluids, secretions, excretions, mucous membranes, and contaminated medical equipment.
- Q** *Where are infection control policies located?*
- A** In the Infection Control Manual which is on the MGH Policy and Procedure intranet site (Trove).
- Q** *What is your policy regarding employees and volunteers who have symptoms of, or have been exposed to, infectious disease/illness?*
- A** It is mandatory for employees and volunteers to contact Occupational Health Service if they have: Skin lesions and/or rash, especially if lesions are weeping or fever is present; non-intact skin or dermatitis; conjunctivitis or "pink eye"; diarrheal illness; cough of more than two weeks (unless explained by a non-infectious disease); new onset of jaundice; exposure to chickenpox, TB or other contagious condition; diagnosis of a communicable disease by the employee's primary care provider e.g. chickenpox, staph skin infections, influenza.

Q *How do you know that equipment has been cleaned between patients?*

A Clean equipment located on the LEAN cart is tagged by Materials Management. Equipment that is cleaned on the unit is kept in the clean utility room and/or another designated area. Items in the hallway that are covered with a clear bag are clean. Dirty equipment is kept in the dirty utility room. If I am not sure about a particular piece of equipment, I assume it's dirty and clean it prior to patient use.

Q *Where are you permitted to have food and drink on the patient care units?*

A Food is limited to the staff lounge, conference rooms and private offices. Drinks are permitted in the nursing station in the low anterior spaces as long as they are in areas where they can not be contaminated e.g. where specimens are left for transport. Drinks are not allowed in the hallway e.g. on carts, shelves, etc.

Notes:

The Joint Commission Hospital Survey

What will surveyors evaluate? Priority focus areas will include:

- Scope of Practice
- Communication
- Infection Control
- Physical Environment
- Information Management
- Staff Competence
- Rights and Ethics
- Assessment and Care
- Equipment Use
- Patient Safety
- Quality Improvement
- Patient Education
- Quality Improvement
- Medication Management
- Staffing
- Patient Involvement in Care

What will the survey be like? The JC general hospital survey will be 5 days in length. Using the patient's medical record as a road map, surveyors will assess the care provided to patients in both inpatient and outpatient sites. A surveyor will arrive at your practice area accompanied by MGH leadership. The surveyor will review a patient's record with caregivers, observe care, tour the unit, interview clinicians, and, in some cases, interview patients.

Who will be Involved? The nurse caring for the patient and the Clinical Nurse Specialist and/or Nursing Director will participate in the record review. Because the surveyor will not know the MGH patient record, the nurse will help locate the documentation for which he or she is looking. As the surveyor tours the unit and observes care, he or she may interview other members of the healthcare team including therapists, OAs, PCAs, NPs, and physicians.

What will the JC surveyors look at during the general hospital survey?

The focus will include the care described in the ***DPH Infection Control Survey*** section of this booklet. **In addition**, they will look at the following:

- Advance directives (completed HCP or HCP questionnaire)
- Nursing dataset completed, dated and signed within 24 hours of admission
- Consults initiated based on screening criteria in dataset e.g. nutrition or smoking cessation
- Initial assessments by consults e.g. PT, OT, SLP, social work
- Problem/outcome/intervention sheets initiated, dated, initialed

What will the JC surveyors look at during the general hospital survey? (continued)

- Problem/outcome/intervention sheets updated as problems get resolved and new problems added
- No medical interventions or diagnostic tests without an MD order
- Progress notes reflect interdisciplinary planning and follow-through
- Fall risk assessment (Morse scale on admission and daily)
- Pain assessment and patient's response to medications and other interventions
- Patient understanding of education
- Handoffs including unit-to-unit and unit-to-diagnostic and procedural areas
- Restraint orders and restraint documentation
- Universal protocol checklist completed for invasive procedures (includes those done at bedside)
- Discharge planning
- No unapproved abbreviations
- *Date/time, legible signature and licensure present for all documentation.*
- Specimens collected using appropriate precautions e.g. standard or transmission-based
- Specimens labeled in the presence of the patient
- Doctor's order present for all specimens
- Glucometers cleaned between patients with hospital-approved disinfectant
- Glucometer control solutions (hi/lo) initialed, dated when opened; not expired, (within 90 days of opening)
- Blood transfusions verified and vital signs recorded
- Critical values written down and read back and action documented in progress notes
- Lab-related policies and procedures located by staff

What types of questions will surveyors ask?

Patient Safety and Quality Improvement

Q *Describe an quality improvement initiative you've implemented on your unit during the last year? How has it improved patient care? What data do you have that demonstrates improvement?*

A (Varies by unit; example, hourly safety rounds.)

Q *When do you take verbal orders and telephone orders? Tell me what you do when you take a verbal or telephone order.*

A Verbal and telephone orders are only taken in exceptional circumstances when the physician cannot write the order. When taking a verbal order, I *write* down and *read* back and *receive confirmation*.

Q *Can you tell me any of the unapproved abbreviations that should not be written in the medical record or on MAR's?*

A Examples: MS04, MS, MgS04, ss (for sliding scale), U or u (for units), QD, QOD, HS, unapproved abbreviations can be found on the bottom margin of the progress note.

Q *Tell me how you report an adverse event.*

A Through the Safety Reporting System

Q *What is a sentinel event?*

A A sentinel event is an unanticipated death or permanent loss of function not related to the patient's illness. Examples: death after a fall or overdose of a medication.

Patient Identification

Q *(Inpatient units) How are you sure you are performing a treatment or giving a medication to the correct patient? (NPSG)*

A By using two identifiers to match the patient to the treatment or medication. For inpatients, the two identifiers are name and MRN. For outpatients, they are name and date of birth. (Procedural areas, therapies and social work, check which two identifiers are used in your area.)

Q *When is it necessary to label medications and solutions in procedural areas?*

A It is necessary to label medications and solutions on and off the sterile field when they are not administered immediately. If there is an intermediate step before administering a medication, it must be labeled, even if it is the only medication being given at that time.

Q *If the person who labels the medication is not the one administering it, what do you do to ensure the right medication is being administered at the right time? (NPSG)*

A Two individuals, including the one who will administer the medication, verify the medication label both verbally and visually.

Scope of Practice

Q *When is a doctor's order required?*

A A doctor's order is required for all medical interventions and diagnostics. Examples include medications, blood tests, urinary catheter irrigations, EKG's, point-of-care tests. When a nurse implements a medical intervention or test without an order, he or she is practicing out of the scope of nursing practice.

Q *When can oxygen be administered without an order?*

A Only in an emergency only, can oxygen be initiated prior to a doctor's order; the doctor must write the order within 12 hours.

