**TL 3 EO: Describe and demonstrate the outcomes that resulted from the planning described in TL 3.**

As described in TL 3, the annual strategic and operating planning process is an integral component of the work of Nursing and Patient Care Services (PCS). On a regular basis, the goals and tactics articulated in the strategic plans are reviewed and revisited by the PCS Executive Team to ensure that the expected results are being achieved. Each associated tactic is assigned a leader (or owner) and interdisciplinary project teams are formed, as appropriate, to advance the work. The tactic owner is responsible for the tactic’s implementation and provides progress reports back to the PCS Executive Team on their respective tactic’s status at Patient Care Services Executive Committee meetings (Attachment TL 3 EO.a). In 2010-2011, PCS developed a strategic plan (OOD 3.h) with three strategic goals, each of which had a number of associated tactics. Charters were created to address the work of each tactic. An example of a charter can be found in Attachment TL 3 EO.b. In this source of evidence, the results of the tactical plans will be presented.

**Goal 1: Meet or Exceed Expectations of Patients & Families**

| **TACTIC 1:** Enhance staff communication & responsiveness to patients & families |

**Purpose and Background:**

Patient satisfaction with nursing communication and responsiveness are two components of the HCAHPs patient satisfaction survey that can be influenced by nursing. In addition to being a key nursing quality indicator, it was also one of MGH’s targeted pay-for-performance quality measures. At the time of the strategic planning retreat, current performance ranked MGH at the 50% percentile in the nation – so there was opportunity for improvement.

**Description of Work:**

The group utilized an existing committee established in 2009, the PCS Communication and Responsiveness Committee (Attachment TL 3EO.c), to focus on this tactic. This interdisciplinary team was convened to develop strategies to improve the patient experience including the HCAHPs staff communication and responsiveness survey scores (Attachment TL 3EO.d). After reviewing the evidence, it was identified that hourly rounding (coined “hourly safety rounds” at MGH), were effective in not only improving quality outcomes such as decreased patient falls and hospital-acquired pressure ulcer rates, but were also one of the best ways to improve staff communication and responsiveness scores. Implementation of hourly safety rounds had begun during the previous strategic planning cycle, but had only been implemented on 78% of the inpatient units. Towards that end, an hourly safety rounds tool kit was developed (Attachment TL 3EO.e) to facilitate the roll-out of rounds on all inpatient units (39 units).
**Team Membership:**

The team included representation from Nursing, Social Services, Quality and Safety, Communications, and representatives from different health professions such as Physical Therapy and Speech/Language Pathology. The roster is contained in Attachment TL 3EO.c, p. 2)

**Measurement:**

By implementing hourly safety rounds across all inpatient units, in addition to other unit-based strategies, the hospital achieved both of its improvement goals in these areas, with “top box” H-CAHPS scores of 78.9% in Nurse Communication and 63.7% in Staff Responsiveness in fiscal year 2011.

<table>
<thead>
<tr>
<th>H-CAHPS Measure</th>
<th>2010 Baseline</th>
<th>Target Score</th>
<th>2011 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Communication</td>
<td>78.8%</td>
<td>&gt;78.8%</td>
<td>78.9%</td>
</tr>
<tr>
<td>Staff Responsiveness</td>
<td>63.1%</td>
<td>&gt;61.4%</td>
<td>63.7%</td>
</tr>
</tbody>
</table>

Although the target scores were exceeded, the PCS Executive Team acknowledged that the staff responsiveness score is at the 50th percentile and the nurse communication score remains in the 50th to 70th percentile and requires continued attention in the next strategic plan.

**TACTIC 2: Implement hourly safety rounds**

**Purpose and Background:**

As noted in Tactic 1, evidence suggests that hourly safety rounds can improve both patient safety outcomes and satisfaction with care delivery. The MGH hourly safety rounds are built around the 7 P’s: Person, Plan, Priorities, Personal hygiene, Pain, Position, and Presence. These regular prompts ensure that patients’ needs are consistently being met and monitored.

**Description of Work:**

In the 2009 strategic goal setting process, it was decided to begin implementation of evidence-based hourly safety rounds as a practice improvement strategy to enhance patient outcomes and satisfaction. At the beginning of the 2011 fiscal year (October 2010), only 78% of MGH inpatient units had implemented some form of hourly safety rounding (Attachment TL 3EO.f). Thus, the goal set out in 2011 was to implement hourly safety rounds on all inpatient care units.

**Team Membership:**

The Safety Rounds Team, led by the late Director of the PCS Office of Quality and Safety, was comprised of his staff in the PCS Quality and Safety (three Staff Specialists, two
Nurse Clinicians and two Senior Project Managers). This team, in conjunction with the Communication and Responsiveness Committee, coordinated the continued roll-out of hourly safety rounds across all inpatient units. The hourly safety rounding toolkit (Attachment TL 3EO.c) discussed in Tactic 1 also facilitated achievement of Tactic 2.

**Measurement:**

The PCS Office of Quality & Safety conducted a survey to measure scope of hourly safety rounds implementation. The team was able to achieve the goal of 100% hospital wide-implementation on 39 inpatient units PCS (Attachment TL 3EO.g).

<table>
<thead>
<tr>
<th>TACTIC 3: Ensure equitable care for patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>TACTIC 3a: Create a Proactive Advocacy Program</td>
</tr>
</tbody>
</table>

**Purpose and Background:**

To improve the patient, family, and employee experience, a “proactive”, rather than “reactive”, Advocacy Program is required. A “proactive” Advocacy Program supports an organizational culture of patient-centeredness. Patient- and family-centered care is linked to improved outcomes such as reduced medical errors, greater patient and family satisfaction, and more effective allocation of resources.

**Description of Work:**

In addition to working on initiatives to ensure responsiveness to patient and family issues to promote a proactive advocacy structure, a hospital-wide Patient & Family Advisory Steering Council was created. The Director of the Office of Patient Advocacy collaborated with the Director, PCS Office of Quality and Safety and the Director, Service Improvement to plan for the PCS Patient & Family Advisory Steering Committee launch.

**Team Membership:**

The new Patient & Family Advisory Steering Council, chaired by the Director of the Office of Patient Advocacy (Attachment TL 3EO.h), included many patient and family representatives, along with representatives from service improvement, Social Services, Volunteer Services, and Nursing and Physician leadership.

**Measurement:**

The goal and measurement for this tactic was to launch a Patient & Family Advisory Steering Council. Bylaws were developed (Attachment TL 3EO.i) and the first meeting held on October 25, 2012 (Attachment TL 3EO.j), signaling the implementation of an important strategy to promote dialogue with patients and families to proactively advocate for the greater MGH patient/family community.
**TACTIC 3h: Implement Disabilities Program plan**

**Purpose and Background:**

To meet and exceed the needs of our patients, it is imperative that the hospital patient care areas be as accessible as possible to patients and family members with a disability. In addition, it is MGH's commitment to provide seamless care to patients with disabilities, many wide-ranging initiatives were undertaken to improve accessibility of patient care sites.

**Description of Work:**

Communication tools and resources were developed for both internal staff and external visitors. Information systems were adjusted to include methods to alert providers to the disability needs of patients. Staff were provided training and awareness about the best methods for caring for patients with disability.

**Team Membership:**

An interdisciplinary team, the Council on Disabilities, (Attachment TL 3EO.k), including representation from the hospital’s construction department, communications specialists and many representatives from disciplines within Patient Care Services, came together to implement these initiatives across all of the patient care areas in the hospital, including inpatient, outpatient, and health center settings.

**Measurement:**

The group identified the following three areas of focus for 2011:

- **Target:** Disability education to staff and new hires through Health Stream education rolled out by April, 2011.
  On 4/15/11, the Healthstream Training module for staff, titled “MGH: Creating a Welcoming and Inclusive Environment for Patients with Disabilities” was assigned to PCS staff and new hires. New hires were assigned at their “start date” and they had 200 days to complete the module. Completion rate: 97.12%.

- **Target:** Disability flag added to electronic information systems by July, 2011.
  Attachment TL 3EO.l highlights the disability flag in red in the PATCOM system.

- **Target:** Develop web page of educational resources available to staff by Dec, 2011.
  An externally-facing MGH Accessibility web page (Attachment TL 3EO.m) was launched and work is underway to add educational resources available to staff to the site. In addition, Patient Care Services designed an Excellence Every Day portal page in December, 2011, that focused on Accessibility and contains a disabilities toolkit, resources, and policies and procedures to guide clinicians' work with patients and families with disabilities (Attachment TL 3EO.n).
All three of these goals were met by the team, and these initiatives greatly improved the awareness and ability to meet the diverse needs of patients with disabilities. In addition, ADA compliant equipment was purchased to improve accessibility:

- 116 Hi/Lo exam tables, procedural tables and recliners
- 32 Wheelchair accessible scales
- 18 Ceiling lifts and 5 Portable lifts
- 218 Assistive hearing amplifiers
- 105 Sight enhancers
- 2 Video phones for the deaf
- 6 Accessible commodes
- 2 Slings
- 1 Romedic return (single patient dolly type device that allow patient to assist in their transfer)

**TACTIC 3c:** Improve communication with efficient use of resources and technology (e.g. V-POP, communication boards, vision & hearing enhancers, etc.)

**Purpose and Background:**

Each patient should be able to participate fully in the direction of their health care. The hospital aims to provide culturally-competent care to all patients, including those with limited English proficiency (LEP). At the time of 2011 strategic planning, there was under-utilization of the video Modality (V-POP) which prevented available resources to be leveraged to their full potential in delivery medical interpreter service to Spanish and Portuguese speaking patients.

**Description of Work:**

To achieve these goals, and also to create increased efficiencies in medical interpretation, Patient Care Services set a goal to increase utilization of its mobile video interpretation system (V-POP). This required increased roll-out of V-POP technology to additional inpatient units and practices and educating staff about making decisions about interpreter services’ resources (e.g., interpreter, I-POP (phone system) and V-POP).

**Team Membership:**

To address this tactic, the leadership of Medical Interpreter Services collaborated with leadership of inpatient units as well as select outpatient services with high percentages of Spanish or Portuguese-speaking patients, and the Information Systems team, to plan for V-POP installations and associated education.

**Measurement:**

At the beginning of fiscal year 2011, 36% of the 66 inpatient and outpatient units targeted as potential high-users of V-Pop service, had implemented the video interpretation system. By the end of the calendar year, the hospital had achieved its goal of having 72% of the targeted sites using the system. This improved both the effectiveness and efficiency of
these services, and the percentage of interpretation services provided by more costly third-party providers was reduced. The total savings of this transition was at least $120,000 (or more if additional FTEs had been hired to handle the volume of calls).

*IPPOP (Interpreter Phone on Pole) – mobile conference phones used to facilitate the use of remote telephonic interpreting

**VPOP (Video Phone on Pole) – mobile video phones to access in-house Spanish and Portuguese medical interpreters

<table>
<thead>
<tr>
<th>Percentage Change</th>
<th>Oct 2010 through Dec 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient:</td>
<td>-33%</td>
</tr>
<tr>
<td>Outpatient:</td>
<td>-17%</td>
</tr>
</tbody>
</table>
The dual goal of video medical interpreting is to improve communication with LEP patients while maximizing internal resources thereby creating greater efficiencies in the provision of on-demand language services. During FY 11, Medical Interpreter Services staff conducted interdisciplinary focus groups, educational in-services and leadership discussions on the usage of V-POP vs. I-POP. What became clear was that the use of V-POP vs. I-POP depended upon which device was available to clinicians when they needed to communicate with patients. Devices were being placed at the bedside to facilitate the timeliness of communication. What this created was a greater overall awareness of the needs of LEP patients, the various modalities with which those needs could be met and the relative efficiency and cost effectiveness of each modality. Monthly usage of I-POPs and V-POPs varied depending upon the LEP patient mix on the units in any given month.

The percentage decrease change of inpatient I-POP usage was far greater than the outpatient change based on the fact that inpatient units had both I-POPs and V-POPs available to them while the outpatient clinics only had access to V-POPs. This indicates that there was more opportunity for the inpatient units to improve efficient use of resources by utilizing the new V-POP technology available to them.

Savings were calculated by identifying all the V-POP volume during the period and comparing that to the cost of having met that need with I-POP technology or with additional FTEs.

During the period of September 2010 through December 2011:
- A total of 7,646 V-POP calls were made (baseline of face-to-face and I-POP interpretations remained fairly consistent during this time)
- Average V-POP call is approximately 15 minutes
- To meet this added volume with I-POP, the cost would have been $120,425 (7,646 calls x 15 minutes/call x $1.05/minute)
To meet this added volume with additional FTEs, the cost would have been an additional 3.2 FTEs of medical interpreters equating to $272,384.

FTE calculation:
- 7,646 encounters is equivalent to 23.89 interpretations/day (1 V-POP call = 1 face-to-face call)
- 1 interpreter does approximately 7.5 face-to-face interpretations/day
- 23.89 encounters divided by 7.7 encounters/day = 3.2 FTEs
- Average hourly rate for 1 interpreter is $25/hour
- $25 x 40 hours/week x 64 weeks (span between September 2010 and December 2011) + 33% benefits = $85,120/FTE
- 3.2 FTEs = $272,384.

**TACTIC 4: Reduce hospital acquired pressure ulcers**

**Purpose and Background:**

Reducing hospital-acquired pressure ulcers is an important tactic in improving the overall quality and safety of care at MGH. Between March of 2009 and March of 2010 there was a rise in the prevalence rate of hospital-acquired pressure ulcers at MGH, from 3.2% to 3.5% respectively. The PCS Executive Team recognized the need and opportunity for a group to identify the cause for the increase and implement evidence-based practice changes with the goal of eliminating all hospital acquired pressure ulcers (HAPU).

**Description of Work:**

Patient Care Services set out to review and improve the hospital’s practices related to the prevention of hospital acquired pressure ulcers, including assessment, preventative interventions, and documentation. In order to achieve this, PCS Executive Team identified the importance of creating an evidence-based standardized approach to prevention of HAPU.

An evidence-based initiative to improve patient skin condition titled Save Our Skin (SOS) was launched. This initiative was centered on a Skin Care Bundle, used to guide nursing staff in routinely implementing skin-saving interventions (SE 1EO).

**Team Membership:**

An interdisciplinary, nurse-led Tiger Team was convened to address this issue across the hospital care settings. Nursing members represented numerous role groups and specialties including Advanced Practice Nurses, Staff Specialist, Nurse Scientists, Wound and Ostomy Care Nurse (WOCN), representatives from Nursing Management Systems, Nursing Informatics, Evidenced-based Practice Program, and Quality & Safety (Attachment TL 3EO.o).
**Measurement:**

PCS aimed to improve the hospital’s rates of pressure ulcer prevalence to lower than the NDNQI benchmarks. After rollout of the evidence-based initiative to improve patient skin condition titled “Save Our Skin” (SOS) (SE 1EO), hospital-wide prevalence rates for pressure ulcers dropped from 2.8% to 1.7%.

<table>
<thead>
<tr>
<th>Prevalence Study Date</th>
<th>Rate</th>
<th>Pre/post SOS Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2010</td>
<td>2.8%</td>
<td>Pre-intervention</td>
</tr>
<tr>
<td>September 2011</td>
<td>1.7%</td>
<td>Post-intervention</td>
</tr>
</tbody>
</table>

Attachment TL 3EO.p illustrates unit type performance against NDNQI benchmarks for hospital-acquired pressure ulcers from October 2010 through December 2011. For the five quarters spanning October 2010 through December 2011, the following table summarizes MGH performance by unit type compared to NDNQI mean benchmarks:

<table>
<thead>
<tr>
<th>Unit Type</th>
<th># Quarters Outperforming NDNQI Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care - Adult</td>
<td>4/5</td>
</tr>
<tr>
<td>Critical Care - Pediatric</td>
<td>4/5</td>
</tr>
<tr>
<td>Level III Neonatal ICU</td>
<td>5/5</td>
</tr>
<tr>
<td>Medical - Adult</td>
<td>1/5</td>
</tr>
<tr>
<td>Med/Surg - Adult</td>
<td>3/5</td>
</tr>
<tr>
<td>Med/Surg - Pediatric</td>
<td>5/5</td>
</tr>
<tr>
<td>Surgical - Adult</td>
<td>4/5</td>
</tr>
</tbody>
</table>

Continued attention to decreasing HAPUs, particularly in the Adult-Medical units, and the strategies employed to address this nursing-sensitive indicator are presented in EP 32EO.

**TACTIC 5: Improve hospital cleanliness**

**Purpose and Background:**

Hospital cleanliness is an important component of the overall satisfaction of patients with the care environment at MGH as measured by the HCAHPs survey. To improve the overall satisfaction of patients and families, PCS set out to improve hospital cleanliness through staff empowerment, improved processes, patient outreach, education and training, and quality oversight.

**Description of Work:**

Three tactics were undertaken to improve the overall cleanliness scores within the hospital:
- Continue improvement and oversight efforts underway
- Broaden involvement of all roles and disciplines in improving cleanliness and patient satisfaction
- Explore new cleaning techniques, tools, and processes to enhance quality and efficiency

One of the initiatives that was launched was the “Wet is the New Clean” Campaign. An overview of the program is in Attachment TL 3EO.q. An example of the marketing materials for the program can be found in Attachment TL 3EO.r.

**Team Membership:**

This tactic was coordinated by the leadership of Clinical Support Services with support from the Norman Knight Nursing Center for Clinical & Professional Development. It was identified that it would take a village to work on this goal so leadership from all members of the PCS Executive Team was required.

**Measurement:**

The primary measure for improvement using this tactic was the hospital’s Room Cleanliness H-CAHPS score. The FY2010 baseline for this score was 71.4%, and the FY11 target was set at 71.7%. Unfortunately, the hospital experienced an unexplained degradation in this score in the last quarter of 2011 (see chart below). However, the score has rebounded and even improved in 2012.
Goal 2: Enhance Care Delivery by Improving the Efficiency & Effectiveness of Systems

**TACTIC 6: Increase documentation efficiency and quality**

**Purpose and Background:**

The purpose of the Acute Care Documentation (ACD) project was to electronically document the care provided to the inpatient population in order to increase efficiency for staff and improve the quality of the documentation within the patients’ electronic record (e-chart). There were many disparate systems involved in acute care documentation that need to be anchored into one system. Some systems were electronic, e.g., POE, Results, and some are paper, e.g., vital signs, flowsheets. There needs to be one electronic inpatient health record.

**Description of Work:**

This ACD initiative created a single database that was shared by both MGH and Brigham and Women’s Hospital. The application included over 20,000 data fields mapped within flow sheets or complex structured notes, and approximately 100 notes for all disciplines including: admission, progress notes, and consults.

**Team Membership:**

A combined group of clinical and Information Systems staff, including a MGH Nursing Subcommittee and a MGH Health Professions Subcommittee, developed an e-chart to be tested (Unit Acceptance Test) on three inpatient units at each facility. MGH’s three units were: Ellison 4 Surgical ICU, Ellison 9 Cardiac ICU and White 9 General Medicine. See Attachment TL 3EO.s for full membership of the ACD organization structure and their responsibilities.

**Measurement:**

At the beginning of 2011, the ACD system was 85% designed and as yet, untested. The goal for 2011 was to complete both the design and testing of the system. The ACD project continued to expand resulting in numerous delays to the timeline. This included the development of an administrative tool to identify missing document signatures, an enterprise patient problem list and more complex application interfaces than had been originally expected. While the project was ultimately cancelled due to a strategic shift within Partners HealthCare System, many milestones and measurements were successfully achieved. This included completing 90% of the design and 50% of the testing in 2011.

**Design of the ACD application:**

- Over 20,000 data fields were identified, built and mapped within flow sheets or complex structured notes
Creation of approximately 100 notes for all disciplines including: admission, progress notes, and consults.

Detailed analysis and problem resolution in order to integrate two separate e-MAR applications

- Achieved 90% completion by December, 2011
- Achieved 100% completion by March, 2012.

Integration Testing:
- Performed Unit Testing on every data field, form, flow sheet and note prior to initiating integration testing
- Performed with 33 different applications, databases, or servers
- Achieved 50% completion by May, 2011
- Second phase underway March, 2012 when project was halted.

**TACTIC 7:** Revise the payroll system so that non-exempt employees are paid according to HR policies. Begin revising scheduling policies & practices to more precisely meet workload demands.

**Purpose and Background:**

Scheduling and payroll processes are performed at a unit level. With the anticipated implementation of a new timekeeping systems on the horizon (automated system was being rolled-out Partners-wide), the PCS Executive Team identified that it would be an opportune time to critically review its scheduling and payroll processes.

**Description of Work:**

The team looked at three primary methods to improve the efficiency of scheduling and payroll systems:

1. Explore available/current systems to streamline processes.
2. Increase efficiency of current practices for scheduling and payroll.
3. Update system capabilities to meet current/future needs.

The team identified the need to revise the timekeeping policy.

**Team Membership:**

The team included representation from Human Resources, Nursing Directors, Operating Room Staff, Operations Managers, Staff Nurses, PCS Financial Management Systems, and PCS Informatics. Their recommendations applied to all of the inpatient clinical areas in the hospital.

**Measurement:**

The primary measurements that the team targeted for improvement were the development of a timekeeping policy and successful implementation of the automated
TACTIC 8: Increase direct care time

Purpose and Background:

Clinical staff are spending time hunting for and gathering supplies that could be better spent at the patient’s bedside. Some supplies are improperly stored in patient rooms leading to waste, infection control issues, and decreased patient satisfaction with cleanliness.

Description of Work:

The team proposed to increase the amount of time nurses spent at the bedside and decrease supply waste through implementation of new processes for in-room supply stocking, storage, and handling. This intervention was modeled after the work implemented on the MGH Transforming Care at the Bedside (TCAB) unit as described in Attachment TL 3EO.v). A HealthStream on-line training deck was developed (Attachment TL 3EO.w).

Team Membership:

This effort was led by the Clinical Support Services (CSS) team who reached out to unit leadership and staff to implement the bedside carts on all units, with the exception of the inpatient psychiatric unit. Attachment TL 3EO.x contains the checklist used by the CSS team to guide unit-based implementation.

Measurement:

The team’s goal was to implement across every eligible inpatient unit in order to maximize the gains to nursing time at the bedside. At the beginning of 2011, four out of a possible 40 units were implemented. The goal for 2011 was to have 100% implementation. At year end 2011, 30 units (75%) had implemented the bedside carts, with implementation underway on the other 10 units.

TACTIC 9: Learn about how to prevent unnecessary readmissions

Purpose and Background:

Nationally, 12% of patients are readmitted within 30 days of discharge; many of these readmissions are unnecessary. To improve the efficiency and effectiveness of care, PCS aims to reduce unnecessary readmissions by identifying or developing best practices related to the discharge process and patient teaching.
**Description of Work:**

The following interventions have been identified by IHI as effective strategies in reducing rehospitalization and are being piloted as part of an interdisciplinary effort: (1) enhanced assessment of post-discharge needs (2) enhanced teaching/learning (3) enhanced communication at discharge (4) timely post-acute follow-up.

The Discharge Nurse Role was piloted on Ellison 16 Medicine: focused on facilitating/coordinating discharge activities for high-risk patients being discharged home who met pre-defined inclusion criteria. Post-discharge phone calls by pharmacist to patients discharged home from Ellison 16 Medicine who met one of the high risk criteria: CHF, Diabetes, COPD, Asthma, Pneumonia, UTI, Anticoagulation, and Renal Failure.

Staff Nurse completion of simple VNA referrals were implemented. Case Management provided training for staff and staff were granted access to a designated database.

Patient education was provided as follows:
- Discharge teaching folders/tools for patients with CHF, Diabetes and who required Wound Care
- Lovenox administration teaching

Nurse participated in education re: Teach-Back methodology

**Team Membership:**

A team of PCS leaders and clinicians, including Staff Nurses, Clinical Nurse Specialists, and Patient and Staff Educators, was pulled together to identify and implement evidence-based best practices. These interventions were piloted on Ellison 16 General Medicine and Ellison 6 & White 6 Orthopaedics.

**Measurement:**

The goal of the team was to reduce readmissions within 30 days of discharge. The pilot was moderately successful in reducing readmissions, lowering rates from baseline in 2 of the 3 pilot units.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Baseline: Patients Readmitted within 30 days of discharge 10/1/08 – 7/31/09</th>
<th>Post-Implementation: Patients Readmitted within 30 days of discharge 6/1/10 – 5/31/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellison 16 Medicine</td>
<td>19%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Ellison 6 Orthopaedics</td>
<td>7.5%</td>
<td>7.1%</td>
</tr>
<tr>
<td>White 6 Orthopaedics</td>
<td>6.3%</td>
<td>7.2%</td>
</tr>
</tbody>
</table>
The most successful implementation was on Ellison 16, where readmissions were reduced from baseline by 1.2%.

In addition to improving readmission rates, the initiative also had the benefit of improving pre-noon discharges on Ellison 16 as well.
**TACTIC 10: Execute a successful move into the Lunder Building**

**Purpose and Background:**

MGH opened a new clinical building in September of 2011. Patient Care Services played a key role in the planning for the execution of a successful move into the Lunder Building. The move had to be on schedule, on budget, safe for patients and employees and, operationally effective.

**Description of Work:**

The goal was to complete the move into the Lunder by Fall 2011, including five inpatient units, 28 ORs, Radiation Oncology, three new PACUs, Sterile Processing and the Emergency Department. To accomplish this, the team would have to redesign operational processes for each unit/department, coordinate with allied and support departments, educate and orient staff, and execute pre- and post- move logistics.

**Team Membership:**

The Associate Chiefs, Executive Director of the Institute for Patient Care and Director of Clinical Support Services oversaw the work of their respective areas of accountability in preparation for the Lunder moves. They had representation on the Lunder Building “Go-Live” Committee (Attachment TL 3E.O.y) which took the lead on the move in planning training, orientation, communications, actual moves and post-move work. The “Lunder moves” are discussed throughout the sources of evidence including TL 5 and NK 9.

**Measurement:**

The transition into the Lunder building was a seamless and efficient operation, in large part because of the work of PCS leadership and staff engaged in to prepare for the move. No patient safety issues were encountered, and the moves went so quickly that whole units such as the Lunder 10 floor were transitioned in less than 90 minutes (Attachment TL 3E.O.z).

**TACTIC 11: Reduce non-salary expenses**

**Purpose and Background:**

In 2011, the hospital was undergoing a zero-based budget process in which many areas of the institution, including PCS, were asked to offer ideas to reduce expense. Because non-salary expenses are preferable to staffing changes, PCS aimed to reduce non-salary expenses even beyond the requested budget cuts.
Description of Work:

The initial strategic focus was on mid to large size savings opportunities: Linen practices, specific product reduction opportunities (Pulse Oximetry first), Clinical Supplies at the Bedside, and non-clinical supplies (Printers Fax & Copiers first. In addition to specific product initiatives listed above the tactic includes implementation of a formal product review process.

Team Membership:

The Director of Clinical Support Services was the owner for this tactic. He is a member of the Partners Clinical Advisory Committee (in addition to three MGH Clinical Nurse Specialists) which is looking for non-salary cost reduction opportunities across the system (Attachment TL 3EO.aa). In addition to this systems-wide work, the Director of Clinical Support Services convened a Tiger Team to convert from disposable pulse oximeters to reusable ones. The pilot occurred on the following five General Medicine Units: White 8, 9, 10, 11 and Bigelow 11. The Nursing Directors, Clinical Nurse Specialists, Operations Managers and Staff Nurses on these units participated in the pilot.

Measurement:

The major source of non-salary savings in 2011 was switching from disposable pulse oximeters to reusable ones. This resulted in $86,000 in savings in 2011 compared to the baseline of spending in 2010, and another $100,000 of savings in 2012.

Goal 3: Ensure Staff Have a Strong Voice in Design of Care & Services

TACTIC 12: Enhance staff input in decision-making that influences care delivery

Purpose and Background:

Created in 1997, the Collaborative Governance Committee communication and decision-making structure had remained essentially unchanged since its launch. In 2011, the Patient Care Services Executive Team identified the need to more fully-integrate the practice and quality committees’ work. It was also an opportune time to critically review what committees were still required and which new committees should be launched.

Description of Work:

The redesign of Collaborative Governance built on the lessons learned from Excellence Every Day (EED) and Magnet Champions on how to engage practicing clinicians in key organizational initiatives. Toward that end, the philosophical framework of EED, which focuses on regulatory readiness, was adopted for guiding and organizing the work for all Collaborative Governance committees moving forward. The charges of the Diversity, Ethics, and Patient Education remained unchanged.
The Collaborative Governance redesign initiative focused on the Nursing Practice and Quality committees, the introduction of an Informatics committee and transitioning the Nursing Research committee to an interdisciplinary research committee. Through the creation of five sub-committees reporting into a joint Practice and Quality committee PCS would be able to address the practice and quality issues related to fall prevention, pain management, policy, procedure and products, restraint usage and skin care and positively improve the care delivered to patients and in compliance with regulatory statues.

**Team Membership:**

Led by Guardia Banister, Executive Director of the Institute for Patient Care, an interdisciplinary team comprised of: Associate Chiefs, Executive Director of PCS Operations, Director, PCS Office of Quality & Safety, Directors of Social Services, Physical Therapy, and Speech/Language Pathology, and a Professional Development Manager met to propose a new structure for Collaborative Governance.

**Measurement:**

In the development of the new Collaborative Governance structure, the team identified two metrics to measure their success post implementation of the new structure in April 2011:

1. Attendance at committee meetings will be 80% (Baseline = 0%, Target = 80%)
2. All PCS disciplines will be represented across the Collaborative Governance structure (Baseline = 0%, Target = 100%)

At the end of 2011, an audit of committee minutes reflected that 72% of Committee Champions attended meetings, short of the 80% attendance target.

<table>
<thead>
<tr>
<th>Tactic Measure</th>
<th>Target Score</th>
<th>2011 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee Attendance</td>
<td>80%</td>
<td>72%</td>
</tr>
<tr>
<td>Discipline Representation</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

As noted in the table above and below, representation by all disciplines within Patient Care Services on collaborative governance committees, (Nursing, Medical Interpreters, Chaplaincy, Social Services, Occupational Therapy, Physical Therapy, Speech/Language Pathology and Respiratory Care) was achieved.

<table>
<thead>
<tr>
<th>Collaborative Governance Committee</th>
<th>PCS Discipline(s) Represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity</td>
<td>Nursing, Medical Interpreters, Chaplaincy, Social Services</td>
</tr>
<tr>
<td>Ethics in Clinical Practice</td>
<td>Nursing, Social Services, Respiratory Therapy, Chaplaincy</td>
</tr>
<tr>
<td>Informatics</td>
<td>Nursing, Social Services, Speech/Language Pathology</td>
</tr>
<tr>
<td>Falls Reduction</td>
<td>Nursing, Occupational Therapy</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Nursing, Social Services</td>
</tr>
<tr>
<td>Restraint Usage</td>
<td>Nursing, Occupational Therapy, Social Services</td>
</tr>
<tr>
<td>Policies, Procedures and Products</td>
<td>Nursing, Respiratory Therapy, Physical Therapy</td>
</tr>
<tr>
<td>Skin Care</td>
<td>Nursing</td>
</tr>
<tr>
<td>Patient Education</td>
<td>Nursing, Occupational Therapy, Social Services, Respiratory Care, Speech/Language Pathology</td>
</tr>
<tr>
<td>Interdisciplinary Research</td>
<td>Nursing, Social Services, Respiratory Care, Speech/Language Pathology</td>
</tr>
<tr>
<td>Staff Nurse Advisory</td>
<td>Nursing</td>
</tr>
</tbody>
</table>

**TACTIC 13: Create and implement a Diversity Leadership Fellowship Program**

**Purpose and Background:**

In order to continue to increase the diversity of the Patient Care Services workforce, particularly the leadership team, strategies such as developing and implementing a Diversity Leadership Fellowship are important.

**Description of Work & Team Membership:**

The Director of PCS Diversity collaborated with Human Resources Director for PCS, the Executive Director of the Institute for Patient Care, and the Director of Speech/Language Pathology to develop the curriculum for the Diversity Fellowship.

**Measurement:**

Although a robust curriculum was developed (Attachment TL 3E.O.bb), funding for the Fellowship was not obtained in 2011. Collaboration with the MGH Development Office is underway to seek donor funding for the Diversity Leadership Fellowship Program.

**TACTIC 14: Increase efficiency and effectiveness of educational offerings across PCS departments**

**Purpose and Background:**

The aim of this work was to economize resource use for approaches to staff education and training of selected material/topics in order to decrease redundancies and increase efficiencies across PCS disciplines. The committee’s work was guided by the PCS mission statement which places the accountability for patient-focused care with the interdisciplinary team. In addition to identifying efficiencies, the group recognized the potential this work provided in enhancing the existing strong, interdisciplinary, collaborative relationships inherent in the PCS departments and resultant affect on promoting positive patient care outcomes.
**Description of Work:**

The team analyzed the issues related to PCS educational initiatives through departmental survey and dialogue (Attachment TL 3EO.cc). The group has collaboratively developed the following recommendations to achieve the aim of the project charter:

1. Centralize aspects of departmental orientation programs to create a PCS orientation program.
2. Increase utilization of HealthStream (online training) to decrease the need for instructor-led programming.
3. Centralize the development and delivery of in-service education sessions when appropriate (i.e., content targeted at more than one PCS discipline).
4. Develop an interdisciplinary educational program designed to improve staffs’ ability to mentor/precept/supervise new employees.

**Team Membership:**

An interdisciplinary group, representative of PCS departments with accountability for the education product line developed the recommendations to improve and streamline educational offerings across all of PCS (Attachment TL 3EO.dd).

**Measurement:**

The two measures of success were proposed for this tactic: completing the baseline assessment by January 15th of 2011, and creating their improvement recommendations by March 1st of 2011. Each of the recommendations was accepted and is in the process of being implemented by the Institute for Patient Care.