Assessment and Care Planning

Q *Where do caregivers document their initial assessment?*

A All caregivers document in the body of the patient record.

- Nurses document the functional health pattern assessment on the Nursing Dataset and document the physical assessment on the flowsheet
- MD's, SLP's and social workers document in the progress notes
- PT and OT document on discipline specific forms.

Q *What do nurses do when a patient problem is identified?*

A Initiate the appropriate problem/intervention/outcome sheet. RNs individualize interventions based on the patient's specific risk factors. The P/I/O sheets are updated as problems and interventions change.

Restraints

Q *Describe to me a patient's behavior that would warrant restraint for behavioral reasons vs. non-behavioral reasons.*

A Non-behavioral (non-violent/non-self destructive): When the patient is at risk of injury to self/medical healing, e.g. is pulling at invasive lines/tubes.

Behavioral (violent/self destructive): when a patient is putting self or others at risk of injury, e.g. demonstrating violent/aggressive behaviors such as biting, kicking, hitting, clawing or cutting.

Q *Describe your training regarding use of restraints? When were you trained and what did your training include?*

A Trained during orientation; training is repeated annually. Training included alternatives to restraint, reasons for use, safe application and removal of restraints, assessment and monitoring of response, and documentation.

Q *Give me an example of least restrictive measures you would try before applying restraints.*

A Move the patient to a more visible location, provide an observer, provide a visual/auditory cue not to get up without assistance, use bed/chair alarms, maintain a quiet environment.

Q *Is chemical restraint used as an alternative to physical restraint at MGH?*

A No. Medications are not used to involuntarily restrain patients (restricting their freedom of movement). Medications are used to treat medical conditions such delirium, acute alcohol withdrawal or are administered in an emergency to prevent immediate irreversible deterioration of serious mental illness. These, by definition, are not chemical restraints.

Q *How often are non-behavioral restraint orders written?*

A Restraint orders are written

- Before restraints are applied except in emergency situations
- When a different type or number of restraints is needed because the patient's behavior has changed.

Q *When the patient's behavior requiring restraint resolves and you assess that restraints can be discontinued what do you do?*

A Remove the restraints; and as soon as possible, but no later than the end of the shift, I get the doctor's order to discontinue restraints. I document the time the restraints were discontinued and the rationale in my progress note or on the restraint sticker.

Q *If the behavior recurs and patient needs to be restrained again, do you need a new doctor's order?*

A **Yes** because this is a new episode of restraint; this is true even if the patient has only been out of restraints a short time.

Q *Can you do a "trial" to see how the patient does out of restraints?*

A **No**; if the patient is taken out of restraints and needs to be put back in, this is a new episode and a new order is required.

Q *Are mitts considered a restraint?*

A **Yes**, mitts are always considered a restraint because they restrict the use of the patient's fingers. This is true even when mitts are not attached to wrist restraints.

Q *When are siderails considered a restraint and when are they not considered a restraint?*

A Siderails are considered a restraint when the **intent** is to **restrict** the patient from getting out of bed; this is true even if there are fewer than 4 siderails.

Siderails are not considered restraint if used to **prevent** a patient from sliding or **rolling out of bed**; this includes padded side rails for seizure precautions.

Overall, it's the intent and not the number of siderails that determines whether or not siderails are restraint.

Q *Where do you document your assessment and interventions re: patient in restraint?*

A In my shift note on the restraint sticker. Documentation includes specific behaviors requiring restraint, type and location of restraint, least restrictive measures tried; patient's response to restrain.

Q *Where do you document the updated care plan?*

A On the Restraint Problem/Outcome/Intervention sheet.

Pain Assessment and Reassessment

Q *When do you initially assess patients for pain?*

A On admission or transfer to the unit, after a procedure requiring sedation, or when the patient's condition changes.

Q *How do you assess for pain? What pain scale do you use?*

A Describe which pain scale you used based on your patient population. Examples:

- Verbal adults: Numeric pain scale, verbal descriptor scale, functional pain scale
- Pediatrics: The **N**eonatal, **P**ain, **A**gitation & **S**edation Scale (N-PASS), Faces Pain Scale, the **F**ace, **L**egs, **A**ctivity, **C**ry, **C**onsolability (FLACC)
- Non-verbal or critically ill: The **C**hecklist of **N**on-verbal **P**ain Indicators (CNPI), **C**ritical **C**are **P**ain **O**bservation **T**ool (CCPOT), **A**ddult **N**onverbal **P**ain **S**cale.

Q *How frequently do you reassess for pain?*

A Reassessment is patient specific, depending on the expected onset, peak and duration of medications and other interventions.

Q *Where do you document the patient's response to pain interventions?*

A Nurses document pain assessments in EMAR or on the flowsheet. All disciplines document in the progress notes re: current treatment, response to therapy, and adjustments if needed.

Fall Prevention

Q *Describe your falls prevention program.*

A All inpatients are assessed for fall risk on admission and daily using an age-appropriate scale e.g. Morse Scale

- If the patient is at risk, the nurse initiates a Falls Problem/Intervention/Outcome sheet and documents in the nursing progress notes.
- Interventions are matched to the specific risk.
- Patient/family is instructed about fall risk and interventions.

Q *Can you give me examples of interventions?*

A Hourly rounding, call light within reach, placement near nurses station, consults to PT or OT, toileting, assistive devices, bed alarms, teaching regarding side effects of medications, clutter and obstacle-free floors.

Q *What is the fall rate on your unit?*

A (Find out rate from your Nursing Director/CNS)

Q *When the patient is transferred off the unit to a test or procedure, how do staff receiving the patient know the patient is on fall precautions?*

A The risk is noted on the "Sticker to Ride."

Q *What initiatives have you implemented on your unit to reduce the number of falls and falls with injury?*

A (Varies by unit; includes implementing Safety Rounds.)

Skin Integrity

Q *Describe your program to prevent pressure ulcers.*

A Skin integrity is assessed on admission as part of the nursing data set; risk for impaired skin integrity is assessed on admission and daily using the Braden scale. If the Braden score is <19, the patient is considered at risk. The nurse initiates a *Skin Integrity Problem/Intervention/Outcome Sheet* and documents in the nursing progress notes.

Q *Can you give me examples of interventions to prevent pressure ulcers?*

A Interventions are matched to the specific risk. Examples: To manage nutrition, consult dietician; to relieve pressure and/or manage sheer and friction, consult PT to mobilize the patient, reposition, protect elbows and heels; to manage moisture, use 3M Cleanser with each incontinent episode, scheduled toileting, use absorbent cloth incontinent pads.