1. Centralize aspects of departmental orientation programs to create a PCS orientation Program. Attachment TL 3EO.ce contains the slide deck from the PCS orientation program.
2. Increase utilization of HealthStream (online training) to decrease the need for instructor-led programming. Utilization of HealthStream, particularly for continuing education continuation is presented in OOD 10.
3. Centralize the development and delivery of in-service education sessions when appropriate (i.e., content targeted at more than one PCS discipline). Attachment TL 3EO.ff presents 2010-2012 courses developed to reach PCS-wide audiences. In addition, all educational offerings hosted by the Norman Knight Nursing Center for Clinical & Professional Development are open to all disciplines, as appropriate.
4. Develop an interdisciplinary educational program designed to improve staffs’ ability to mentor/precept/supervise new employees. The Nursing Preceptor Workshop has been modified to be applicable to all disciplines across Patient Care Services.
At the end of 2011, many of the goals laid out by the organization had been achieved, leading to meaningful improvements in the efficiency and effectiveness of care, and the satisfaction of patients, families, and staff. Attachment TL.3EO.gg graphically displays achievement of the 2010-2011 strategic goals and tactics. This robust strategic planning process helps PCS, and the hospital, achieve its mission to provide the best possible care to every patient and family in every moment of every day.
Patient Care Services Executive Committee  
October 27, 2010  
2:30pm to 4:00pm  
Massachusetts General Hospital  
Trustees Room  
MINUTES

Presiding: J. Ives Erickson, RN
Guest: L. Lebrun
Staff Support: K. McCullough

I. Updates

- R. Corder requested input from the committee regarding a potential donor who is interested in extending a $25k initial gift towards efforts to reduce noise and light in patient rooms at night. He suggested that this could be a cost-effective campaign to raise awareness using posters and promotion. He created a document which he distributed to the group and requested input on prior to the end of the week when he plans to respond to the potential donor.
- J. Ives Erickson announced that Deb Washington has been extended an invitation to serve a 2-year appointment as Director for the newly designated American Organization of Nurse Executives (AONE) Foundation, which is a new 501 (c) 3 supporting organization with a mission to support the research and educational priorities of AONE.

II. PCS Retreat Recap – J. Ives Erickson

J. Ives Erickson recapped the 2011 Strategic Goals that were agreed upon at the 2010 PCS Retreat and highlighted the need to organize and package them in a way that can be communicated in language that will resonate with staff. Each charter was then presented by its author(s) and reviewed by the committee for final approval. It is important to consider that the people who took the assignment to create the charters did not volunteer to own the work nor are they necessarily the appropriate owner. An example is the work around safety rounds. Although the charter was created by K. Perleberg, much of this work should belong to the line mgt team. It will be important to think about and confirm who the real owners are for each tactic.
J. Ives Erickson reviewed a list of the July budget cutting ideas and noted that some of them are “just do it” items, while others require more formal proposals (i.e. M. Sullivan’s proposal to Foxboro and A. Daniels’ work with the patient family lodging). She is pleased that we have a running start on the inevitable budget mandates that will be coming our way, but there is still a long way to go. We have to keep this momentum. It will also be important to decide what to do with the many other priorities that we are working on to make sure that we don’t lose sight of them. Identifying available baseline data is also crucial as we set our priorities for our 2011 Strategic Goals.

At one of our upcoming meetings, we will try to schedule a longer meeting to discuss packaging, timeline, who has the “D”, measurement and rollout. While the strategic goal tactics will likely remain constant, the specific strategic goals these tactics fall under will be refined over the next weeks; J. Ives Erickson reminded the group that this is still a draft.

In addition to summarizing the information that was included on each charter (attached), there was additional discussion surrounding several of the tactics. Discussion points are noted below.

- **Tactics - Cleanliness**: Work is already underway on this effort. Partners is in negotiations with payers about what quality indicators will be tied to our pay-for-performance (P4P) targets. Although a final decision has not yet been made around the P4P targets, it was agreed that PCS would like to focus on improving cleanliness and staff responsiveness no matter what. This team is taking a new focus by involving all roles and developing a deeper understanding around why and when there are shifts in our performance. They plan to dig deeper into units with variation to try to make their performance more consistently positive. The taskforce is also taking a look at cleanliness from a workforce perspective to see if there might be new, more efficient and effective techniques that are less taxing on staff.

- **Tactic - Staff Responsiveness**: Similar to the efforts around cleanliness, work is already well underway on this issue and there is a high likelihood that this metric will be selected as a P4P target. And similarly, PCS has agreed that this is an area to focus on regardless of whether or not it is selected. This is a very diverse group that is leveraging tactics that are both unit-based and across the house. For goal setting on this initiative, the group could decide on a stretch target that is separate from the P4P target. J. Ives Erickson suggested that the PCS practice-based dashboard could be leveraged as a tool to help us move the units that score in the red to work towards getting up to the norm and to encourage units that are already in the green towards making incremental improvements. P. Bartush also noted that it will be important to pay extra attention to staff responsiveness during the Lunder Building move and to consider issues around patients potentially feeling isolated without roommates.

- **Tactic - Safety Rounds**: The group is pleased to report that already 75% of the units have implemented safety rounds. Those units that reported not having done so, actually have, but in their own individualized way. For now, the group is not yet sure whether or not ED boarders should be considered out of scope. J. Ives Erickson suggested that the ownership of this really belongs to the line management team. With that said, as discussed at the
retreat, K. Perleberg will work to operationalize and define a minimum core standard for what rounding is and how to integrate that across the hospital.

- **Tactic - Reducing Hospital Acquired Pressure Ulcers:** It will be important to get data from the recent prevalence survey broken down between practice, systems and environment. This will be discussed at the upcoming interdisciplinary Pressure Ulcer reduction meeting which is scheduled for next week. The group will present the new metrics at our next PCSEC meeting.

- **Tactic - Acute Care Documentation:** Sally Millar explained that although there are various charters for aspects of this initiative, she is still looking for the overarching charter. In the meantime, she summarized that the goal of the project is to increase efficiency and quality of acute care documentation and to reduce redundancy. The problem statement is that there are many disparate systems that need to be anchored into one system. The target of the initiative is to create one system that will improve the efficiency and quality of acute care documentation and be leveraged for reporting, education and research purposes. In scope will be all inpatient documentation excluding the EMR which is already automated. Out of scope will be the PACU, SDSU and ED. The deliverable will be to have this system piloted by early 2012.

- **Tactic - Medical Interpreter Technology Utilization:** P. Bartush noted that leveraging technology to efficiently and effectively deliver medical interpreter services is an ongoing endeavor that is gaining momentum. The group has already beaten their milestones and is pleased to report that they are ahead of schedule.

- **Tactic - Payroll Process & Scheduling Process:** During this discussion it was noted that they still need to determine if this effort will address the scheduling and payroll processes for all of Patient Care Services or just the nurses. The group is working to set time targets for the deliverables and will come back to the group once those have been finalized.

- **Tactic - Collaborative Governance Re-Design:** Work on this effort has been underway for quite some time and the group is getting close to some of the key milestones. They had a 4-hour retreat earlier in the week with an interdisciplinary group of representatives to discuss issues related to the implementation of the new design. Leadership will be reconvening later in the week to collate all of the input that was shared and to determine next steps. The goal will be to implement the redesign after the 1st of the year.

- **Tactic - Supplies at the Bedside:** This group has been actively working to fast-track their work in order to try to complete the rollout by the end of January. In order to accomplish this, they have been rolling it out to multiple units at a time. G. Reardon noted that it has been a challenge to put out such an aggressive timeline without having communicated it to the staff as being part of the strategic plan.

- **Tactic - Readmit Pilot:** J. Ives Erickson noted that this project charter, like many others, has to take a look at wording to make sure that appropriate language is being used to accurately paint the big picture about why it is important. In particular, she suggested...
that the project title should be changed from the “readmit pilot” to “Avoiding Unnecessary Readmissions.” This effort ties into some work that Ellison 6 Orthopaedics and 16 General Medicine have been piloting as part of an Partners initiative in conjunction with the Institute for Healthcare Improvement (IHI). Beyond this pilot, PCS is thinking about what we must do across the hospital to avoid unnecessary readmissions. It is important for us to decide if we are going to go along with the IHI or if we want to go beyond the pilot to take this on as our own PCS initiative. Currently, the carter is written for nursing but it should be adapted to include all of PCS. J. Ives Erickson also pointed out that the scope of the project does not include physician related issues around readmissions. With this in mind, it will be important to tie the metrics to interventions that we control and can influence.

- **Tactic - Diversity – Workforce, Leadership, and Disabilities Support & Awareness:** D. Washington raised her concern that one of their biggest challenges will be around how to handle situations in which people who have taken advantage of these programs are still struggling to find work. There is also some concern that these services are primarily nursing focused and the group wants to extend to all services. R. Lipkis-Orlando will work to include staff with disabilities in these workforce development activities. It will be important to develop a leadership fellowship using Hausman funds. J. Ives Erickson also emphasized that given the current climate, it is important to focus on the retention of our diverse workforce members since hiring opportunities will be less. Along those lines, it will be important to measure the right metrics to gauge our success.

See PowerPoint attached:

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### III. Action Items and Next Steps

- J. Ives Erickson said that she will share Partners’ Structure for patient affordability at one of our next meetings.
- Schedule a longer meeting to discuss packaging, timeline, who has the “D”, measurement and rollout. Confirm who the real owners are for each tactic. While the strategic goal tactics will likely remain constant, the specific strategic goals these tactics fall under will be refined over the next weeks. We will need to organize and package the goals in a way that can be communicated in a language that will resonate with staff.
- M. Ditomassi will follow up with G. Chisari and G. Banister to include a tactic that focuses specifically on education.
- At our next PCSEC meeting, the Pressure Ulcer Reduction group will present the new metrics identified in the recent prevalence survey broken down between practice, systems and environment.
- The Payroll Process & Scheduling Process group is working to set time targets for the deliverables and will come back to PCSEC once those have been finalized.
• The Avoiding Unnecessary Readmissions group will get back to the PCSEC once they have determined if they will go beyond the pilot and take this on as our own PCS initiative. They also will adapt the charter to include all of PCS and will tie the metrics to interventions that we control and can influence.
• R. Lipkis-Orlando will work to include staff with disabilities in workforce diversity and leadership development activities.
• R. Corder, T. Elliot and K. Perleberg will work to identifying available baseline data for the various strategic initiatives.
Tactic 3c: Ensure Equitable Patient Care – Improve communication with efficient use of resources and technology

Next Step Owners: P. Bartush, A. Nunes

Aim/Linkage to Strategic Goal: Provide Culturally Competent Care to all patients. Provide opportunities for LEP patients to participate fully in their health care.

Problem Statement: Current under-utilization of video modality (V-POP) is preventing available resources to be leveraged to their full potential in order to deliver medical interpreter services to Spanish and Portuguese speaking patients.

Target/Benefit: Increase usage of video modality (V-POP) to create efficiencies in effort to:
- support mission of MGH by allowing LEP patients to participate fully in their health care
- respond to clinician and patient need more rapidly (support throughput)
- reduce expenses associated with language vendor (I-POP)

In Scope: All Inpatient Units, select outpatient practices with high volume of Spanish and Portuguese speaking patients

Out of Scope: MGH West, MGH North Shore and MGH Health Centers (all have existing systems)

System Capabilities/Deliverables: Monthly reporting at a unit level. Quarterly Reporting at a unit level.

Resources Required/Team: Medical Interpreter Services leadership, select inpatient unit leadership, IS team support

Metrics/Measurements:
1. % of units where VPOP is live.
   Baseline 26/72; 36%. Target 72%
2. % of over utilization of IPOP (vendor) where VPOP could have been used.
   Baseline = 33% Target =/< 5%

Milestones:
Live FY10: W8, W9, W11, E13, E16, E17, E18, B13, G6, G11, G12, B4, CRP9
11/30/10 W10, W12, E11, E21 & G13
9/30/11 E6, E8, E19, B8, B10, L LLC and D, L2, L3, L4, L6, L7, L8, L9, L10, G3 OR
12/31/11 W6, B12, W12 & E12 CPC
I. OVERVIEW
The Communication and Responsiveness Committee was initiated in December, 2009, in response to the need to address Strategic Goal #1: Improve the patient, family, and employee experience (quality, safety and service). The Communication and Responsiveness Committee is comprised of the leadership for each of the disciplines in Patient Care Services.

The evidence-based practice identified to enhance the patient and staff experience is Hourly Patient Rounding; the patient experience is enhanced while safe, effective care is delivered by reducing falls and pressure ulcers. Hourly Rounding also supports the delivery of more efficient care by proactively addressing patient needs by providing a timely, controlled and manageable method for addressing the primary needs of patients.

Rounding is an evidence-based practice where nurses and other care staff work together to engage patients and build relationships built on trust - it is practicing in a pro-active versus reactive manner. With rounding, the questions are very intentional and the behaviors are very specific. To demonstrate to patients that the hospital cares about them, rounding must come from the heart.

II. GOALS
Strategic Goal #1: Improve the Patient, Family, and Employee Experience (Quality, Safety and Service)
- Improve clinician and support staff communication with patients and families
- Improve responsiveness
- Increase patient satisfaction/quality and safety
- Provide patients with a heightened sense of security and caring - build relationships and trust
- Enhance service quality and patient-centered care
- Improve HCAHPS scores
### III. Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. Banister, RN</td>
<td>Co-Chair</td>
<td>Institute for Patient Care</td>
</tr>
<tr>
<td>K. Perleberg, RN</td>
<td>Co-Chair</td>
<td>Office of Quality and Safety</td>
</tr>
<tr>
<td>P. Bartush</td>
<td>Member</td>
<td>Volunteer Department, Interpreter Services</td>
</tr>
<tr>
<td>L Carbunari, RN</td>
<td>Member</td>
<td>International Program</td>
</tr>
<tr>
<td>G. Chisari, RN</td>
<td>Member</td>
<td>Norman Knight, Nursing Center</td>
</tr>
<tr>
<td>R. Corder</td>
<td>Co-Chair</td>
<td>Service Improvement</td>
</tr>
<tr>
<td>M. J. Costa, RN</td>
<td>Staff Support</td>
<td>PCS</td>
</tr>
<tr>
<td>A. Daniels, LICSW</td>
<td>Member</td>
<td>Social Services</td>
</tr>
<tr>
<td>T. Gallivan, RN</td>
<td>Member</td>
<td>Nursing Practice</td>
</tr>
<tr>
<td>L. Holden, RN</td>
<td>Member</td>
<td>Center for Quality &amp; Safety</td>
</tr>
<tr>
<td>G. Peirce</td>
<td>Member</td>
<td>Promotion, Communication and Publicity</td>
</tr>
<tr>
<td>G. Reardon</td>
<td>Member</td>
<td>Clinical Support Services</td>
</tr>
<tr>
<td>M. Sullivan, DPT</td>
<td>Member</td>
<td>Physical Therapy and Occupational Therapy</td>
</tr>
<tr>
<td>C. Vega-Barachowitz, CCC-SLP</td>
<td>Member</td>
<td>Speech-Language Pathology</td>
</tr>
<tr>
<td>Suzanne Algeri, RN</td>
<td>Member</td>
<td>Nursing Practice</td>
</tr>
<tr>
<td>Sharon Badgett-Lichten, LICSW</td>
<td>Member</td>
<td>Service Improvement</td>
</tr>
<tr>
<td>Colleen Gonzalez, RN</td>
<td>Member</td>
<td>Nursing Practice</td>
</tr>
<tr>
<td>Nancy Sullivan</td>
<td>Member</td>
<td>Case Management</td>
</tr>
<tr>
<td>Brian French, RN</td>
<td>Member</td>
<td>Blum Patient &amp; Family Learning Center</td>
</tr>
</tbody>
</table>
IV. COMMITTEE STRUCTURE

The organizational chart below illustrates the relationship between the Communication & Responsiveness Leadership and its Committees.

♦ EVIDENCE-BASED PLAN/ACTION PLAN
  ▪ PURPOSE
    ▪ To define the evidence-based practice parameters; the actual process and specific actions for actions and behaviors to include role responsibilities and designated time frames for rounding.
    ▪ Identify key words
    ▪ Define the expectations
    ▪ Create the documentation requirements
    ▪ Describe the implementation plan
    ▪ Determine how to “hardwire” the discipline of rounding

♦ EDUCATION COMMITTEE
  ▪ PURPOSE
    ▪ To develop the educational curriculum based on the evidence-based data on rounding, and to provide systems and technology for the dissemination of this knowledge for patients, staff and the organization.
    ▪ Educate nursing leadership, clinicians and staff support
      ▪ PowerPoint presentations
      ▪ Healthstream
      ▪ Video
      ▪ Vignettes
      ▪ Orientation program / Competencies
      ▪ Focus groups
COMMUNICATION/ MARKETING COMMITTEE

- **PURPOSE**
  - To develop the organizational communication strategies to advance the goals of the rounding initiative.
    - Caring Headlines
    - Poster campaign
    - Welcome cards
    - Pocket cards
    - Pillow cards

MEASUREMENT COMMITTEE

- **PURPOSE**
  - To provide outcome measurement data for hourly clinical rounding.
    - Collect baseline data and define goals
    - Create hourly rounding dashboard report
    - Monitor patient and staff satisfaction
    - Measure fall & hospital-acquired pressure ulcers rates
    - Measure call light usage
    - Acknowledge and recognize success!

TECHNOLOGY

- **PURPOSE**
  - To evaluate technological applications that will enhance real-time communication capabilities, reduce patient response times, and increase nurse satisfaction.
    - To collaborate with PHS wide initiatives exploring I-Phone applications.

REFERENCES

Landmark study: Specific nursing actions performed at set intervals were associated with statistically significant reduced patient use of the call light overall, as well as a reduction of patient falls and increased patient satisfaction. Conclusions: A protocol that incorporates specific actions into nursing rounds conducted either hourly or once every two hours can reduce the frequency of patients' call light use, increase their satisfaction with nursing care, and reduce falls. Based on these results, we suggest operational changes in hospitals, emphasizing nurse rounding on patients to achieve more effective patient-care management and improved patient satisfaction and safety. Meade C, Bursell A, Ketlesen L. Effects of nursing rounds on patients’ call light use, satisfaction and safety, *American Journal of Nursing*. 2006; 106: 58-70.