Q *Describe what you do if the patient has a pressure ulcer?*

A

- Clean and irrigate the wound per hospital standards and providing wound care as ordered
- Consult the CNS via Nursing Orders if a pressure injury
- Measure and document the wound on admission, weekly or whenever acute changes are noted
- Document location, wound bed, exudate and periwound areas with dressing changes
- Document the patient response to treatment
- Document measurements within 24 hours of discharge.

Q *What initiatives have you implemented on your unit to reduce the number and severity of pressure ulcers?*

A (Varies by unit; includes implementing Safety Rounds.)

Anticoagulation Therapy (NPSG)

Q *How are you competent to care for a patient on anticoagulant therapy?*

A I received education during orientation. There are additional online and electronic resources including a HealthStream module. The CNS and resource nurse are also available for questions. The AMS (Anticoagulation Management Service) staff also provide education.

Q *Describe the steps you take to reduce the harm related to anticoagulation therapy.*

A

- Assess for potential food interactions (triggered by dataset)
- Infuse **premixed** infusion bags through a programmable **infusion pump**
- Monitor anticoagulation lab data.
- Provide education to patients and their families.

Q *What does the patient and family education need to include?*

A Each patient who is started on warfarin receives a copy of the “Guide to Using Warfarin.” This provides information regarding the importance of follow-up monitoring – especially the concept of who their “warfarin manager” is and how communication will proceed. It also informs the patient about why periodic blood testing (INR) is important and how to identify their pill size and color. The patient and family should be able to accurately describe the daily dose regime, food-drug-herbal interactions, and recognize signs and symptoms of complications and subsequent actions to take as a result of the education provided.

Medication Reconciliation (NPSG)

Q *Describe your process for reconciling medications across the continuum.*

A Medications are reconciled at admission and on discharge.

- Within 24 hours of admission, the admitting clinician generates the Preadmission Medication List (PAML)
- The nurse verifies the list with the patient and communicates discrepancies to the clinician;
- The pharmacist reconciles all ordered medications with the PAML medications to ensure accuracy of drug, dose, frequency and route.

Q *What is the reconciliation process at discharge?*

- A**
- At discharge, the physician reconciles each medication on the Pre-Admission Medication List (PAML) with the inpatient orders to generate a discharge medication list.
 - The nurse reviews the list, and gives the patient a copy of his/her Discharge Medication List (PSML) which includes medication instructions to follow after discharge.

Q *What is the reconciliation process when the patient is discharged to another health care facility?*

A A copy of the PAML and the PDML are sent to the next health care facility. Electronic copies are also available to providers within the Partners system.

Q (Outpatient practices) What is your process for establishing an accurate medication list for outpatients?

- A**
- PCP's and specialists develop an electronic medication list, ideally at the first visit but no later than the third. As medications are prescribed, changed, or discontinued, the providers, within their scope of care, document each change in the electronic medication list.
 - Support staff may assist prescribers in collecting medication information from the patient and documenting that the patient is taking, not taking, or taking medications differently.
 - Only prescribers may add, delete, or change medications on the medication list itself.
 - The patient is given an updated medication list at the conclusion of any visit where medications prescribed for 90 days or longer are added, changed or discontinued.
 - The patient is educated about the importance of updating their med list and sharing it with providers.

Q (Procedural areas) What is your reconciliation process for outpatients who come in for a procedure?

- A** Medication information is collected and documented prior to the procedure. The level of detail included varies depending upon the procedure and the patient's condition. If chronic medications are changed following the procedure, the patient is given a new, complete medication list which will include both the new and ongoing medications.

Transfusion Therapy (NPSG)

Q How do you verify the identity of a patient who is receiving a transfusion?

- A** Two RNs are required for bedside verification, one who has completed the educational packet and competency packet for transfusion, and one who has completed the verification education process. Or, the bedside verification process may be done by one MD and one RN who has completed the verification education process. The individual administering the blood must be one of the individuals conducting the verification.

Q *What is your procedure for monitoring VS before and after transfusion of blood products.*

A Temperature, pulse, BP, RR are done within one hour prior to transfusion, 15 minutes after the transfusion is started (no later), every hour during the transfusion, and within one hour after the infusion.

Q *What are the signs of a transfusion reaction? What would you do if you suspected one was occurring?*

A Fever, chills, rigor, changes in VS, respiratory symptoms, pain, nausea, vomiting, flushing, urticaria, and pruritis are possible signs of transfusion reactions. Stop the transfusion; remove the blood product but do not discard; administer .9% NaCl IV slowly through the IV line; obtain VS; draw a 10cc blood specimen in a lavender top tube; place blood bag, tubing, and lavender top tube in plastic bag along with *suspected transfusion reaction* paper and send to blood bank. Send urine for hemaglobinuria to Hematology.

Critical Results (NPSG)

Q *What is a critical result? A critical result, also called a critical value, is a result that, if left untreated, could be life threatening or place the patient at serious risk. e.g. elevated K⁺.*

Q *What is your process when the laboratory reports a critical result by phone?*

A The person receiving the critical result writes it down and reads it back to laboratory personnel and receives confirmation. The RN notifies the physician as soon as possible not to exceed 10 minutes. The nurse documents in the progress notes the action taken by the provider, even when the decision is no action.

Patients at Risk for Suicide (NPSG)

Q *What is done at MGH to protect patients who may be at risk for suicide?*

A All inpatients are screened to identify those who may be at risk for suicide. Those screened to be potentially at risk are fully assessed by the responsible physician or psychiatric consult and next steps are determined. If a nurse assesses a patient to be at immediate risk for suicide, he or she may institute suicide precautions and contact the

responsible physician who will determine next steps while the patient is in the hospital. When a patient at risk for suicide leaves the care of the hospital, the hospital provides the appropriate referrals and information to the patient and family such as crisis hotlines.

Universal Protocol

Q *How do you know a surgical or invasive procedure is being done on the correct patient?*

A Universal protocol: hard stop time out verification, right patient, right procedure, right site, right side. Site marking should be visible after patient is prepped and draped.

Q *Which procedures require universal protocol to be followed?*

A Generally invasive procedures that require an informed consent. There are some exemptions, for example procedures done during a code.

Q *Can you give me an example of procedures on a general unit that require universal protocol?*

A Insertion of a PICC line, chest tube insertion.

Response to Change in Patient Condition

Q *What do you do if the patient's condition begins to worsen and you need additional assistance?*

A Call the Rapid Response Team by dialing 6-3333 and letting the operator know whether I need the adult or pediatric response team. I also notify the patient's care team if they don't already know.