## Communication and Responsiveness
### Committee Meeting
January 24, 2011
4:00 – 5:00 pm
Founders 311

**Minutes**

Chair(s): Gaurdia Banister, RN, PhD, Paul Bartush, Richard Corder, Keith Perleberg, RN

Present: Suzanne Algeri, RN, Sharon Badgett-Lichten, LICSW, Gino Chisari, RN, Richard Corder, Theresa Gallivan, RN, Colleen Gonzalez, RN, Lela Holden, RN, Jennifer Lassonde, Keith Perleberg, RN, George Reardon, Michael Sullivan, DPT, Nancy Sullivan, Brian French, RN, PhDc

### Topic Discussion Action/Follow Up

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
<th>Action/Follow Up</th>
</tr>
</thead>
</table>
| HCAHPS:  
2010 Re-cap  
2011 Targets  
2010 Focus Chart- Priorities for Clinical Care areas | Richard shared with the committee that MGH exceeded the 2010 targets for RN communication, staff responsiveness and room cleanliness. MD communication was below target. P4P targets for 2011 will be RN and MD communication and staff responsiveness. Cleanliness will remain as a target for PCS however no compensation will be attached.  
A grant submission to the Picker Institute to further our efforts to address staff responsiveness is in development. | A discussion ensued on the drivers that predict HCAHPS scores. Richard and his team are analyzing the quantitative and qualitative data. He provided focus charts on the influence of key priorities such as quiet at night or management of pain on performance measures. The group discussed the effects of the high census, semi-private rooms, etc on performance outcomes. Richard responded that in the qualitative comments, approximately 10% of the respondents mention noise and less than 1% mention the behavior of a roommate. Specific targets for FY11 are in development and will be available by the next meeting.  
The committee continues to emphasize the importance of an interdisciplinary approach to the patient experience. |
| Communication Technology Update | Jen gave an excellent presentation on a process improvement Kaizen with staff on White 11 and Phillips 21. Prior to introducing new technology, it was essential to understand the challenges and opportunities related to communication between clinicians and staff with patients and their families. | The findings from the presentation will be shared in a variety of forums for review and feedback. Before widespread dissemination, the participants agreed that it would be prudent to continue to monitor and evaluate the outcomes. Sustainability is essential. |
Communication and Responsiveness
Committee Meeting
January 24, 2011
4:00 – 5:00 pm
Founders 311

Minutes

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
<th>Action/Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of Value Based Purchasing from CMS</td>
<td>A comment period is underway by CMS in regard to value based purchasing. The proposal is to eliminate “likelihood to recommend” and combine cleanliness and quiet at night. The comment period ends March 8th.</td>
<td>Informational.</td>
</tr>
<tr>
<td>Patient/Family Education Video Update</td>
<td>Brian discussed a survey that was sent to the committee. Everyone was asked to provide feedback by January 26th. In the meeting, the committee discussed the importance of focusing the message, including a link to quality and safety and having the information available in multiple mediums i.e., website, patient education channel.</td>
<td>A suggestion was made to include patients and families in the development of the video i.e., members of PFACs.</td>
</tr>
<tr>
<td>Safety Rounding Update</td>
<td>Keith shared that a survey was distributed to the nursing leadership and that focus groups were being held. He will also be addressing the NDs tomorrow providing information on what units have rounding in place, the frequency, the personnel conducting the rounds and whether scripting is being used.</td>
<td>Safety rounding updates will be provided each month.</td>
</tr>
</tbody>
</table>

Next Meeting:

Monday
February 28, 2011
3:00 - 4:00 pm
Founders 311
Massachusetts General Hospital
Patient Care Services

Hourly Safety Rounds Tool Kit

MAY 2011
Frequently Asked Questions, Hourly Safety Rounds

What is new about hourly safety rounds?
Nurses have always assessed their patients on a regular basis. What’s new about hourly safety rounds is that they are evidence-based, predictable, need-driven, and scripted for consistency.

What are the proven outcomes of hourly safety rounding?
- Decreased patient falls
- Decreased skin breakdown
- Improved patient satisfaction
- Improved nursing satisfaction including decreased call light usage and distance walked each day by nursing staff

How will we know if hourly safety rounds are working?
- Review quarterly fall rates
- Review quarterly pressure ulcer rates
- Review HCAPH scores/patient comments
- Review/discuss hourly safety rounds regularly at staff meetings

What are key elements that need to be in place for hourly safety rounds to be successful?
- Involvement of patients, families, nurses, patient care associates, and the other roles and disciplines comprising the Care Team
- Predictability (rounding every hour between 6:00AM and 10:00PM and then every two hours between 10:00PM and 6:00AM)
- Focus (use of the 7P’s)
- Scripting (using the same message for consistency)
**Resources for hourly safety rounds?**
- Hourly Safety Rounds Toolkit
- Nursing Director, Clinical Nurse Specialist, PCS Office of Quality and Safety Staff
- Unit/Practice-Based Nursing Sensitive Indicator Manual

**Do hourly safety rounds apply to ICU settings?**
- Yes. When 7P’s cannot be used with the patient, some of them can be used with the patient’s family
HOURLY SAFETY ROUNDS
PATIENT CARE SERVICES
OFFICE OF QUALITY AND SAFETY

May 2011
SAFETY ROUNDS: AN EVIDENCE-BASED APPROACH


- Found that a protocol which incorporates **specific actions** into nursing rounds either hourly or once every two hours:
  - decreased patient falls by 50%
  - decreased skin breakdown by 14%
  - increased patient satisfaction scores by 8.9 Points
  - decreased call light use by 38%
  - reduced distance walked each day by nursing staff by 20%
THE 7 P’s

Presence

• Person
• Plan
• Priorities

Part of first Safety Round at beginning of shift, and may include interaction with Others (e.g., family)

• Personal Hygiene
• Pain
• Position

Part of each Safety Round
SAFETY ROUNDS: THE PATIENT CARE SERVICES (PCS) STRATEGIC PLAN

• PCS 2011 Strategic Plan Goal #1: Enhance Responsiveness To Patients and Families by Meeting Or Exceeding Expectations

• Tactic #2: Implement Safety Rounds on All Inpatient Care Units (Including ICUs) by January 1, 2011
GUIDING PRINCIPLES FOR SAFETY ROUNDS

• **RN Accountability:** With attempt to involve all role groups and disciplines (e.g., Operations Associate response to call lights, plan for other disciplines to communicate patient needs to nursing, importance of Unit Service Associate engagement in Safety Rounds, etc.).

• **Sustainability:** Importance following the metrics (e.g., falls, pressure ulcers, patient satisfaction).

• **Rounds must be Focused and Predictable:** Importance of scripting and clarity about frequency of rounds.
HOURLY SAFETY ROUNDS RESOURCES

• PCS Office of Quality and Safety Staff (#3-0140)

• Nursing Directors and Clinical Nurse Specialists

• Knight Nursing Center for Clinical and Professional Development
Scripting for The Seven P’s

<table>
<thead>
<tr>
<th>“P”</th>
<th>Script</th>
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</thead>
</table>
| Person | Knock on door.  
Hello Mr/Mrs/Ms (name of patient).  
I am (name of nurse).  
I will be your nurse for (time frame).  
I, or another member of your team, will be making rounds every hour to make sure you have what you need. |
| Plan  | I would like to remind you of your plan for today. |
## Scripting for The Seven P’s

<table>
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<tr>
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</table>
| Position | Would you like help with changing your position?  
Note: Make sure the call light, telephone, TV remote control, bed light, bedside table, glasses, water, trash receptacle, and tissues are all within the patient’s reach. |
## Scripting for The Seven P’s

<table>
<thead>
<tr>
<th>“P”</th>
<th>Script</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priorities</td>
<td>What’s the most important thing you would like to get done today?</td>
</tr>
<tr>
<td>Personal Hygiene</td>
<td>Do you need help to go to the bathroom?</td>
</tr>
<tr>
<td>Pain</td>
<td>How is your pain on a scale of 0-10?</td>
</tr>
</tbody>
</table>
Scripting for The Seven P’s

<table>
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<tr>
<td>Presence</td>
<td>Is there anything else I can do for you?</td>
</tr>
<tr>
<td></td>
<td>I will be back in one hour.</td>
</tr>
</tbody>
</table>
**Frequency and The Seven P's**

**PRESENCE**: > Always

**PERSON**  \[ \rightarrow \]  **PLAN**

Part of the **first** hourly safety round at beginning of the shift

**PRIORITIES**

**PERSONAL HYGIENE**  \[ \rightarrow \]  **PAIN**

Part of **each** hourly safety round

**POSITION**
Hourly Safety Rounds Toolkit Checklist

- Education and engagement of all role groups and disciplines
- Rounds performed hourly between 6:00AM and 10:00PM
- Rounds performed every two hours between 10:00PM and 6:00AM
- Rounds performed by both RNs and PCAs
- Scripting is used
- The “Seven Ps” are used
- Falls data reviewed quarterly
- Pressure Ulcer data reviewed quarterly
- Patient Satisfaction data reviewed quarterly
Massachusetts General Hospital
Patient Care Services
Office of Quality and Safety

Results of Hourly Safety Rounds Survey
(November 2 – 11, 2010)

Report for Associate Chief Nurses
November 17, 2010
Survey Methodology

An electronic survey was disseminated by the PCS Office of Quality and Safety on November 2, 2010 to assess the current state of safety rounds implementation. Nursing directors were encouraged to complete a survey for their area(s) of accountability between 11/02/2010 – 11/16/2010.

Sample Size

The sample was limited to “inpatient” units only (i.e. any unit where patients stay overnight). The Emergency Department responded to the survey. The OR and procedural areas were excluded.

Summary of Survey Results

Based on N=41.

- 78% of units have initiated some form of safety rounds (i.e. 32 out of 41 units).
- 22% of units plan to implement safety rounds by January 1, 2011 (i.e. 9 out of 41 units).

Next Steps

1. PCS Office of Quality and Safety staff will collaborate with Nursing Leadership from the various units to implement safety rounds by January 1, 2011. This will include developing sustainability.
2. A follow up survey will be completed week of January 10, 2011.

Survey Response by Associate Chief Nurse

<table>
<thead>
<tr>
<th>Implemented Safety Rounds</th>
<th>D. Burke</th>
<th>T. Gallivan</th>
<th>J. Somerville</th>
<th>D. Tenney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blake 11</td>
<td>Bigelow 11</td>
<td>Bigelow 14</td>
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<tr>
<td>Blake 13</td>
<td>Blake 8</td>
<td>Bigelow 6</td>
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<tr>
<td>Blake 14</td>
<td>Ellison 1/ED</td>
<td>Ellison 6</td>
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<td>Bigelow 6</td>
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<td>Ellison 12</td>
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<td>Bigelow 7</td>
<td>Ellison 9</td>
<td>Ellison 14</td>
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<tr>
<td>Ellison 6</td>
<td>Ellison 10</td>
<td>Ellison 19</td>
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<tr>
<td>Blake 10/NICU</td>
<td>Ellison 11</td>
<td>White 6</td>
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<td>Ellison 17</td>
<td>Ellison 16</td>
<td>White 7</td>
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<td>Ellison 18</td>
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<td>White 10</td>
<td>Phillips 21</td>
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<td>White 13</td>
<td>Blake 12</td>
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<td>Bigelow 12</td>
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Massachusetts General Hospital
Patient Care Services
Office of Quality and Safety

Results of Hourly Safety Rounds Survey
(February 11-18, 2011)
Survey Methodology

An electronic survey was disseminated by the PCS Office of Quality and Safety on February 11, 2011 to assess the current state of safety rounds implementation. Nursing directors were encouraged to complete a survey for their area(s) of accountability between 02/11/2011 – 02/18/2011.

Sample Size

The sample was limited to “inpatient” units only (i.e. any unit where patients stay overnight). The OR and procedural areas were excluded.

Summary of Survey Results

Based on N= 39.

- All units have initiated some form of safety rounds (100%)

Rounding Frequency
- 75% of units round at least every hour (29 units out of 39)
- 24% of units round using other frequencies either than hourly ( 10 units out of 39)
  - 4 units round every two hours
  - 6 units use a varied combination of hourly, every two hours and every 30 minutes

Clinicians Involved In Rounds
- Most units have RNs rounding (85%, 33 out of 39 units)
  - RN only 16 units 41%
  - RN + PCA 19 units 49%
  - PCAs only 2 units 5%
  - RN + PCA+ other 2 units 5%

Elements included in Rounds
- All units included some elements of the 7Ps of rounding for local unit-based rounds
  - Pain 39 units 100%
  - Person 35 units 90%
  - Position 35 units 90%
  - Personal Hygiene 32 units 82%
  - Presence 27 units 69%
  - Plan 26 units 67%
  - Priorities 25 units 64%

Scripts
- Most units do not use any form of scripting (74%, 29 units out of 39)
Patient Family Advisory Council Membership

Chair:
Robin Lipkis-Orlando, RN, Director, Office of Patient Advocacy

Co-Chairs:
Sharon Badgett Lichten, LICSW, Project Manager, Practice Improvement
Rick Evans, Director, Service Improvement

Patient/Family Members:
Susanne Goldstein
Kathy Varela
Sue Lunn
Patrick Brannelly
Win Hodges
David Wooster

MGH Staff Members:
Bessie Manley, RN, Nursing Director, Phillips House 22 Surgery
Linda Kane, LICSW, Office of Patient Advocacy
Steve Reardon, MPH, Office of Patient Advocacy
Karen Tanklow, LICSW, Clinical Director, Social Services
Touquir Zahra, MD, Hospitalist
Sandy Clancy, PhD, Pediatrics
Kay Bander, MGH Volunteer Services
Massachusetts General Hospital
Patient and Family Advisory Council (PFAC) Bylaws

Article 1. Overview

The MGH Patient Family Advisory Council (PFAC) will provide a formal communication vehicle for patients and families to take an active role in improving the patient experience at the MGH. The council will focus on discovering what programs and practices represent the most successful patient and family experience within MGH and will help to replicate and share those best practices across the entire community.

Our vision is to achieve a level of care where patient and family involvement is expected and welcomed by all. We will achieve this through collaborative efforts between patients, families, staff, physicians and administration of the hospital.

Article 2. Mission Statement

Guided by the MGH Mission, Credo and Boundaries, the PFAC is dedicated to ensuring that our patients and families have a successful, compassionate, and supported healthcare experience.

Article 3. Goals

  Section 1. Advise: Work in an advisory role to enhance patient and family centered care initiatives at the MGH by collaborating with existing Patient Family Centered Councils and focus groups.

  Section 2. Support: Staff and MGH leadership in their patient–family centered activities and initiatives. Act as a sounding board for implementation of new programs and existing programs across the MGH.

  Sections 3. Participate: Provide patient/family member representation to committees and work groups including, but not limited to patient safety, quality improvement, facility design, service excellence, ethics and education.

  Section 4. Identify: Identify existing best practices in patient and family centered care and explore ways to share and replicate those across the organization.

  Section 5. Represent: Patient and family perspectives about the healthcare experience at the MGH and make recommendations for improvement.

  Section 6. Educate: Collaborate with MGH staff to facilitate patient and family access to information. Influence and participate in MGH staff orientation, patient/family education, discharge/transition planning.

  Section 7. Evaluate: The role of Patient Family Advisory Councils in improving outcomes for patients and families.
**Article 3. Structure and Membership**

The PFAC will consist of 10-15 members representing the diversity of the MGH community. Up to 6 MGH staff members may also serve on the PFAC. The structure of the Council may change over time and patients themselves may lead the Council as appropriate.

**Article 4. Nomination and Application Process**

Recruitment of patient and family council members is initiated by referral from all disciplines including MGH physicians, nurses, other healthcare providers and professional staff.

**Section 1. Membership Recruitment:** Sources of recruitment may also include Office of Patient Advocacy, Development Office, Volunteer Office, Blum Patient and Family Learning Center, Diversity Council, Community, Office of General Counsel.

**Section 2. Membership Criteria:** Members are selected based on the following criteria:
- Current experience as a patient or family member at MGH
- Ability to represent patient care experience
- Willingness to work in an advisory role
- Good listening skills
- Ability to interact well with differing groups of people
- Respect of others’ perspectives
- Ability to participate in a consistent and agreed upon schedule of meetings and potential subcommittee efforts
- Commitment to serve for a 2 year term with potential to renew or step down at the end of the term

**Section 3. Membership Selection:** Applications forms are sent to prospective members and, once selected, the applicant receives an acknowledgement letter from staff of the PFAC and a thank you letter is sent to the referring MGH staff member.

**Section 4. Terms of Appointment:**
- Members of the PFAC select and grant 2 year terms to council members
- Council members may request to be reappointed
- Resignation will be submitted in writing or via e-mail to the MGH PFAC
- Vacancies may be filled during the year as needed

**Article 5. Roles and Responsibilities**

**Section 1. Roles and Responsibilities for Patient/Family Members:**
- Attend each PFAC meeting or notify a staff member in advance if unable to meet
- Engage thoughtfully and constructively around the issues and ideas discussed during each session
- Be proactive in driving improvement and bring creative ideas for change
- Be respectful of the unique background and perspective of each member
• Be realistic and mindful of the hospital’s budgetary constraints

Section 2. Roles and Responsibilities for Staff/Employee Members:
• Attend each PFAC meeting
• Prepare meeting agendas
• Identify, invite, vet and orient potential PFAC patient and family members
• Facilitate discussions and engage all members
• Provide a report back to the PFAC of progress on ongoing projects and any hospital changes of interest to the group
• Assist with operations behind the scenes (ie. book rooms)
• Minimize potential barriers to achieving established goals
• Be an advocate for the utility, spread, and patient engagement of PFACs.