Q *How do you know when to call the Rapid Response Team?*

A MGH has identified early warning signs for adult, pediatric patients and newborns that should trigger a call to the RRT.

Patient Rights

Q *What resources are available for patients and families with complaints?*

A Representatives from the Office of Patient Advocacy

Q *What do you do if the patient is unable to be asked about the Health Care Proxy (HCP) due to his/her condition?*

A Look in CAS to see if patient has one on record, check with the family; if patient does not have one, I note it on the HCP Questionnaire.

Q *How do you communicate with a non-English speaking patient or a patient who is deaf or hard of hearing? What resources are available to you? What do you do on weekends and off shift?*

A For non-English speaking patients, interpreter services; (available 24/7) and IPOPs. For deaf or hard of hearing patients, we use devices provided by communications. We also write messages and use cue cards.

Q *What resources are available to you for ethical issues?*

A Representatives from Optimum Care Committee are available to clinicians and patients to help address ethical issues.

Interdisciplinary Communication

Q *How do you communicate with other members of the health care team?*

A Interdisciplinary rounds and one-on-one discussion with other providers. Also through documentation in the record.

Handoffs

Q *What information do you receive about a patient when they are transferred to your unit from another unit?*

A Patient history, all active problems, status of the problems and next steps, information about the family/significant others. (Specialty areas such as OR may have additional handoff requirements.)

Q *(Nurses) I understand that on this unit, you get report by reading the progress note of the nurse on the previous shift, what do you do if you have questions?*

A I ask the nurse handing off the patient to me. The nurse doesn't leave until I've read the progress notes to be sure I have no questions.

Q *(Therapists and social work).* If a different therapist or social worker is seeing a patient, what is your process for handoffs? What do you do if you have questions?

A *(Check department policy)*

Q *How do you communicate pertinent patient information to staff in procedural and testing areas?*

A The nurse completes the “Sticker to Ride” which contains relevant information that the receiving area needs upon arrival of the patient.

Patient/Family Involvement and Education

Q *How do you encourage patient’s active involvement in their care?*

A Teach the patient and family how to report concerns about their care, hand hygiene, and respiratory hygiene. We evaluate their understanding and document it in the record.

Q *What do you consider when you are teaching the patient and family?*

A Their ability to learn, preferences, desire, motivation, and readiness. We also consider cultural and religious practices and emotional, physical, cognitive, or language barriers.

Q *Where do you document the patient’s understanding of your teaching?*

A In the progress notes

Medication Administration

Q *How do you store insulin in order to prevent administering the wrong one?*

A Different types of insulin are physically separated in Omnicell.

Q *What does your pharmacy do to prevent errors with sound-alike/look-alike drugs (SALAD)? Can you give me examples of these drugs?*

A Pharmacy uses tall man lettering, visual warnings such as “shelf talkers”. The pharmacy also physically separates sound-alike/look alike medications. Examples include: oxyCONTIN and OXYcodone; hyrdoCODone and hydroMORPHone.

Q *Does a patient who receives a new medication receive special monitoring during the first dose?*

A Patients are monitored after a first dose for adverse effects and anaphylaxis. The patient's response is documented in the progress notes.

Q *When there is a range order for pain medication,, how do you know which dose to use?*

A Based on how patient rates pain, objective signs of pain, patient's previous response to medication.

Competency and Credentialing

Q *How are you competent to do your job?*

A Through basic education, orientation, continuing education, and annual training.

Q *If a physician shows up on your unit to do a procedure, how do you know he or she is credentialed?*

A Through the MGH intranet you can find out the procedures each attending physician is credentialed to perform.

Specimen Collection and Point of Care Testing (POCT)

Q *Describe your procedure for obtaining specimens? (NPSG)*

A Match the patient's name and unit number on the label with the name and unit number on the patient's wristband. Label the specimens in the presence of the patient. Label the container, not the cap.

Q *What POCT do you perform on your unit?*

A (Units vary. Includes blood glucose, stool guaiac on most units.)

Q *Who performs phlebotomy on your unit? When and how are they trained? How is competency evaluated?*

A Patient Care Associates (PCAs) perform phlebotomy. During orientation, PCAs receive didactic training, and complete a precepted practicum during which they demonstrate competencies on the skills checklist. RNs who have the skill when hired can continue to perform phlebotomy if they demonstrate competency by completing the skills checklist. Competency is maintained through frequent performance of blood draws.

Q *How are you competent to perform POCTs?*

A I demonstrate competency during orientation and as part of annual required training. Annually I complete a training module in HealthStream and complete the required quiz. I also successfully perform a quality control test at least once a year.

Q *How do you prevent spread of infections while performing POCTs?*

A Glucometers are wiped between patients with a hospital-approved disinfectant such as Super Sani-cloth. Standard precautions or transmission-based precautions are used depending on the patient

Q *How do you know the glucometer is working properly?*

A A hi/lo control test is performed every 24 hours by either an RN or PCA. If a PCA performs the test and the result is out of range, he or she reports to the RN. The RN arranges for the meter to be replaced.

Q *How long are glucometer controls good for?*

A Controls are labeled with the date when opened and are good for 90 days.

Q *What do you do if a glucometer result is 462?*

A Results above 400 are considered a critical value. If the procedure was performed by a PCA, he or she notifies the RN immediately. The RN notifies the physician who then orders a venous specimen.

Q *What do you do if a glucometer result is 42?*

A Same as above.

Q *What is a hemocult slide used for?*

A To check for blood in the stool. It is not designed to check for blood in other specimens such as gastric contents.

Q *How do you ensure that the hemocult slides perform correctly?*

A By storing them away from moisture and light, and by conducting the performance monitor (QC) with each test; QC's are documented on the log.

Q *Where do you document results of a guaiac test?*

A On the Hemocult QC log and in the patient record e.g. progress notes, flowsheets.

Q *What do you do if a guaiac test is positive?*

A Report the result to the physician.

Environmental of Care Tour

Who will be involved? The JC surveyor will tour the unit or department accompanied by the MGH escorts, unit or department leadership, e.g. Nursing Director. During the tour, the surveyor will observe practice and will ask different staff questions about the work environment and fire safety.

What will the surveyor observe?

- Hand hygiene and Standard and Transmission Precautions per policy
- Protective equipment and supplies available
- Needle boxes present and not overfilled
- Equipment correctly cleaned and disinfected between patients with hospital approved disinfectant (i.e. contact time)
- Clean equipment identified and properly stored
- Precaution gowns properly worn and secured
- Gloves pulled over cuff of gown
- Gowns and gloves not worn in hallways
- No expired supplies, no external shipping boxes; no supplies on floor, windowsill or underneath sinks
- Clean supplies/linen on covered cart or in cabinet/container or clean supply room;
- Clean and soiled utility rooms doors closed
- Sterile water and saline labeled when opened and replaced q 24 hours
- Compliance with HIPAA regulations
- Security of medications and IVs (med carts, med and IV closets locked)
- Medication refrigerator temps logged; includes action if out of range
- Code Cart locks checked daily
- Fire extinguisher not blocked by equipment
- Oxygen tanks secured and stored per standards

What will the surveyor observe? (cont)

- Access to exit doorways not blocked
- Corridors kept clear (all equipment on one side of hallway)
- Response to clinical alarms and call lights
- Patient food refrigerator checked; out of range actions noted; patient food dated
- No food or drink in patient care areas, clean supply or soiled areas, or where specimens collected

What will the surveyor ask while touring the area?

Equipment

Q *What do you do if you if a piece of medical equipment malfunctions or fails?*

A Remove the device, sequester, call Biomedical Engineering to report; submit a safety report, complete a yellow tag.

Q *How do you know a medical device is safe to use?*

A Each piece of equipment has a sticker which shows when it was inspected by Biomedical Engineering.

Q *What is the process if there is a recall or hazard alert on a piece of equipment?*

A MGH has a recall officer; Biomed and Materials Management work together to act on the alert.

Q *What is your policy regarding checking the defibrillator on the general units?*

A Nursing staff check the defibrillator every 24 hours. This includes checking to see that the defibrillator is plugged in and that all the needed supplies are there e.g. paddles, pads, gel, and that the pads are not expired. A biomedical engineer discharges the defibrillator weekly on the general units.

Medication Storage and Security

Q *How do you ensure that medications are secure in all locations?*

A Medications not under direct observation of the RN are secured in closets, Omnicells, etc., not left on the counters. This includes IV's and saline flushes.

Q *How do you know none of the medications on the code cart are expired?*

A The date of the first medication to expire is noted on the outside of the cart.

Spills

Q *What do you do if there is a chemo spill on this unit?*

A The chemo spill kit, which is available on the unit, is used to clean it up. The materials used to clean it up are placed in the chemo bucket.

Q *Show me your MSDS (Material Safety Data) sheets.*

A MSDS sheets for drugs are available through pharmacy. MSDS sheets for other chemicals are available on the MGH Safety website (Start→Partners Applications→Utilities→MSDS Material Safety Data Sheets).

Disaster and Fire Safety

Q *What is your role in a disaster that results in an influx of patients to your organization?*

A Follow directions of my nursing director, charge nurse, or supervisor.

Q *What would you do if you saw smoke coming out of a patient's room?*

A I would implement the hospital's fire plan which, is R.A.C.E., by "R"escuing the patient, sounding the "A"larm, "C"ontaining the fire by closing the door to the room after the patient has been evacuated, and, finally, if it is safe to do so, "E"xtinguish the fire.

Q *Show me the fire extinguishers and fire alarms on this unit.*

A (Fire alarm pull stations are usually located by exit doors and by the nurse's station.)

Q *Where are the oxygen shut off valves? Under what circumstances would you turn off the oxygen supply?*

A *(Locate in you practice area.)* If a patient is on oxygen in the room where the fire is and I couldn't get in the room safely to turn off the bedside oxygen flowmeter.

Unit Refrigerators

Q *How long can patient food remain in the refrigerator before you must throw it away?*

A Three days.

Q *What do you do if you find out that the temperature in the refrigerator has been out of range?*

A Call Buildings and Grounds and/or notify the OM.

Patient Interview

Who will be involved? The JC surveyor will ask the nurse caring for the patient if the patient is able to be interviewed. If yes, the JC surveyor will interview the patient and family without other members of the healthcare team present.

Questions to patients and families may include:

- Patient and family education
- Advance directives
- Understanding of medications
- Participation in care planning
- Continuity of care
- Pain management
- Environment e.g. noise, cleanliness
- Help when they need it
- Response to questions
- Preparation for discharge

Remember!

- Surveyors know the standards, but YOU know your practice and your patients and families.
- Relax and take your time answering the surveyor's questions, but be direct and to the point with your response
- You will not be alone, your CNS, Nursing Director and others will be there to help you.
- If you don't know the answer to a question, it's okay to say "I don't know but I know where to find it."
- Tell positive stories! If the surveyor asks you a question that relates to special project on your unit or in the hospital, tell about it!

Patient Care Services Resources

- Your Nursing Director, Clinical Nurse Specialist , Operations Managers, Collaborative Governance Champions
- Your Infection Control Liaison
- Staff from the PCS Office of Quality and Safety (ext. 3-0140)
 - **Keith Perleberg, RN, MDiv**, Director
 - **Linda Akuamoah-Boateng, BSPT**, Senior Project Specialist
 - **Judy Carr, RN**, Nurse Clinician
 - **Deb Frost, RN**, Staff Specialist
 - **Amy Giuliano, MPH**, Senior Project Manager
 - **Carol Camooso Markus, RN**, Staff Specialist
 - **Patti Shanteler, RN**, Staff Specialist
 - **Mary Ann Walsh, RN**, Nurse Clinician

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Patient Care Services



Magnet Recognition Journey
Resource Guide

Massachusetts General Hospital Mission

Guided by the needs of our patients and their families, we deliver the very best healthcare in a safe, compassionate environment; we advance that care through innovative research and education; and, we improve the health and well being of the diverse communities we serve.

Patient Care Services 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 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-focused values of this institution.

It is through our professional practice model that we make our vision a demonstrable truth everyday 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.

Patient Care Services Guiding Principles

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.

What values do we want to uphold as we strive toward our vision?

- 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 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.

Professional Practice Model



Magnet Redesignation Journey Resource Guide

Overview

During 2013, During there will be a site visit by Magnet Appraisers as part of the Magnet Redesignation Journey. This section of the resource guide is designed to help you feel ready for the Magnet Redesignation Site Visit.

In 2011 and 2012, MGH is scheduled to have 3 surveys by regulatory agencies: I. The Joint Commission (JC) Laboratory Survey, II. The DPH Infection Control Survey, and III. The JC Hospital Survey. For more information about the regulatory surveys, close the resource guide, flip it over, and you'll find what you are looking for!

Magnet Redesignation Journey

The next Magnet site visit which will occur in late 2012-early 2013. This section includes information about the revised Magnet model, the site visit process, and sample interview questions.