Section 3. Roles and Responsibilities of Chair/Co-Chair:
• Attend each PFAC meeting
• Communicate activities of the PFAC to the leadership of MGH
• Co-Chair will support duties of Chair in his/her absence

Article 6. Outputs of the PFAC

• The PFAC will provide regular updates to the MGH leadership and annual progress reports to DPH
• The PFAC shall engage in a variety of information gathering activities such as open discussion with patients and family members, including focus groups, surveys, and open forums.
• The PFAC may engage in educational and policy making forums
• The PFAC may serve as community liaisons, engaging other patients and families in various programs as necessary.
• Members of the PFAC may also serve on other committees as appropriate across the hospital system

Article 7. Orientation and Training

All selected patient and family applicants will receive orientation and training as to the mission and goals of the institution and the advisory council, as well as hospital regulatory and privacy issues.

Article 8. Confidentiality

PFAC members must not discuss any personal or confidential information revealed during a council meeting outside of these sessions. Council members must adhere to all applicable HIPPA standards and guidelines. If an advisor violates these guidelines, a staff member will remind them of the guidelines. On-going violations may result in repeating HIPPA training or reevaluation of membership status.
Article 9. PFAC Meetings

Meetings will be held monthly on a day and time that best meets the schedules of members. Each meeting will be 1 1/2 hours in length.

   Section 1. Agenda: Meeting agenda will be set by the designated staff/employee member and distributed to the membership prior to each session.

   Section 2. Meeting Minutes: The designated staff/employee will distribute the minutes in a timely manner to all PFAC staff and patient/family members. Council minutes will be retained for a minimum of 5 years.

   Section 3. Attendance: It is expected that the members of the council will make every attempt to attend every session during their term. Teleconference call in is acceptable. Participation by every patient will provide the most effective meeting and make the most impact on the patient experience at MGH. However, if a member is not able to make one or more sessions, notification to a staff member as soon as possible is expected in order to make any needed adjustments prior to the group meeting.

   Section 4. Inclement Weather: Business meetings will be cancelled if the City of Boston declares a snow emergency and driving to and/or from the Boston areas becomes unsafe. Council members will be notified in a timely manner.

Article 10. Termination

The Chair and Co-Chair of the PFAC reserve the right to dismiss any member who is not compliant with the rule and bylaws.
Massachusetts General Hospital
Patient Family Advisory Steering Council
October 25, 2011
MINUTES

Members Present: Robin Lipkis-Orlando, RN, Sharon Badgett-Lichten, LICSW, Susanne Goldstein, Linda Kane, Steve Reardon, Karen Tanklow, LICSW, Touqir Zahra, MD, Kay Bander, Kathy Varela, Sandy Clancy, Sue Lunn, David Wooster, Win Hodges

Guests: Denise Mallen (Heart Center), Margaret Carvan (Cancer Center), Seta Atamian (Pediatrics)

- R. Lipkis-Orlando facilitated the discussions of members and invited guests.
- S. Goldstein shared a story from her perspective as a former patient about the important of patient and family input into the healthcare organization’s strategic initiatives.
- R. Lipkis-Orlando described the evolution of the new Patient and Family Advisory Council (PFAC) which will focus on: engagement of patients and families in broad organizational initiatives; seek, share and replicate best practices; seek opportunities to promote patient/family involvement; and maintain and maximize linkages and collaboration with established PFACs.
- Invited guests from the existing Cancer Center, Heart Center and Pediatric PFACs were asked to share successes of their councils and advice.

Cancer Center PFAC
Successful councils pay attention to the membership recruitment process: create a level playing field between council staff and patients, focus on the patient experience have leadership that are engaged, open and can move agendas forward and create opportunities for rotating members.

- Council Projects- Improved patient experience with waiting times in outpatient clinics by providing buzzers so that patient/family may leave the area to go to resource room, healing garden, etc. and be buzzed 10 minutes before they are ready to be seen.
- Participated in the design and function of Yawkey and Lunder buildings by meeting with architects.
- Meet with new Fellows and Residents every six months in a safe and comfortable environment to talk about what it feels like to be a patient and allow them to ask questions.
- Created a Survivorship Group.

Heart Center PFAC
Successful councils have strength in the diversity of membership, have a give and take relationship, focus on patient perspective, strong staff administrative support in terms of organizing meetings, minutes and getting the word out about the work of the council. Agendas are planned by staff and incorporate ideas from departments within the specialty. Patient/Family members need to see things happening that ideas are actualized.

- Council Projects-Members perspectives and ideas were incorporated into the revised MGH Mission statement.
- Patient information and education was developed and revised to make it understandable and include topics related to safety, comfort and communication.
Developed pathway for inpatients going to the cardiac catheterization lab.
Instituted a call for chaplain when there is a code.
Made recommendations to have a social worker in the outpatient clinics.

**Pediatric PFAC**
Successful councils pay attention to the planning process, develop goals and tactics, never lose sight of promoting family centered care. Look to see who’s sitting around the table—leadership staff help to makes things happen. Councils have to effect change to keep members involved, motivated and committed.

- **Council Projects**- Established Multidisciplinary Family Centered Grand Rounds and ongoing meetings with new residents to educate about family centered communication. Utilize simulation as an educational tool.
- Family representation on a variety of committees including ethics and quality. Serve as consultants to staff, committees, and task forces.
- Establish family centered rounds at the bedside and develop literature to provide to families about their role in rounds.
- Create pediatric friendly environments within a primarily adult setting.

**New Members** - What would you like to change about the healthcare experience for patient/family at MGH?

- Improve communication among team members. Facilitate an understanding of what the care process is (what are the next steps) based on the pt/family level of understanding. Develop a care process tool.
- Develop a triage function so that whenever and where ever information, concerns, technology needs are identified, a system is in place to convey this, resolve issues and implement change in a timely manner.
- Improve coordination of care for patients with disabilities across the spectrum of services. Use social stories on face sheets to facilitate understanding.
- Find ways to acknowledge and celebrate good care.
- Look at the patient as a member of the team.
- Reduce burden on patients by improving clinician’s follow up process related to tests and results.
- To feel important and valued as a consumer of care.
MGH Council on Disabilities Awareness
2012 Members

Jeffrey Adams, RN, PhD - Nursing - Administration and Support Services / The Yvonne L. Munn Center for Nursing Research / Nurse Scientist
Lorraine Allan, MBA, RD, LDN - Nutrition and Food Services
Zary Amirhosseini - Office of Patient Advocacy / Disability Services
Guillermo Banchiere - Environmental Services
Guardia Banister, RN, PhD - Nursing - Administration and Support Services / The Institute for Patient Care
Dorothy Bergold, MSW - Spaulding Rehab, Case Management
Stephen Brodette - Radiology Engineering
Melinda Bryant - Real Estate
Joey Buizon - Community Representative (non-MGH Employee)
Roger Chisari, RN, DNP - Nursing - Administration and Support Services / The Knight Nursing Center for Clinical & Professional Development / Director
Nancy Connery - Admitting Services/Administration
Susan Cronin-Jenkins, RN - Real Estate / Planning & Construction
Joseph Crowley - Police, Security and Outside Services
Pam Daly - Community Representative (non-MGH Employee)
Maggie DeBarros - Human Resources
Leonard DeBenedictis - Employee Assistance Program
John Duffy - Buildings and Grounds
Mary Beth Ellbeg, RN - Preadmission Clinic
Joanne Empoliti, RN - Nursing - Clinical Nursing Services
Richard Evans - Practice Improvement Division / Service Improvement Department
Michael Fisher - Research Space Management Group
Ellen Forman, MSW, LICSW - Social Service
Brian French, RN, PhDc - Nursing - Administration and Support Services / The Institute for Patient Care
Sheila Golden-Baker, RN - Nursing - Administration and Support Services / The Knight Nursing Center for Clinical and Professional Development / Clinical Educator
Andrew Gottlieb, RN, NP - Occupational Health
Fiona Graeme-Cook, MD – Physician
Peggy Griffin – MGH employee
Stacey Houghton - Practice Improvement Division / Ambulatory Care Practice Support Unit
Lisa Iezzoni, MD, MSc - Mongan Institute for Health Policy
Debra Jacobson - Revere Health Center Administration
Keith Jennings - Information Systems / MGH / MGPO - IS
Linda Kane, MSW - Office of Patient Advocacy
Maureen Larkin - Human Resources
Nan Leonard - Community Representative (non-MGH Employee)
Robin Lipkis-Orlando RN, Office of Patient Advocacy
Abby Losordo - Cancer Center
George MacNeil - Buildings and Grounds
Scott Martin - Police, Security and Outside Services
Vanessa McLinches – MGH employee
Bonnie Michelman, CPP, CHPA - Police, Security and Outside Services
Oswald Mondejar - Spaulding Rehab, Human Resources Administration
Estelle Mullen - Medicine / Primary Care / Bulfinch Medical Group
Susan Muller-Hershon - Interpreter Services
Paul Nealey - Patient Service Center
Ellen Nelson - Human Resources - Employee/Labor Relations
Liza Nyeko - Center for Quality and Safety
Tucker O'Day, MSPT, MS - Human Resources
Georgia Peirce - Patient Care Services Administration
Elizabeth Pillsbury - Spaulding Rehab, Human Resources
Joanne Prince – Community Representative (non-MGH Employee)
Carlyene Prince-Erickson - Human Resources - Training and Workforce Development
Edward Raeke - Materials Management Administration
Janet Razulis - BWH, Patient Care Services
George Reardon - Patient Care Services Clinical Support Services
Tracey Ritucci - Materials Management / Transportation
Ronnie Sanders - Corporate Administration / Community Benefit Programs
Amanda Savage, RN - Orthopaedics/Administration
Darlene Sawicki, MSN, NP-BC - Neurology Outpatient Access
Jennifer Searl - Nursing - Administration and Support Services / The Blum Patient/Family Learning Center / Health Educator
James Simpson - Emergency Services / Nursing Services
Elizabeth Souza - Cancer Center Administration
Marilyn Spivak - Spaulding Rehab, Neurotrauma Outreach Rehabilitation
Andrea Stidsen, LICSW, CEAP - Employee Assistant Program
Michael Stone - Information Desks
Lisa Susser - Practice Improvement Division / Ambulatory Care Practice Support Unit
Amy Swartz, PT, DPT - Neurology Research
Steven Taranto - Human Resources
Carmen Vega-Barachowitz, CCC-SLP - Speech, Language, Swallowing and Reading Disabilities
Alfred White - Radiology
Carolyn White - Police, Security and Outside Services
PATCOM Disabilities Flag
Accessibility

Massachusetts General Hospital is committed to making our facilities and medical services accessible, creating a welcoming environment for all.

Our dedication to moving beyond ADA compliance ensures that Mass General is as accessible and accommodating as possible for all patients, visitors and staff.

The information presented here will guide you through the hospital and directs you to available resources and facilities to help you plan your visit or hospital stay.

For access to more valuable information, visit disability.gov, the federal government’s Web site for people with disabilities, their family members, veterans, caregivers, employers and others.

NEWS ITEM:

Partners founding hospitals join disability community to launch initiative to improve access and care for people with disabilities...more

http://www.massgeneral.org/accessibility/default.aspx
Approximately one in five Americans has a disability, and that prevalence will likely increase as the population ages. Joining with BWH and the Boston Center for Independent Living, MGH is involved in a major initiative to improve access and care for people with disabilities. The effort focuses on employee awareness and education, the physical environment, patient services, and equipment.

The Council on Disabilities Awareness (CDA) was formed in 2003 to help the hospital address the many and diverse needs of Mass General staff, patients and families, and visitors with disabilities. Its mission is clear: to advise, challenge, and engage the Mass General community in moving beyond the mandates of compliance to create a welcoming and accessible environment for all.

Multidisciplinary team recognized for individualizing care
Undergoing an operation can be frightening for anyone. For a patient with autism, surgery is even more daunting. This spring, a multidisciplinary team of more than 20 staff members went above and beyond in coordinating care for Matt Lunn, an adult patient with autism who required a surgical procedure as part of his ongoing care.

Read a letter from patient Matt Lunn’s mother...
Educational Resources at MGH

Disabilities Training Sessions

HealthStream Offerings:
(internal access only)

- Equal Access to Healthcare: Working with Patients with Disabilities (Clinical and Non-clinical modules)
- Good Practice Series: Weighing Patients with Disabilities
- Guidelines for using Wheelchair Accessible Scale

MGH Contacts:

MGH Council on Disability Awareness
Bonnie Michelman, Chair
Director of Police and Security
(617) 726-7979

Fred (Alfred) White, Cochair
Operations Manager, Clinical Support Services, Department of Radiology
(617) 726-3066

MGH Office of Patient Advocacy
Wang Ambulatory Care Center Lobby, Room 018
8:30am-5:00pm, Monday through Friday
(617) 726-3370

Zary Aminhosseini, MEd
MGH Disability Program Manager
(617) 726-3370 or (617) 643-7148

Links to Resources (partial listings)

(Click here for extended lists: internal | external)

Internal

- Disability and Accessibility Programs and Services
- EAP: Disability, Accessibility and Family Caregiving Resources
- MGH Disability Program
  Email: MGHAccessibility@partners.org
- Coordinated Care Clinic in MGHIC
- Partners Ergonomics
- Resources for Family Caregivers
- Resource Locators by Type of Disability

External

- Boston Center for Independent Living
- Disability.gov
- Massachusetts Commission for the Blind
- Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH)
- The MBTA RIDE

For many patients, communication may be inhibited by language differences, hearing, visual or cognitive impairments, health literacy, or other disabilities. The Joint Commission has new and revised requirements to improve patient-provider communication that will increase quality and safety through effective communication, cultural competence and patient- and family-centered care. Read more about the eight new and revised elements of performance...click here

Magnet Recognition

The American Nurses Credentialing Center (ANCC) requires Magnet-designated organizations to track nationally-benchmarked nursing sensitive indicators (NSIs) to continually inform improvement efforts related enhance patient outcomes. Examples of NSIs include, but are not limited to: patient falls, hospital-acquired pressure ulcers, blood stream infections, ventilator-associated pneumonia, and restraint use.

GLOSSARY OF TERMS

click here...

There are numerous terms and acronyms in healthcare that may be unfamiliar. Please click here to visit a Glossary of Terms that may be helpful. And please email any suggested additions.

This month’s featured term: Assistive Device

A technical aid, communication device or medical aid modified or customized, that is used to increase, maintain or improve the functional abilities of people with disabilities. Assistive technology can include mobility devices such as walkers and wheelchairs, as well as hardware, software and peripherals that assist people with disabilities in accessing computers or other information technologies. For example:

- people with limited hand function may use a keyboard with large keys or a special mouse to operate a computer
- people who are blind may use software that reads text on the screen in a computer-generated voice
- people with low vision may use software that enlarges screen content
- people who are deaf may use a video
- or people with speech impairments may use a device that speaks out loud as they enter text via a keyboard

Excellence Every Day represents an MGH commitment to providing the highest quality, safest care that meets or exceeds all standards set by the hospital and external organizations.