Overview:

The American Nurses Credentialing Center (ANCC) developed the Magnet Recognition Program in order to recognize quality patient care, nursing excellence and innovations in professional nursing practice. The original model was built upon the “14 Forces of Magnetism” which represent characteristics that distinguish Magnet organizations from others. In 2008, the ANCC introduced the next generation Magnet Model which is designed to provide a framework for nursing practice and research in the future. Though the 14 Forces of Magnetism are still foundational to the program, the new model has a new, simpler look and reflects a greater focus on measuring outcomes related to nursing practice.



Crosswalk: ANCC Model Components and 14 Forces of Magnetism

Model Elements	Overview	Forces of Magnetism
Transformational Leadership	Transformational leadership is essential to meet the demands of the future. Leaders are visionary, and strategic.	Quality of Leadership Management Style
Structured Empowerment	Structures and processes provide an innovative environment in which professional practice flourishes. The organization needs to develop and empower staff in order to identify best practices and achieve desired outcomes.	Organizational Structure Personnel Policies and Programs Community Professional Development Image of Nursing
Exemplary Professional Practice	The essence of a Magnet organization is exemplary professional practice which drives better outcomes.	Models of Care Autonomy Nurses as Teachers Interdisciplinary Relations Resources/Consultation
New Knowledge, Innovation & Improvement	Magnet organizations contribute to the organization and profession new knowledge and innovative models of care and contribute new evidence to the science of nursing.	Quality Improvement
Empirical Quality Results	Magnet organizations must use quality data to measure outcomes and demonstrate improvements in care delivery.	Quality of Care

Magnet Journey: Redesignation Process

An important step in the redesignation journey is submission of written evidence that MGH fully meets Magnet requirements. This evidence is lengthy and thorough and includes specific examples of how the spirit of Magnet is alive at MGH. The documentation will be reviewed by a team of appraisers; after determining the evidence reflects excellence, the same team will conduct a site visit.

What is the focus of the site visit?

The focus is to evaluate the overall hospital environment and culture as one that promotes excellence in patient care and service. Appraisers look for evidence of empowerment, collaboration and excellence as exemplified in the documentation submitted prior to the visit. It is an opportunity for staff to showcase the excellent care that is provided to patients and families at MGH.

Who will appraisers talk to during the unit visits?

- Appraisers will visit as many patient care units and practice sites as possible. Appraisers will speak directly with staff nurses about any of the topics described above. The visit will also involve all members of the healthcare team as well as patients and families regarding how clinical practice is delivered and supported. They may also speak with staff from other departments to discuss how they work with nurses to ensure patients get the equipment and services they need.
- Appraisers may request to speak with patients, families and visitors.

There will also be other forums throughout the site visit where nurses will have the opportunity to interact with appraisers.

What will appraisers look at? Examples:

- Nurses' participation in decision-making
- Outcomes e.g. falls, pressure ulcers, restraints
- Unit-based performance improvement activities
- Evidence-based practice, research, innovation
- Peer review and professional development
- Communication flow between nurses and leaders
- Community activities and involvement
- Interdisciplinary patient- and family-centered care
- Continuity of care across the continuum
- Patient/family involvement in plan of care
- Patient advocacy program
- Diversity
- Practice environment
- Delegation and teamwork

What types of questions will the surveyor ask? Below are examples:

Transformational Leadership

Q *What guides the practice of nursing at MGH?*

A The hospital's mission, Patient Care Services/Nursing vision and value statement, and guiding principles all guide the MGH practice of nursing.

Q *What are Nursing's strategic goals?*

A Every year, the MGH Patient Care Services/Nursing Executive Team sets strategic goals based on an assessment of organizational priorities and input from patients, families, staff. Goals focus on enhancing the patient experience; continually improving care delivery through increasing the efficiency and effectiveness of systems; and, creating and sustaining a strong, supportive practice environment in which staff have a strong voice in the design of care and services. Each of these goals has tactics with defined measures of success.

Q *If you have a question or want to communicate with your Chief Nurse, Associate Chief Nurse and/or Nursing Director, what ways do you use to contact them?*

A Our Chief Nurse is visible and accessible to staff through formal nursing presentations, monthly Collaborative Governance Staff Nurse Advisory Committee, and unit rounds. She is accessible to staff anytime via telephone, e-mail and face-to-face with her open-door-policy. These strategies are also used by the Associate Chief Nurses and Nursing Directors. All nurse leaders carry their pagers and cell phones 24 hours a day, seven days a week. Staff has the ability to page or call these leaders at any time to address a need on the unit or personal issue. It is common for Nursing Directors to work on evenings, nights or weekends to support staff during routine operations, special projects and for emergency situations. Clinical Nursing Supervisors augment the unit Nursing Director's leadership presence and accessibility, particularly on the off-shift and weekends.

Q *Describe ways in which your nursing leadership has improved the work environment?*

A Some examples of ways in which nursing leadership has improved the work environment include the installment of ceiling lifts and new beds in all patient rooms; establishment of tiger teams (ad-hoc groups) to address issues such as workplace violence; incorporation of peer review in the performance evaluation process; as well as, provision of education and support for conflict resolution.

Q *Give examples of how the input of nurses has effected the work environment?*

A Input from the nursing staff has influenced many aspects of the work environment including the design of the new Lunder Building, Collaborative Governance redesign, Acute Care Documentation design and testing, along with ER and Perioperative process improvement initiatives.

Structural Empowerment

Q *Describe the professional practice model?*

A The Professional Practice Model is a comprehensive framework to guide care delivery across the disciplines in Patient Care Services. 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. We use the analogy of a puzzle to describe our professional practice model. The many pieces of the puzzle come together to create a complete picture of the professional practice model at the MGH.

Q *How do nurses influence what the professional practice model is at MGH (adapt or modify)?*

A The staff perceptions of the professional practice environment survey is an evaluation of our professional practice model at the MGH. It is administered to clinicians throughout Patient Care Services every 12-18 months. Feedback from this survey is critically reviewed and used to influence changes that are made. Examples of this would be the redesign of our Collaborative Governance model and development of conflict-resolution education programs.

Q *How do nurses participate in decision-making (individually and through groups)?*

A Nurses participate in decision-making through their involvement in unit-based activities, clinic rounds, as a member of a Collaborative Governance committee, and in the role of resource nurse.

Q *Give examples of how participation in decision-making has resulted in improvements on the unit (e.g. through participation in collaborative governance, tiger teams, unit-based committees, etc.).*

A (Varies by unit; cite unit-based examples)

Q *How does MGH support nurses' participation in professional organizations and pursuit of formal education and certification?*

A Flexible scheduling supports staffs' participation in professional organizations. Flexible hours, tuition reimbursement, scholarships, support service grants, college fairs, Pro-tech student mentorship, shadowing opportunities promote staffs' pursuit of academic education.

The MGH Department of Nursing supports professional certification by providing reimbursement for certification and recertification exams for nationally-recognized professional and specialty nursing organizations. The Norman Knight Nursing Center provides on-site educational preparation programs for many types of certification.

Q *Describe improvements on your unit that resulted from participation in professional organizations?*

A (Varies by unit; cite unit-based examples)

Q *Describe how MGH supports continuing education/professional development (internal and external)?*

A The MGH and The Norman Knight Nursing Center provide hospital-based continuing education programs that provide continuing education units (CEUs) to staff in attendance. The Norman Knight Nursing Center for Clinical & Professional Development offers over 125 programs each year in addition the availability of hundreds of online and web-based educational opportunities. Although funds are limited, the Department of Nursing also financially supports staff attendance at strategic conferences and seminars outside the MGH. Paid educational time and flexible scheduling practices ensure staff nurses are able to attend professional development opportunities.

Q *How do MGH nurses support the education of undergraduate and graduate students?*

A Education is an integral part of our mission. Every year approximately 30 schools place over 1700 students for clinical practicum experiences or 1:1 clinical preceptorship. MGH nurse preceptors provide education and clinical experiences for nursing students for a required number of hours and assist the student in meeting course objectives. Preceptors provide role modeling for students, as well as clinical and professional guidance. On White 7 and Ellison 7 Surgical Units, a Designated

Education Unit model is in place. In this case, the MGH has a collaborative relationship with the University of Massachusetts, Boston, and staff nurses serve in the role of clinical instructor and are responsible for on-unit clinical education for 1-2 nursing students. A faculty member from UMASS, Boston, oversees and guides the staff clinical instructors.

Q *How do nurses participate in community health-related activities, including community education?*

A MGH nurses regularly participate in health-related community activities including, but not limited to, health fairs, a variety of information sessions in the MGH Lobby, Blum Center Lecture Series, the annual Pediatric Health Fair, Senior HealthWISE Series, the Boston Health Care Expo, Durant Fellowship for Refugee Medicine, the community volunteerism, and national and international disaster response teams. PCS has established guidelines to address the pay and benefits for employees embarking on domestic and/or international service work. Beyond formal compensation policies, MGH encourages participation in community activities by communicating opportunities through E-mail and hospital publications. In addition, staff's participation is supported through flexible scheduling.

Q *What is the process at MGH for developing, implementing and evaluating standards of practice and standards of care?*

A Several processes exist to facilitate the development, implementation and evaluation of standards of practice and standards of care. Examples include: the Collaborative Governance Practice and Quality Committees, unit-based practice committees, perinatal review, the evidence-based care initiative coordinated by the Yvonne L. Munn Nursing Research Center, staff and leadership participation in professional and specialty organizations, etc.

Q *How do nurses get results about nurse satisfaction data and patient satisfaction data? In what ways are the findings discussed and analyzed? Describe the results for your unit?*

A Nurse and patient satisfaction results are shared with nurses through staff meetings, bulletin board postings, quarterly email distributions, and presentations from the Chief Nurse and leadership in various meeting forums. *(Cite unit-based examples)*

Exemplary Professional Practice

Q *What is your patient care delivery model?*

A Interdisciplinary patient-and family-centered care. Describe *how* this is operationalized on your unit.

Q *Give an example of how you involved a patient and family in the plan of care.*

A (Cite personal example: Possible answers to this would include goal setting, identifying priorities, family meetings, and obtaining health information through the Patient / Family Learning Center).

Q *Who are your expert resources? How do you access them?*

A Expert resources include: Nursing Directors, Clinical Nurse Specialists, Resource Nurses, The Institute for Patient Care (comprised of The Norman Knight Nursing Center for Clinical & Professional Development, The Yvonne L. Munn Center for Nursing Research, The Blum Patient and Family Learning Center and The Center for Innovations in Care Delivery), the PCS Office of Quality and Safety, etc. Resource contacts are available by email, phone or in person.

Q *How do nurses influence recruitment and retention?*

A Nurses influence recruitment and retention through word-of-mouth, preceptorship of students, involvement in residency rotations, participation in interviews, shadowing, sharing information about our Magnet status, voicing their input in decisions around practice, as well as ownership and accountability for their practice. *(Cite unit-based examples)*

Q *How do nurses impact their staffing budget?*

A On many inpatient units, nurses impact their unit's staffing budget through completing Quadramed, a productivity measurement system, which quantifies patient acuity and workload. This data provides invaluable information that guides resource allocation decisions to match staffing to workload. Other productivity measurement systems are used in the Emergency Department, Operating Rooms, etc. MGH nurse are empowered to make decisions to match staffing to workload on a shift-to-shift basis.

Q *How is staffing determined on a shift by shift basis and by whom?*

A Direct care staffing requirements occurs at three levels: long term projections for the Fiscal Year, near-term scheduling for successive four-week cycles, and daily shift to shift requirements. Staff decisions are: made at the unit level, based on patient acuity and based on the competency of available staff. Daily and shift-to-shift decisions regarding staffing are made at the unit level by Nursing Directors and/or their designees, such as staff Resource Nurses. In the event that additional staff are needed for a particular shift there are several options available including: calling in staff scheduled for “on call” or standby, negotiating changes in scheduled time among the unit staff, utilizing cross-trained staff from other units, using staff from the Central Resource Team, accessing per diem staff, using part-time staff to work beyond their standard hours and/or working long-week/short-week hours. In addition, the Department of Nursing is committed to providing clinical support to all nurses providing direct care. Resources such as the Clinical Nursing Supervisors, The Central Resource Team Staff Nurses, Unit Resource Nurses, Clinical Nurse Specialists and expert Advanced Practice Nurses are available to assist all nurses regardless of years of experience or competence in a clinical specialty.

Q *Give examples of interdisciplinary performance improvement activities.*

A Examples include: The LEAF fall-prevention program, the skin team work in preventing hospital-acquired pressure ulcers; safety rounds implementation; central line associated bloodstream infection team, etc. *(Cite unit activities)*

Q *How do nurses influence technology at MGH? (equipment and electronic documentation)*

A Examples include nurses’ involvement on the Collaborative Governance Informatics Committee, piloting all new equipment and technology, and participating in the design and testing for Acute Care Documentation.