If you have questions or suggestions related to the EED portal, please contact Georgia Peirce at (617) 724-9865 or via email at gwperce@partners.org.
MGH Institute for Patient Care  
Save Our Skin (SOS) Tiger Team

Team Leader: Ginger Capasso, RN, PhD, Co-Director, MGH Wound Center

Project Support: Mandi Coakley, RN, PhD, Staff Specialist

Members: Jill Pedro, RN, Clinical Nurse Specialsit, Orthopaedics  
Jacqui Collins, RN, Clinical Nurse Specialsit, Medicine  
Debra Frost, RN, Staff Specialist, PCS Office of Quality & Safety  
Deb D’Avolio, RN, PhD, Clinical Nurse Specialist, Geriatrics  
Tiash Sinha, Dietician, Nutrition and Food Services  
Pat Grella, RN, Clinical Leader, Acute Care Documentation  
Joyce McInyre, RN, Clinical Nurse Specialist, Emergency Department  
Mary O’Brien, RN, Professional Development Specialist, Knight Center  
Maureen, Walsh McCarthy, RN, Wound/Ostomy Specialist, Surgery  
Judy Gullage, RN, Patient Education Specialist, Blum Center  
Susan Gavaghan, RN, Clinical Nurse Specialist, Respiratory Acute Care Unit  
Sandra Sylvestri, RN, Clinical Nurse Specialist, Operating Rooms  
Charlene O’Connor, RN, Clinical Nurse Specialist, Operating Rooms  
Patricia English, RRT, Respiratory Therapist  
Karen Waak, DPT, Physical Therapist  
Claire Seguin, RN, Compliance Office  
Barbara Blakeney, RN, Innovation Specialist, Center for Innovations in Care Delivery  
Linda Brandt, Project Specialist, Munn Center for Nursing Research  
Deb Jameson, Librarian, Treadwell Library  
Nancy McCarthy, Staff Specialist, PCS Financial Management Systems  
Zary Amhosseini, Disabilities Program Manager
## Massachusetts General Hospital
### Patient Care Services Office of Quality and Safety
### Percentage of Patients With Hospital Acquired Pressure Ulcers (All HAPU)

### Critical Care-Adult

<table>
<thead>
<tr>
<th>Fiscal Year/Quarter</th>
<th>2011 Q1</th>
<th>2011 Q2</th>
<th>2011 Q3</th>
<th>2011 Q4</th>
<th>2012 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>MGH Critical Care-Adult</td>
<td>8.86%</td>
<td>5.19%</td>
<td>5.13%</td>
<td>6.49%</td>
<td>6.06%</td>
</tr>
<tr>
<td>NDNQI Critical Care-Adult Mean</td>
<td>8.53%</td>
<td>9.86%</td>
<td>8.86%</td>
<td>8.22%</td>
<td>8.15%</td>
</tr>
</tbody>
</table>

### Critical Care-Pediatric

<table>
<thead>
<tr>
<th>Fiscal Year/Quarter</th>
<th>2011 Q1</th>
<th>2011 Q2</th>
<th>2011 Q3</th>
<th>2011 Q4</th>
<th>2012 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>MGH Critical Care-Pediatric</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>14.29%</td>
<td>0.00%</td>
</tr>
<tr>
<td>NDNQI Critical Care-Pediatric Mean</td>
<td>4.26%</td>
<td>4.25%</td>
<td>4.38%</td>
<td>4.08%</td>
<td>4.86%</td>
</tr>
</tbody>
</table>

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**Graphs (not fully transcribed as per the instruction):**

- **MGH Critical Care-Adult vs. NDNQI Critical Care-Adult Mean** (Hospitals With >=500 Beds)
- **MGH Critical Care-Pediatric vs. NDNQI Critical Care-Pediatric Mean** (Hospitals With >=500 Beds)
### Level III Neonatal ICU

<table>
<thead>
<tr>
<th>Fiscal Year/Quarter</th>
<th>2011 Q1</th>
<th>2011 Q2</th>
<th>2011 Q3</th>
<th>2011 Q4</th>
<th>2012 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>MGH Level III Neonatal ICU</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>NDNQI Level III Neonatal ICU Mean</td>
<td>2.61%</td>
<td>0.91%</td>
<td>1.03%</td>
<td>1.47%</td>
<td>0.82%</td>
</tr>
</tbody>
</table>

![Graph showing MGH Level III Neonatal ICU vs. NDNQI Level III Neonatal ICU Mean (Hospitals With >=500 Beds)](image)

### Medical-Adult

<table>
<thead>
<tr>
<th>Fiscal Year/Quarter</th>
<th>2011 Q1</th>
<th>2011 Q2</th>
<th>2011 Q3</th>
<th>2011 Q4</th>
<th>2012 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical-Adult</td>
<td>5.66%</td>
<td>3.93%</td>
<td>3.66%</td>
<td>2.73%</td>
<td>3.30%</td>
</tr>
<tr>
<td>NDNQI Medical-Adult Mean</td>
<td>3.07%</td>
<td>3.28%</td>
<td>2.81%</td>
<td>2.93%</td>
<td>2.76%</td>
</tr>
</tbody>
</table>

![Graph showing Medical-Adult vs. NDNQI Medical-Adult Mean (Hospitals With >=500 Beds)](image)
### MedSurg-Adult

<table>
<thead>
<tr>
<th>Fiscal Year/Quarter</th>
<th>2011 Q1</th>
<th>2011 Q2</th>
<th>2011 Q3</th>
<th>2011 Q4</th>
<th>2012 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>MedSurg-Adult</td>
<td>3.39%</td>
<td>3.57%</td>
<td>0.00%</td>
<td>1.82%</td>
<td>1.96%</td>
</tr>
<tr>
<td>NDNQI MedSurg-Adult Mean</td>
<td>2.51%</td>
<td>3.22%</td>
<td>2.70%</td>
<td>2.08%</td>
<td>2.33%</td>
</tr>
</tbody>
</table>

#### MedSurg-Adult vs. NDNQI MedSurg-Adult Mean (Hospitals With >=500 Beds)

![Graph showing MedSurg-Adult vs. NDNQI MedSurg-Adult Mean](image)

### MedSurg-Pediatric

<table>
<thead>
<tr>
<th>Fiscal Year/Quarter</th>
<th>2011 Q1</th>
<th>2011 Q2</th>
<th>2011 Q3</th>
<th>2011 Q4</th>
<th>2012 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>MGH MedSurg-Pediatric</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>NDNQI MedSurg-Pediatric Mean</td>
<td>0.61%</td>
<td>0.84%</td>
<td>0.50%</td>
<td>0.28%</td>
<td>0.85%</td>
</tr>
</tbody>
</table>

#### MGH MedSurg-Pediatric vs. NDNQI MedSurg-Pediatric Mean (Hospitals With >=500 Beds)

![Graph showing MGH MedSurg-Pediatric vs. NDNQI MedSurg-Pediatric Mean](image)
### Percentage of Patients With Hospital Acquired Pressure Ulcers (All HAPU)

**Surgical-Adult**

<table>
<thead>
<tr>
<th>Fiscal Year/Quarter</th>
<th>2011 Q1</th>
<th>2011 Q2</th>
<th>2011 Q3</th>
<th>2011 Q4</th>
<th>2012 Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td>MGH Surgical-Adult</td>
<td>4.69%</td>
<td>2.29%</td>
<td>1.09%</td>
<td>1.53%</td>
<td>2.08%</td>
</tr>
<tr>
<td>NDNQI Surgical-Adult Mean</td>
<td>2.64%</td>
<td>2.43%</td>
<td>2.54%</td>
<td>2.00%</td>
<td>2.49%</td>
</tr>
</tbody>
</table>

**MGH Surgical-Adult vs. NDNQI Surgical-Adult Mean (Hospitals With >=500 Beds)**

- **% of Patients**: 0.00% to 12.00%
- **Reporting Period**: Oct - Dec 2010 to Oct - Dec 2011

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**MGH Surgical-Adult**

- Oct - Dec 2010: 4.69%
- Jan - Mar 2011: 2.29%
- Apr - Jun 2011: 1.09%
- Jul - Sep 2011: 1.53%
- Oct - Dec 2011: 2.08%

**NDNQI Surgical-Adult Mean**

- Oct - Dec 2010: 2.64%
- Jan - Mar 2011: 2.43%
- Apr - Jun 2011: 2.54%
- Jul - Sep 2011: 2.00%
- Oct - Dec 2011: 2.49%
Wet is the New Clean

Bacteria-loving string mops and the accompanying heavy bucket of dirty water are out; flat mops (think **Swiffer**)—one per patient room—are in. Spray bottles and a swipe with a paper towel simply pushes dirt around; Applying a solution of Virex with a microfiber cloth and letting it air dry on a surface for 10 minutes kills microorganisms that lead to infection.

These new cleaning products are just part of a comprehensive campaign to improve the products, processes, and techniques involved in keeping patient rooms clean and safe. Research shows that cleanliness is one of the top three factors patients look for when choosing a hospital. HCAHPS scores verify these findings and are, in fact, one of the pay for performance goals for MGH for 2010. In addition, we know that keeping our patient rooms clean and disinfected is a vital aspect of patient safety. Working with Infection Control, Environmental Services and with the support of the unit service associates (USAs), Clinical Support Services set out to standardize cleaning practices, investigate new cleaning products, and ensure all staff have the tools and ability to do their jobs effectively.

In April 2010 a baseline quality assurance audit was done on the work of each USA. Various levels of training were provided to bring everyone up to a common, high standard. On going QA, training and support is provided to each employee. Perhaps one of the most important aspects of the program is the on-going communication with staff and patients about what we are working on and why it is so important.

Since May, the Clinical Support Services team has been interviewing patient directly about cleanliness and their perceptions of the environment. Here are some of the things they discovered:

- Patients will say a room is dirty if they see clutter, such as an empty candy wrapper.
- If the room is cleaned when a patient isn’t there, they may not realize it’s been cleaned.
- Patients may see a USA in the room, but not know why he or she is there.
- Patients and clinical staff did not fully understand the cleaning process, thus the need to roll out the “Wet IS the new Clean” campaign.

In addition to using better products and improved processes, USAs also keep patients better informed about cleaning by introducing themselves to patients and letting patients know how to reach them if the room needs attention. They also explain their cleaning methods and leave behind a signed card verifying the room has been cleaned.

Staff can assist in these efforts by being mindful of any clutter you may leave behind—pick up all wrappers from dressings or medications, discard gloves in the trash receptacles, and let a USA know if a room needs to be cleaned. And finally, it’s important to understand that to effectively clean and disinfect a room for a new admission takes one person 45 minutes to an hour (less if the room is cleaned by a team). An electronic system, called CBEDS, communicates room status to concerned parties throughout the hospital. The USAs each wear a pager. When a patient is discharged, they are notified via a page that the room needs to be cleaned. The first thing the USAs do before starting the actual cleaning is to dial in to the telephone in the room and enter a code indicating that they have started cleaning. This changes
the color of the bed in the electronic system and lets the unit staff, as well as admitting, the ED, transferring units, etc. that cleaning is in progress. When the cleaning is completed, the USA again dials in to the phone and again, all are alerted that the bed is ready for the next patient. This is one more way they are working to create an efficient and effective system for our patients and staff.

For more information about the inpatient cleaning program, contact Stephanie Cooper, Senior Operations Manager for the Environment at sacooper@partners.org, (617) 724-7841.
The way we clean your room every day may look a bit different — because it is. Infection control is a top priority, so we use the most advanced cleaning products and techniques.

What’s different?
To work well, our cleaning agents need to go on wet and then air dry for 5 to 10 minutes. And there’s no smell of harsh chemicals like most household products. (That’s the last thing you need when you’re not feeling 100%.)

So remember:
At Mass General, WET IS the new CLEAN.

And ...
If you ever have a cleaning need, please tell any one of us. We’re always available to help.
MGH ACD Project Governance

**CHARGE:**
- Ultimate Problem Solving & Decision Making Authority relative to MGH Electronic Clinical Documentation
- Approve and prioritize projects, direction setting and resolve decisions that cannot be resolved by BO Group
- Oversight of progress and issues generated from within Work Groups

**CHARGE:**
- Decision Making Authority
- Implementation Planning Group
- Defines/sheets guiding principles for how individual groups will work and the expectations of the work product
- Assures inclusion of all professional disciplines and health professionals
- Defines configuration work plan
- Defines structure of work groups

**CHARGE:**
- Manage issues and conflicts
- Assess hardware requirements and bring forward recommendations to BO Group
- Provide weekly updates of current work efforts
- Provide structure and direction to the UAT Leadership Committee
- Participate in all mini projects and all aspects of building, training and implementation
- Facilitates discussions with all clinicians

**CHARGE:**
- Decision Making Authority
- Provide oversight of work groups
- Approve and coordinate design and content recommendations
- Manage issues and conflicts
- Assess hardware requirements & bring forward recommendations to BO Group

**ACD Steering Committee**
- Business Sponsors
  - Business Owners
  - IS Directors
  - IS Manager
- IS Project Manager
- Clinical Project Manager
- HIS Project Manager

**ACD Business Owner Group**
- Physician
- Nursing
- HIS

**ACD Project Team Committee**
- MD's, RN's, HIS, PT, OT, ST, RT, Pham, SS, CM, IS, BioMed

**ACD Multidisciplinary Working Group**
- MD's, RN's, HIS, PT, OT, ST, RT, Pham, SS, CM, IS, BioMed

**Physician Committee**

**Nursing Committee**

**Health Professions Committee**

**MGH Physician Committee**
- HIS: C. Schiffliti, R.N, M. Cullen, R.N

**MGH Nursing Committee**
- HIS: C. Schiffliti, R.N, M. Cullen, R.N

**MGH Health Professions Committee**
- PT: N. Goode
- OT: J. Evans
- SS: A. Sobran and K. Tinklow
- RT: D. Chipman, K. Strong
- CM: E. Hughes
- BD: A. Cohen
- F.A.M: M. Lynch, C. Breen
- HIS: S. Brown, K. Wolf
- Phrusa: P. Khoury
- BioMed: L. Melendez
APPLIES TO: Weekly paid employees

1. Policy

1.1. It is the policy of the Hospital to pay its employees all compensation they are entitled to receive in compliance with applicable federal and state laws.

1.2. This policy describes:

- the time reporting process for non-exempt employees
- Employees' and managers' responsibilities to ensure that employees are paid properly for all time worked
- How to report problems

2. Definitions

2.1. Non-Exempt Employee – An employee subject to the minimum wage and overtime provisions of the Fair Labor Standards Act (FLSA) and Massachusetts state law. Non-exempt employees are paid for all time worked and are eligible for overtime as defined in 2.2. In addition, some non-exempt roles are eligible for shift and weekend differentials and holiday premium pay.

2.2. Overtime – Employees are paid at the rate of one and one-half times their regular hourly rate of pay for all time worked in excess of forty (40) hours per week. All overtime must be approved in advance by the manager.

2.3. Work Week – The work week (pay period) begins Sunday morning at 12:01am and ends Saturday night at 12:00 midnight.

2.4. Work Schedule – An employee’s start and end times for daily work time that have been established and approved in advance by the manager.

2.5. Meal Period – A thirty (30) minute continuous, uninterrupted, unpaid meal period during which an employee is not required to remain in the workplace. Any employee who works more than six (6) consecutive hours is entitled to a meal period.
2.6. **Interrupted/Missed Meal Period** – If an employee is willing to have their meal period interrupted or if the employee agrees to remain in the workplace during the meal period at the request of the manager, then the employee must be paid for the entire meal period.

2.7. **Meal Period Waiver** – An employee may voluntarily waive his/her right to a meal period, if requested by his/her manager and approved by Human Resources, but may not be required to do so. Any employee electing to voluntarily waive his/her right to a meal period must sign a meal period waiver evidencing this decision in advance of voluntarily waiving any meal period. The employee or Hospital may revoke the agreement at any time by providing a written notice of the decision to do so. Meal period waiver forms may be requested from Human Resources. If an employee requests an on-duty meal period, the request should be reviewed by the manager and Human Resources.

2.8. **Off-Clock Work** – Any work performed when an employee’s time was not recorded is considered off-clock work. Off-clock work includes, but is not limited to, the following:
   - unrecorded work performed before or after an employee’s shift
   - unrecorded work done at home

Off-clock work is strictly prohibited. An employee must report all time worked and it must be reported in the applicable timekeeping system.

2.9. **Attestation** – The process by which an employee certifies each day that:
   - s/he did or did not perform any work duties since they last signed out
   - s/he did or did not receive at least a full thirty (30) minute continuous, uninterrupted, meal period during which s/he was not required to remain at the workplace.
   - the work start and work end times recorded in the timekeeping system are or are not accurate

2.10. **Time and Attendance Process (Kronos timekeeping system)** – The steps used to capture an employee’s worked time accurately and consistently to ensure full compliance with applicable federal and state laws. The Hospital uses the Kronos timekeeping systems to accomplish this process. The worked time recorded in either system is a legal record. (Process outlined in Section 3)

3. **Time and Attendance Process (Kronos timekeeping system)**

3.1. Using either a Kronos Terminal (KT) or Kronos Self Service (KSS), an employee must:

   3.1.1. **Sign in to work each day**

      3.1.1.1. When signing in, report if s/he has performed any work since last signing out. If s/he has performed any work, the employee must report the time and reason for the work immediately to his/her manager to ensure correct pay.

   3.1.2. **Sign out of work each day**
3.1.2.1. When signing out, confirm if s/he has taken at least a thirty (30) minute continuous, uninterrupted meal period (if applicable).

3.1.2.2. When signing out, report if the sign in and sign out times for the day are correct.

3.1.2.3. If an employee reports that s/he did not receive a full meal period or that the KT/KSS does not accurately reflect the correct start and end times for the day, the employee must report this immediately to the manager to ensure correct pay. An employee will be paid for all time worked.

3.2. Recording Time Using a Kronos Terminal (KT)

3.2.1. An employee using KT will be required to swipe in before performing any work for the day and swipe out after completing all work for the day to capture all working time.

3.2.2. The manager will designate which terminal(s) an employee may use.

3.2.3. The employee will use his/her hospital issued ID badge to swipe the terminal and will then follow the prompts displayed on the terminal.

3.3. Recording Time Using Kronos Self Service (KSS)

3.3.1. An employee who has private use of a personal computer may be instructed to use KSS.

3.3.2. An employee using KSS will be required to log on before performing any work for the day and log out after completing all work for the day to capture all working time.

3.3.3. The employee will log on to KSS and follow the prompts displayed on the web page.

3.4. Other Timekeeping Methods

3.4.1. Any employee who cannot use the electronic time recording methods described above will be provided with an alternative method and instructions by Human Resources.

3.5. Recording Time Away

3.5.1. An employee is required to report to his/her manager any time worked while away from the worksite, for example, attending a training, conference or meeting.

3.5.2. An employee must report to his/her manager any scheduled or unscheduled absence from work.

3.6. Pay for Late Start or Early End

3.6.1. A benefit eligible employee who begins work late or leaves work early must use Earned Time (ET) for all time scheduled but not worked.

3.6.2. An employee does not have the option to be unpaid for time scheduled but not worked unless they do not have time available in their ET bank.

3.6.3. Exceptions may occur in accordance with the Weather, Severe Conditions policy.
4. Employee Responsibilities

4.1. An employee is required to accurately record all time worked through the applicable timekeeping system.

4.2. An employee is required to follow the process for attesting to the accuracy of recorded time worked as outlined in Section 3.

4.3. An employee is required to follow the assigned work schedule unless changes are approved by the manager.

4.4. An employee must not work outside of, or in addition to, the assigned work schedule unless approved in advance by the manager. If an emergency situation requires that an employee work before signing in or after signing out, the employee must report the time worked to his her manager immediately so that the employee will be paid for that time.

4.5. An employee who does not receive a meal period, or whose meal period is interrupted by work, must inform his/her manager immediately and attest accordingly in the applicable timekeeping system. Under these circumstances, the employee will be paid for the entire missed/interrupted meal period.

4.5.1. Unless otherwise instructed, an employee who carries a pager, two-way radio, or any other electronic communication device used for work purposes is responsible to turn off the device during the meal period. If an employee responds to an inquiry during the meal period, the employee must be paid for the entire meal period.