- Q** *Describe ways in which peer review and self-appraisal are used at MGH?*
- A** Peer review takes place at every level of nursing at MGH and is incorporated into our annual performance evaluation process. In addition, the clinical narrative is used as a tool for self-reflection.
- Q** *How do nurses use external standards and resources such as the ANA Code of Ethics?*
- A** Resources to guide ethical decision-making at MGH include: Collaborative Governance Ethics in Clinical Practice Committee, Optimum Care Committee, Advance Care Planning Task Force, MGH Ethics Task Force, Pediatrics Bioethics Committee, Harvard Ethics Leaders Council, Interdisciplinary Ethics Resource Program, Unit-Based Ethics Rounds, MGH Employee Assistance Program and individual consultation with the Ethics Clinical Nurse Specialist. The ANA Code of Ethics is a key document and is shared and discussed at Ethics Forums each year. A recently-awarded Clinical Ethics Residency for Nurses is funded by HRSA and uses the ANA Code of Ethics, and other well-respected sources to guide education for nursing.
- Q** *What does MGH do to meet the needs of such a diverse patient population?*
- A** MGH has a number of resources including our Culturally-Competent Care Program, Disabilities Awareness Initiative, Medical Interpreters Services, Patient Care Services Diversity Program, etc.
- Q** *How are problems managed related to unsafe or unprofessional conduct?*
- A** Unsafe or unprofessional conduct can be reported through our MGH Safety Reporting System, and directly to Unit Directors. There is also a confidential compliance hotline where staff can report issues.

Q *Give examples of what has been done to improve workplace safety and safe patient handling?*

A Numerous examples exist illustrating efforts to improve workplace safety and safe patient handling, including: installation of ceiling lifts; Management of Aggressive Behavior (MOAB) training; and the work of the Safe Patient Handling Committee, Workplace Safety Committee, Workplace Violence Tiger Team, and the Safe Handling Chemo Team. *(Cite additional unit examples)*

Q *Give an example of an action that was taken proactively to prevent a problem and improve safety?*

A The Police and Security Off-Shift Visitors Initiative was established to improve safety for our patients, family and staff.

New Knowledge, Innovation & Improvement

Q *Describe difference between research, evidence-based practice and performance improvement.*

A **Research** is the analysis of data collected from a homogenous group of subjects who meet study inclusion and exclusion criteria for the purpose of answering specific research questions or testing specific hypotheses.

Evidence-Based Practice is the practice of applying knowledge (research findings, expert opinion, case reports) to a particular patient's situation as well as considering the patient's preferences and values as well as the clinician's expertise.

Performance improvement is the concept of measuring the output of a particular process or procedure, then modifying the process or procedure to increase the output, increase efficiency, or increase the effectiveness of the process or procedure. Remember the steps **(PDCA)**: 1) **Plan** (identify and opportunity and gather information and measure the current situation), 2) **Do** (design and improve and implement the change, 3) **Check** (measure again to see if the plan worked), and 4) **Act** (sustain the change).

Q *Give an example of a practice you implemented based on research findings?*

A Examples include: hourly safety rounding to influence patient outcomes and satisfaction; development of sensory cart to decrease restraint use, and using wound care research findings to identify skin care and pressure ulcer prevention strategies. (*Cite unit-based examples*)

Q *What processes are in place to promote evidence-based practice at MGH?*

A The Yvonne L. Munn Center for Nursing Center is the organizational structure that supports and promotes nursing research. Research components include: Collaborative Governance Research Committee, the Clinical Nurse Specialist Research Task Force, the Nursing Research Operations Group, the Norman Knight Visiting Scholar Program, the Yvonne L. Munn Nursing Research Awards, the Yvonne L. Munn Post-Doctoral Fellowship, and the Doctoral Forum. Internal consultation is also widely available through the Munn Center's Senior Nurse Scientists, MGH doctorally-prepared staff and the Mongan Institute for Health Policy. The unit-based CNSs actively promote evidence-based practice at MGH. The Munn Center received a grant to promote evidence-based practice.

Q *How is research disseminated at MGH?*

A Examples include: Did You Know posters designed by the Research and Evidence-Based Practice Committee, Journal Club, research poster display during Nurse Recognition Week, presentations at conferences and through publications.

Q *What is innovation and how is innovation supported at MGH?*

A Clinicians are challenged every day to find solutions to problems in care delivery. The Center for Innovation in Care Delivery's (part of The MGH Institute for Patient Care) focus is to bring teams together to identify opportunities, to estimate the impact of change (including workforce demographics, new technologies and regulatory change) and to construct innovations. The Center works to provide clinicians with knowledge, skills and opportunities to solve problems at the bedside and within the system.

The Center for Innovations in Care Delivery looks to research in user driven innovation (Eric von Hippel) and disruptive innovation (Clayton Christensen) to form the theoretical basis for much of its work. The Center, often in partnership with others, provides education, consultation and support to members of Patient Care Services in addressing issues or problems to be solved. Utilizing Christensen's "What's the job to be done" framework we engage front line staff in problem solving.

Examples include: Transforming Care at the Bedside (TCAB) initiative which trains staff to use the rapid-cycle improvement technique to address and solve issues in an innovative way and finding better solutions to cardiac leads for very premature infants.

Empirical Quality Results

Q *What are the nurse-sensitive indicators related to your unit?*

A As defined by the ANA, "Nursing Sensitive Indicators are those indicators that capture care or its outcomes most affected by nursing care." These indicators have been defined to show clear linkages between nursing interventions, staffing levels and positive patient outcomes. Common examples of nurse-sensitive indicators include: patient falls, hospital-acquired pressure ulcers, restraint utilization, and central line infections. *(Cite unit-based nurse-sensitive indicator)*

Q *Give examples of strategies used on your unit to improve outcomes related to nurse-sensitive indicators?*

A Examples include hourly safety rounds, utilizing the Psychiatric Clinical Nurse Specialist to reduce restraint utilization *(Cite unit-based initiatives to improve nurse-sensitive outcomes)*

Q *Give examples of other improvement projects on your unit? What were the strategies and how do you know they have been effective?*

A *(Cite unit-based initiatives)*

Patient Care Services Resources (Magnet Core Team)

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- **Paul Arnstein, RN**, Clinical Nurse Specialist
- **Guardia Banister, RN**, Executive Director, Institute for Patient Care
- **Carol Camooso Markus RN**, Staff Specialist, PCS Office of Quality and Safety
- **Gino Chisari, RN**, Director, Norman Knight Nursing Center for Clinical & Professional Development
- **Pat Connors, RN, Clinical Nurse Specialist**
- **Grace Deveney, RN**, Professional Development Coordinator
- **Rick Evans, Sr. Director**, Service Improvement
- **Brian French, RN**, Director, Blum Center
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