4.6. An employee must not allow anyone else to report his/her time worked and must not report time worked for another employee.

4.7. An employee may not falsify or incorrectly report time worked or instruct or advise another employee to do so.

4.8. An employee who has knowledge of another employee's falsification or incorrect reporting of time worked must report it immediately to the appropriate manager, Human Resources contact or the MGH Compliance HelpLine (617-726-1446 anonymous line).

4.9. An employee who suspects that any manager is violating this policy must report it to the appropriate department head, Human Resources contact or the MGH Compliance HelpLine (617-726-1446 anonymous line).

4.10. An employee must complete wage and hour training upon hire and on a periodic basis.

5. Manager Responsibilities

5.1. A manager must ensure that employees are paid for all time worked.

5.2. A manager may not falsify, alter or incorrectly report time worked for an employee, or instruct or advise an employee to do so.
5.3. A manager must ensure that an employee who works for more than six (6) hours has a thirty (30) minute continuous, uninterrupted meal period free from any work responsibilities.

5.4. A manager must ensure that an employee who misses a meal period or whose meal period is interrupted by work is paid for the entire meal period.

5.5. A manager who oversees an employee who is willing to sign a meal period waiver must seek prior approval from Human Resources. The manager may provide a meal period for the employee, but there is no guarantee that it will be thirty (30) minutes in duration or uninterrupted by work. The employee or manager may revoke the agreement at any time by providing a written notice of the decision.

5.6. A manager must ensure that timekeepers and time approvers review and approve all timekeeping records before they are submitted for payment. During this review/approval process, it may be necessary to adjust time records to correct any errors or omissions. Any changes on the time sheet record must be discussed with the employee and documented. If the employee disputes the accuracy of any time adjustments, the dispute must be resolved in favor of the employee absent indisputable evidence that the adjusted time is correct. Under no circumstances may an employee be paid for less time than actually worked.

5.7. A manager must complete wage and hour training on initial hire/promotion into a supervisory role and then on a periodic basis.

6. Reporting Errors and Obtaining More Information

6.1. An employee has the opportunity at any time to review his/her timekeeping records by contacting his/her manager. If an employee has a question about a deduction from pay or if the pay does not accurately reflect time worked s/he must contact his/her manager.

6.2. If an employee does not receive an appropriate response to a query within five (5) working days or otherwise feels that the issue has not been satisfactorily resolved, s/he must contact the appropriate department head, Human Resources contact or the MGH Compliance HelpLine (617-726-1446) immediately.

6.3. Employee attestation is not required to submit records for payment if the employee is unavailable or for some reason has been unable to complete attestation (for example, on earned time leave of absence etc.).

6.4. An employee or manager who believes that this policy is being wrongly interpreted or applied must call the appropriate Human Resources contact or the MGH Compliance HelpLine (617-726-1446 anonymous line).

7. No Retaliation

7.1. The Hospital will not tolerate any form of retaliation against an individual who reports alleged violations or who cooperates in the investigation of such incidents. Retaliation of any kind is unacceptable and will result in corrective action.
8. Corrective Action

8.1. An employee found in violation of any part of this policy will be subject to the Corrective Action Policy. In addition, departments may have their own policies which govern attendance and punctuality standards. Information captured in the timekeeping system may be used in support of those policies.

Applicable Policies:
Attendance
Corrective Action
Hours of Work and Alternative Work Schedules
Pay – Compassionate
Pay – Court Attendance
Pay – Differentials
Pay – Earned Time
Pay – Exempt, Professional Exempt and Nonexempt
Pay – Holiday Premium
Pay - Jury Duty
Pay – Overtime
Pay – Pay Period
Pay – Standby Pay
Weather, Severe Conditions

Applicable MA State Law:
M.G.L. chapter 149, sections 100 and 101 (Breaks)
M.G.L. chapter 150, section 1A (Overtime)

Applicable Federal Law:
Fair Labor Standards Act of 1938

Last Revision: 2011

Last Review: 2011
Dear Timekeeper,

Massachusetts General Hospital has always endeavored to pay people correctly for the time they have worked and we are proud of the efforts that you, our timekeepers, have made to ensure accurate timekeeping practices. In order to strengthen our current processes, we are implementing new electronic timekeeping practices.

Your workgroup has been chosen to begin using these new processes Aug. 5. Your non-exempt employees will be asked to use their employee ID to swipe in/out at a Kronos terminal (or utilize Kronos Self Service) and answer questions about work done off-the clock, uninterrupted meal periods and the accuracy of time recorded.

As timekeepers, you will continue utilizing the OneStaff system for scheduling and you will begin utilizing the Kronos system for time reporting. To prepare you for these changes, computer-based timekeeper training sessions will take place with members of the Kronos and Human Resources teams during July.

The training will cover:

- Overview of new Timekeeping policy
- Details of the OneStaff/Kronos interface
- Managing time reporting on a daily basis
- Using the new Action List Genie
- Monitoring and correcting exceptions
- Additional tasks to ensure accurate time reporting

Please make every effort to attend one of the following sessions:

- Friday, July 20, 8 to 9:30 am, Founders 334
- Friday, July 20, 10:30 to noon, Founders 334
- Monday, July 23, 8 to 9:30 am, Founders 334
- Wednesday, July 25, 1 to 2:30 pm, Founders 334
- Friday, July 27, 8:30 to 10 am, Founders 334
- Monday, July 30, 12 to 1:30 pm, Founders 334
- Wednesday, August 1, 8:30 to 10 am, Founders 334

To enroll in one of the sessions click on the link below.
<https://ibridge.partners.org/>  
Enter your user name and password.
Select the PeopleSoft HRMS Production Link. Navigate to Self Service -> Learning and Development -> Request Training Enrollment. Click the "Search by Course Code" link. Enter "MGHONE" in capital letters. Click the "Search" button. You can then click on the class to view available sessions.

In addition, we will be hosting open lab times after go-live to assist you with these new processes. These lab times will be:

- Thursday, Aug. 9: 1 to 3:30 pm, 165 Cambridge St., Room 230
- Friday, Aug. 10: 8 am to noon, 165 Cambridge St., Room 235
- Monday, Aug. 13: 8 am to noon, 165 Cambridge St., Room 230
- Monday, Aug. 17: 8 to 10:30 am, 165 Cambridge St., Room 235

Should you have any questions about the above training, or need additional information about MGH’s new timekeeping practices, please contact your HR generalist or send an e-mail to MGH Time Reporting.

Steve Taranto  
Director of Human Resources
As we continued with our first two tests of change (see Transforming Care at the Bedside, November and December 2008 and January), by November 2007 we were ready to address where we kept our clinical supplies. The idea of relocating often-used supplies to patients’ bedside had come up months earlier, during our TCAB brainstorming retreat (see Transforming Care at the Bedside, October 2008), and we’d targeted it for implementation as a time- and labor-saving tool.

To understand why, it helps to know our floor plan. White 10, our 20-bed general medical unit at Massachusetts General Hospital, consists of one long hallway with four private and eight semiprivate rooms. The nurses’ station, medication room, and supply room are at the center. Although this setup might appear convenient, our nurses and aides spent a lot of time hunting for and gathering supplies. As you walked the hallway, you’d often encounter a nurse who needed supplies, particularly if she or he was caring for a patient in isolation. Dressed in a bright yellow precaution gown, the nurse would hover in the patient’s doorway, hoping to hail a passing coworker: “Can you hand me a flush?” “Can you please grab me a few four-by-fours?” If help was unavailable, the patient’s care was interrupted while the nurse removed the gown, performed hand hygiene, walked to the supply room, and reversed the process before resuming care.

Since our retreat, the staff had been developing a blueprint for housing high-use supplies at the bedside to save everyone time. In our weekly TCAB meetings, we developed an aim statement and a plan, predicted the possible outcomes, and determined what measures we could use to chart our progress.

Following the Plan–Do–Study–Act format of the Institute for Healthcare Improvement’s Model for Improvement, we first solidified our aim statement: we wanted to decrease the amount of time nurses spent looking for supplies and increase the amount of time spent in direct care activities. We predicted that the test of change would result in nurses spending less time looking for and gathering supplies and more time performing direct care, that staff satisfaction would increase, and that the unit’s hospital-acquired infection rate would remain stable. Data from the unit’s time-study personal digital assistants (PDAs), staff feedback, and data on the unit’s nosocomial infection rates would be used to assess our success.
Because our infection control department was concerned that using the bins would put patients at greater risk for hospital-acquired infections, we partnered with our infection control nurse, Maureen Franklin, RN, CIC, to devise a protocol for their use and to train the entire staff. Maureen, as well as our then–unit operations coordinator (a nonclinician who worked closely with the nursing director to manage the care environment), joined our planning meetings.

As a unit, our hand hygiene compliance scores were better than 90% before and after patient contact, but we needed to revise our practice to incorporate accessing the bins. Maureen and the planning group worked together to develop a strict hand hygiene protocol. A bin can only be touched after using our hospital's waterless disinfectant; any items removed from a bin cannot be returned, instead they are added to the patient's supply in the bedside table; and under no circumstances can a bin be touched with gloved hands. The housekeeping staff clean all the bins daily.

Feeling optimistic, we then proceeded to the do stage of the Model for Improvement. Keeping true to TCAB’s emphasis on small tests of change—one nurse, one patient, one shift—we first introduced the bins in one private and one semiprivate room for three weeks. We placed them on a countertop, adjacent to the waterless disinfectant dispenser. The study phase involved soliciting nurses’ and aides’ feedback on the contents of the bins and their overall satisfaction with them, as well as monitoring our infection rate. The comments we heard at our weekly TCAB meetings and in conversation were very positive and included recommendations for some minor modifications to the inventory list. Even more exciting, no new nosocomial infections occurred in either of the rooms during the test period.

With this success and a nod from infection control in hand, after making more small changes to the bins’ contents, we moved on to the act phase. We gradually rolled out the remaining bins, and within four weeks we were using bins in every patient room, including isolation rooms.

To measure time and motion around the clock, nurses rotated carrying one of our two PDAs for one week per month. We had been collecting these same data for three months prior to introducing the bins for a time-use study. The PDA randomly prompted the nurse to answer three questions: previous location, current location, and activity. The data from the first full month after the change showed remark-
able differences. Whereas each nurse had previously spent as much as 17 minutes in each 12-hour shift gathering supplies, that number had dropped to 3 minutes—an 82% reduction! The results in the subsequent two months were similar, at 3.2 and 2.5 minutes. This meant that prior to introducing the bins, the unit nursing staff as a whole had spent 1,400 hours per year gathering supplies. We decreased that number to 238 hours per year.

Moving high-use supplies to the bedside also reduced the distance nurses walked. Rapid Modeling Corporation, the company that developed the time-study software and supports the PDAs for the TCAB initiative, calculated the step savings by superimposing our PDA data on a blueprint of the unit. Again, the results were remarkable. The staff’s combined steps fell from 15,791 feet per hour to 14,908—a 5.6% improvement, and a savings of 4 miles per day or 1,460 miles per year. As impressive as these results were, however, we saw only small fluctuations in the time nurses reported engaging in direct care activities.

An unexpected but significant result of the test of change was the dramatic decrease in nosocomial infections on the unit. The rates decreased gradually over the first five months and then held at zero for three months. We attribute this important outcome to the increased use of the waterless disinfectant resulting from nurses and aides accessing the supply bin. With Medicare no longer paying for treating many hospital-acquired conditions, finding ways to reduce their incidence is vital.

This test of change went very smoothly and is very popular with the staff. The in-room bins improve patient care by decreasing nosocomial infections and interruptions in nursing care. In today’s cost-conscious health care environment, every measure that increases efficiency, streamlines care, and frees nurses from performing tasks that have little value is important, especially in light of the growing shortage in and aging of the nursing workforce.

Next month I’ll cover leadership growth in the staff as a result of participating in the TCAB initiative.

Amanda L. Stefancyk is nursing director of White 10, a general medical unit at Massachusetts General Hospital in Boston. She also coordinates Transforming Care at the Bedside: astefancyk@partners.org.
Moving Clinical Supplies Closer to the Patients

Learning Objectives

At the end of this course, staff will be able to:

1) Describe the process for handling clinical supplies that are stored at the bedside
2) Describe the new stocking process that will be utilized by Unit Service Associates
3) Understand the Do's and Don'ts of bedside supplies

Coming Soon to a Unit Near You!

THE FOLLOWING PREVIEW HAS BEEN APPROVED FOR ALL AUDIENCES

<table>
<thead>
<tr>
<th>G</th>
<th>Good for You &amp; the Patients</th>
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</thead>
<tbody>
<tr>
<td>Content Saves Time, Money, and Increases Satisfaction</td>
<td></td>
</tr>
<tr>
<td>PAR LEVELS, CAL STAT, NO GLOVES</td>
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</tbody>
</table>

Clinical Supplies in the Patient Rooms

What's your practice?

- Kept in a cart or a bin?
- Kept on window sill and thrown out between patients?
- Kept in your pockets?
- Lots of running back and forth to the supply room?

NEW Practice for Keeping Supplies at the Bedside

It's all about HAND HYGIENE

Boom-Boom Chick-
a Chick CAL STAT
Boom-Boom Chick-
a Chick CAL STAT

Background: White 10's Success Story

As a part of TCAB, White 10 identified “running for supplies” as a problem that decreased the amount of time they spent with patients.

Utilizing TCAB principles, they worked together to develop new processes to move clinical supplies to the bedside.
Background: White 10’s Success Story
Over one year, staff saved 1170 hours of “non-value added time” spent looking for supplies!

![Graph showing Time Spent Looking for Supplies over a year, with > 80% Improvement]

Guiding Principles...Waste Reduction
Supplies kept in a clean, dry, dust-free location and handled with clean hands do not need to be discarded upon discharge

Treat the supply bins/carts like a Clean Utility Room

Guiding Principles...Infection Prevention
The inside of the bin/cart is considered “clean”
Items within the cart may only be accessed when:
1) Gloves have been removed
2) Hand hygiene has been performed using Cal Stat

Stocking Process: What may be different?
Unit Service Associates (USAs) will be responsible for stocking supplies at the bedside
USAs must complete the required training and demonstrate competency prior to assuming stocking responsibilities
Times and frequency of unit stocking will be determined by Nursing Leadership

Moving Forward: Sharing Best Practices
This work has been identified as a best practice and over the upcoming year will be spread to all patient care units

For more information about TCAB and the White 10 initiatives, please see TCAB at Mass General
High-Use Supplies at the Bedside

Stocking Process: What may be different?
Each unit will develop their own list of supplies to be kept at the bedside
Par levels will be set for each item; keeping in mind the frequency of the stocking (e.g. every 12 hours)
The USAs will utilize the unit’s inventory list while stocking and will only fill supplies to the assigned par levels
Stocking Procedure: New Process

USA staff will adhere to the following procedure prior to stocking the cart/bin:
1. The external surfaces of the cart/bin will be cleaned and disinfected with Virex from top to bottom
2. Gloves will then be removed and hand hygiene performed using Cal Stat
3. Supplies will be stocked/replenished to the assigned par levels

Infection Prevention: During stocking procedure

To prevent contamination of supplies, USAs should not be interrupted to do other tasks while stocking carts/bins.
Supplies may not be accessed from a room cart/bin during the stocking process unless absolutely necessary and only with clean hands.

Stocking Procedure: Contact Precaution Rooms

How is it different?
USA will wear gown and gloves while cleaning/disinfecting the outside of the cart/bin.
Gowns and gloves will then be removed, hand hygiene performed, and supplies stocked without gown and gloves.
No other surfaces in the room may be contacted during this procedure.

Infection Prevention: When using the cart

Unit staff may not “add to the cart/bin”:
– Excess room supplies may not be put into the cart/bin
– Excess items should be discarded or placed in a clean, dry, dust-free location to be used by the current patient.
– Supplies kept outside of the bedside supply cart/bin should be discarded upon patient discharge.

Infection Prevention: When using the cart

Once an item is removed from the bedside supply cart/bin, it may not be returned to the drawer.

Example: A roll of tape that is removed from the cart/bin cannot be put back in. The roll of tape should be left in a clean, dry, dust-free location to be used by the current patient and then discarded at discharge.

Infection Prevention: Contamination Awareness

If a drawer becomes contaminated, all items within the contaminated drawer must be discarded.
Contamination of items may be evidenced by:
– Seeing someone accessing supplies with gloves and/or not using Cal Stat prior to touching supplies
– Blood or visible dirt within the drawer
– Stained packaging

The contaminated drawer must be cleaned/disinfected with hospital-approved disinfectant before supplies can be replenished by the designated unit personnel.
**Infection Prevention: Metrics of Success**

The following metrics will continue to be measured by unit leadership and communicated to the staff:
- Hand Hygiene Rates
- Nosocomial Infection Rates

**We need your help**

To ensure our success, all members of the care team must be aware; please help us educate them on the new process.

Patients and visitors may not access the cart/bin. Please keep an eye out for this and educate them as needed.

**Do's and Don'ts**

**DO** Cal Stat before accessing bedside supplies
**DO** remind patients, visitors, and staff that bedside supplies are for clinical staff use only
**DO** enjoy the convenience of high-use items at the bedside

**Don't** add items to the cart/bin or overstuff the drawers
**Don't** interrupt the stocking process unless absolutely necessary
**Don't** waste any more time “hunting and gathering” for the most commonly used items

**QUIZ**

True or False

Staff members may not access supplies with gloved hands

True: Gloves must be removed and hand hygiene performed with Cal Stat prior to touching supplies

True or False

USA staff should stock only to the designated par levels

True: Designated 24 hour par levels have been set and routinely will be re-evaluated. Items should not be overstocked.
True or False

Supplies that are removed from the cart/bin but not needed may be placed back into the cart

False: Once an item has been removed from the cart/bin it can not be put back in and should be placed in a clean, dry, dust-free location and discarded at discharge.

True or False

A drawer is considered "contaminated" when a staff member accesses supplies without performing hand hygiene prior to touching the supplies

True: Staff members touching supplies with gloved hands or without using Cal Stat is one way to contaminate the supplies. Once contaminated a drawer must be emptied of supplies, the supplies thrown away and the drawer cleaned per unit procedure.
## Room Stocking Project

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Timeline</th>
<th>Responsible</th>
<th>Status</th>
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</thead>
<tbody>
<tr>
<td><strong>Initial Meeting with Unit Leadership (CNS, ND, Oms), Infection Control rep, &amp; Materials Management Rep</strong></td>
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<tr>
<td>Introduction of the project</td>
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<tr>
<td>Education on TCAB principles</td>
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<tr>
<td>Outline objectives/Goals of the project</td>
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<tr>
<td>Assessment of current unit model for &quot;stocking&quot; (including where, how, who, etc.)</td>
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<tr>
<td>Map out current model; assess strengths, weaknesses, &amp; challenges</td>
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<tr>
<td>Plan for environmental assessment of the unit</td>
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<tr>
<td>Draft a preliminary timeline (including assessment, workflow design, education/training, implementation, and evaluation)</td>
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<tr>
<td><strong>Initial Meeting with the Unit Staff</strong></td>
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<tr>
<td>Introduction of the project</td>
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<tr>
<td>Review objectives/goals of the project (includes increased efficiency, patient safety, cleanliness, increased patient and staff satisfaction, and decreased waste/cost containment (NURSE DIRECTOR TALKING POINTS)</td>
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<tr>
<td>Education on TCAB principles</td>
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<tr>
<td>Discussion of timeline for project</td>
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<tr>
<td>Identify members of the team to form a small core group. Small group to work on different aspects of project while soliciting feedback from peers, reporting back to larger group and helping with staff education</td>
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<tr>
<td>Meeting with Unit Small Group</td>
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<tr>
<td>Development of a &quot;must have&quot; and &quot;would be nice to have&quot; list of supplies for the bedside carts/containers</td>
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<tr>
<td>Explore and evaluate above list to recommend an inventory list and par levels of supplies</td>
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<tr>
<td>Recommend options for location of bedside supplies: carts/containers/drawers?</td>
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<tr>
<td>Make recommendations for the frequency of replenishment of supplies: how many times per day, what time, etc.</td>
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<tr>
<td>Discuss preferences on how to know what to put into cart (method of communication for USA staff)</td>
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<tr>
<th>Leadership Meeting # 2 (new stocking process)</th>
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<tr>
<td>Review and approve list of inventory supplies and par levels</td>
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<tr>
<td>Determine how this list will be available for &quot;stockers&quot;- items labeled, pictures, laminated cards?</td>
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<tr>
<td>Review supply location recommendations and select an option for approval/ testing</td>
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<tr>
<td>Review recommendations and finalize replenishment details for unit: days, times, etc. (collaborate with MM)</td>
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<tr>
<td>Review competency checklist for unit based &quot;stocking&quot; staff</td>
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<tr>
<td>Explore options for logistics of stocking carts (swap out cart, fill at door to room, take inventory, etc.). List out options and review pros and cons of each option</td>
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<tr>
<td>Select method</td>
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<tr>
<td>Review timeline for training/education</td>
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<tr>
<td><strong>Leadership Meeting # 3 (work flow for accessing supply items; guiding principles and infection control procedures)</strong></td>
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<tr>
<td>Gather baseline metrics of hand hygiene rates, unit nosocomial infection rate, etc.</td>
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<tr>
<td>Plan for staff education on supply handling; design competency checklist; communication strategies</td>
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<tr>
<td>Review cleaning process of carts/ containers</td>
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<tr>
<td>What is kept between patients and what needs to be discarded</td>
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<tr>
<td>Assign HealthStream course</td>
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<tr>
<td>Set &quot;Go Live&quot; date (day of the week, time)</td>
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<tr>
<td>Finalize training dates for USAs, RNs, PCAs, Oas</td>
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<tr>
<td><strong>Logistics</strong></td>
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<tr>
<td>Place order for supply holders (e.g. carts, drawers, containers)</td>
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<tr>
<td>Plan for delivery &amp; storage of holders</td>
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<tr>
<td>Set up installation of additional items as needed (e.g. pill crushers on ICU carts)</td>
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<tr>
<td>Submit work orders for any additional work needed (e.g. moving glove boxes, shelves, installation of additional Cal Stat dispensers)</td>
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<tr>
<td>Labeling of carts/ signage for &quot;STOP Cal Stat&quot; (TBD by each group)</td>
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<tr>
<td>Initial stocking of carts/ drawers/ holders (goal to implement fully stocked holders on the Go Live Date)</td>
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<tr>
<td>Special order of supply items with Materials Management</td>
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</tbody>
</table>
Communication of unit to stop stocking and use up current supply of bedside items one week prior to Go Live (IF APPLICABLE)

Plan for getting carts/holders to the floor on Go Live Date

Set up of Stocking Cart (Must be done in advance, order dividers, bins, etc.)

<table>
<thead>
<tr>
<th>Implementation</th>
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<tbody>
<tr>
<td>Implement carts/ holders on unit</td>
</tr>
<tr>
<td>Daily observation of unit stockers for one week; then weekly auditing</td>
</tr>
<tr>
<td>Daily observations on unit handlers for one week; then weekly auditing</td>
</tr>
<tr>
<td>Use a list for unit staff to document suggestions for additions/deletions/ par adjustment of items</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation &amp; Tweaking</th>
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<tbody>
<tr>
<td>Evaluation of supplies (do we have the correct items/ quantities); collect data through clipboard or spot checks?</td>
</tr>
<tr>
<td>Continued monitoring and communication of hand hygiene audits, unit handling and stocking processes</td>
</tr>
</tbody>
</table>

| MISC Notes |
Lunder Building
Go Live Committee

Co-Chairs:
Andrea Paciello, Executive Director, Radiation Oncology
Ed Raeke, Director, Materials Management

Members:
Adel Afridi, Central Sterile Processing and Supplies
Suzanne Algeri, RN, Nursing Director, Lunder 7 Neuroscience
Barbara Cashavelly, Nursing Director, Lunder 9 Oncology
Amanda Coakley, RN, PhD, Staff Specialist, Patient Care Services
Susan Cronin-Jenkins, RN, Co-Director, Planning and Construction
Lynne Dockser Cornell, OR Administration
Daniel Michael Dolan, Associate Director, PCS Clinical Support Services
Joanne L. Ferguson, RN, Staff Specialist, OR Administration
Ellen Fitzgerald, RN, Nursing Director, Lunder 10 Oncology
Douglas Henderson, Administrative Fellow
MaryFran Hughes, RN, Nursing Director, Emergency Department
Ann Kennedy, RN, Nursing Director, Lunder 8 Neuroscience
Renee Langton, Project Manager, Emergency Department
Robert Leahy, Senior Systems and Technology Manager, Security
Catherine Mannix, RN, Nursing Director, Radiation Oncology
Joyce McIntyre, RN, Clinical Nurse Specialist, Emergency Department
Gary Mulrey, Manager of Receiving, Materials Management
Janet Dauphinee Quigley, RN, Nursing Director, PACU
George Reardon, Director, PCS Clinical Support Services,
David Reisman, Administrative Director, Emergency Department
Kelly Seybolt, Assistant Technical Director, Radiation Oncology
Tara Tehan, RN, Nursing Director, Lunder 6 Neuroscience ICU
Robert Sheridan, Director, Interventional Radiology
Mary-Theresa Shore, Director, Clinical Operations, Radiology
Kimberly Plummer, Co-Director, Planning and Construction
Patricia Galvin, Operations Manager, PCS Clinical Support Services
Anthony Branch, Operations Manager, PCS Clinical Support Services
Robert Foster, NBBJ Consulting
Lauren Lebrun, Administrative Fellow
A successful transition

**Excitement heralds arrival of Austen Inpatient Care Pavilion’s first patient**

A FEW MINUTES shy of 8:30 a.m. on Sept. 7, word was given to begin moving the first group of patients from Ellison 14 to the new W. Gerald Austen, MD Inpatient Care Pavilion in the Lunder Building. Leading the way was Nancy Acevedo of East Bridgewater, who had the honor of being the first patient to move into the new building. The trip, ushered by the sound of clapping hands of the Ellison 14 staff who lined the corridor to see Acevedo off, lasted under 10 minutes and was the picture of efficiency.

Escorted by Susan O’Donnell, RN, and Nicolas Ducarmel of MGH Patient Transport Services, Acevedo arrived at the new Cancer Care Center located on Lunder 10, the Emilene J. Brown and Sumner W. Brown Floor of the Austen Inpatient Care Pavilion. After a quick verification of her information, Acevedo – who changed into her own clothes to make the big trip – was resting comfortably in her new room.

“It’s really nice,” Acevedo said. “It’s like something from the future.”

The Austen Inpatient Care Pavilion comprises the top five inpatient care floors in the Lunder Building. Floors 9 and 10 are for medical oncology patients and floors 6, 7 and 8 are for neurology and neurosurgery patients. The Austen Pavilion features 150 large single rooms with ample space for not only the patient and caregivers, but also for the patient’s family and friends. Each room, which features large windows with beautiful views, is not only equipped with the latest technology but also has the capacity to adapt to and include medical advances developed well into the future.

The entire move of patients from Ellison 14 into Lunder 10 was completed within 90 minutes.

“The Austen Inpatient Care Pavilion is a perfect tribute to an MGH giant who has poured so much of his heart and soul into building and shaping the MGH,” says Peter L. Slavin MD, MGH president. “More than anyone, Jerry Austen embodies the spirit of excellence, compassion and innovation that has long defined MGH. We are so fortunate and proud to have the Austen name grace this beautiful center for patients and families.”

**ACD Fair offers glimpse into future of patient care delivery**

THE LAUNCH OF acute care documentation (ACD), an electronic system for assessments, notes and flow sheet data that will streamline and enhance patient care delivery, is quickly approaching. Pilot testing, or user acceptance testing, is scheduled to begin in early 2012 on the Ellison 4 Surgical Intensive Care Unit, the Ellison 9 Cardiac Intensive Care Unit and White 9 General Medicine. The current goal is for ACD – which is known interchangeably as e-chart or MetaVision – is to be fully implemented by spring 2013. For a first-hand look at this new system as well as its training process, all staff who provide patient care are invited to attend the ACD Fair on Sept. 14 from 11 am to 4 pm in the Bulfinch Tent.

“Educating and training staff on how to successfully use the system has been given much thought and careful planning over many months,” says Gino Chisari, RN, DNP, director of the Norman Knight Center for Clinical and Professional Development. “We have collaborated to design a curriculum tailored to physicians, nurses and all of our health care professions colleagues, while remaining time efficient and free of redundancies.”

“The goal is to create a learning environment that fosters proficiency in using the system in a stress-free and well-supported setting,” adds Pat Grella, RN, MHA, clinical leader within the ACD project. “Next week’s fair is the first step in the overall learning process and will be a great opportunity for staff to preview this exciting new system.”
<table>
<thead>
<tr>
<th>Team Member</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bea Thibedeau - RN</td>
<td>NSMC CNO - Idea Leader</td>
</tr>
<tr>
<td>Cohen, Wendy - RN</td>
<td>NSMC</td>
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<tr>
<td>Bolton, Paula - RN</td>
<td>McLean</td>
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<td>Buckley, Leo</td>
<td>BWH</td>
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<td>Duckett, Kathy - RN</td>
<td>Partners HealthCare at Home</td>
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<tr>
<td>Empoliti, Joanne - RN</td>
<td>MGH</td>
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<tr>
<td>Ferdinand, Robert - RN</td>
<td>SRN - B</td>
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<tr>
<td>Flynn, Sylvana - RN</td>
<td>SRN - C</td>
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<tr>
<td>Hines-Clouser, Maura</td>
<td>NSMC</td>
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<tr>
<td>Johnson, Jill - RN</td>
<td>NCH</td>
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<tr>
<td>Kmetz, Karen - RN</td>
<td>NWH</td>
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<tr>
<td>MacDonald, Dennis</td>
<td>Partners Materials Management</td>
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<tr>
<td>McDonald, Ann - RN</td>
<td>Partners Corporate Finance</td>
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<tr>
<td>McIntyre, Joyce - RN</td>
<td>MGH (representing ED system-wide)</td>
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<tr>
<td>Reardon, George</td>
<td>MGH, PCS Clinical Support Services</td>
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<tr>
<td>Rosenberg, Deb - RN</td>
<td>NWH</td>
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<tr>
<td>Stengrevics, Susan - RN</td>
<td>MGH</td>
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<tr>
<td>Tomasin, Peggy - RN</td>
<td>BWFH</td>
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</tbody>
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Updated May 2012
Diversity Leadership Fellowship

PCS Diversity Statement
The concept of diversity encompasses recognizing, accepting and respecting that each person is unique, with individual differences along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical ability, religious beliefs, political beliefs, or other ideologies.

The PCS Diversity Program allows for the exploration of these differences in a safe, positive, and nurturing environment. The goal is to build an understanding and move beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual and each population group.

12 Month Curriculum
The Fellowship will encompass a 12-month period beginning in October of each year. It is designed as a guided experiential learning process for a clinician with a Master’s or Doctorate degree in one of the nine disciplines--- Chaplaincy, Child Life, Medical Interpretation, Nursing, Occupational Therapy, Physical Therapy, Respiratory Care, Social Work and Speech-Language Pathology-- that comprise Patient Care Services.

The 12 months will be divided into two parts.
- 13 weeks of content based skill building
- 39 weeks of performance-coaching with a mentor-leader

The Fellow and the mentor will be guided and coached by the Executive Director for The Institute for Patient Care and the Patient Care Services, Director of Diversity (Advisor).

Learning Methods will include:
- Self-study guide reading modules.
- Seminar that will include discipline specific groups on selected core topics.
- Journal and records of process anecdotes for review with leadership mentor and Director Advisors who represent diversity as described in the PCS Diversity Statement.
- Monthly management narratives for review and coaching by leadership mentor and Director Advisors represented by members of PCSEC.
- Initial Assessment of management/communication skill, e.g. Personalysis.
- Active participation in the management of a domain of practice that is part of Patient Care Services.

The content areas of each experience will include:

1. **Personnel Management (3 weeks)**
   - Recruitment, hiring, performance evaluation, corrective and disciplinary action.
   - Team Building
   - Delegation
   - Collaboration
   - Conflict Resolution
Resources: Human Resource Generalist
Workforce Diversity Program Manager
PCSEC Directors
Nursing Directors
Employee Assistance Staff
Employee Relations Specialists
Grievance Committee Members

2. **Operations Management (3 weeks)**
   - Maintains a safe environment
   - Directs or delegates day-to-day activities
   - Creates a schedule for unit activities
     a) Staff
     b) Patients
   - Fulfills regulatory and licensing requirements
   - Oversees physical space/supplies and equipment long-term planning.
     a) Capital Budget
     b) Program Development

Resources: Environmental Rounds Participants
Safety Committee
Operations Managers
Director, Clinical Support Services
Director, Program and Facility Development
Director, Quality and Safety
Director, Process Improvement
Directors, Health Centers

3. **Administrative Business (3 weeks)**
   - Describes and quantifies unit-based patient care activities
   - Prepares salary and wage and supply budget
   - Monitors unit activity and money expenditures, writes variance reports.
   - Ensures regulatory standards.
   - Negotiates interdepartmental resources.
   - Monitors systems that support patient care and develops or modifies systems when necessary.
   - Manages unit finances to assure effective patient outcomes.
   - Understands impact of reimbursement and managed care contracts.

**Multidisciplinary Collaboration**
- Leads unit-based groups.
- Develops interdisciplinary practice standards
- Forms partnerships with department heads and physician leaders.
- Collaborates with community centers and ambulatory practices.
- Guides and coaches diverse teambuilding.
Resources: Clinical Nurse Specialists  
PCS Directors  
Collaborative Governance Members  
Unit and Program Multidisciplinary Members

4. **Change Management (3 weeks)**

Change management involves the process, tools and techniques needed to manage the people-side of business changes in order to achieve the required business outcomes, and to develop an understanding how business changes effectively within the social infrastructure of the workplace.  
*Adapted from: [http://www.change-management.com/tutorial-definition-history.htm](http://www.change-management.com/tutorial-definition-history.htm)*

- Develops a culturally competent staff  
- Reviews and revises practice protocols and standards  
- Evaluates the outcomes and quality of patient care through the lens of the PCS Statement on Diversity  
- Ensures clinical expertise of patient care staff at the bedside.  
- Leads and participates in committees relevant to domain of practice to support, promote and develop excellence in patient care.  
- Coordinates the delivery of patient care.  
- Develops a Knowledge Management approach to handling patient complaints, incident reports and results documentation  
- Participates in operations improvement initiatives.

Resources: Collaborative Governance Committee Members  
Director, Quality and Safety  
Director and Staff, The Institute for Patient Care  
Office of Patient Advocacy Staff  
Patient Care Services Executive Committee Members  
Clinical Nurse Specialists

5. **Promotes Professional Practice and the Institution**

- Membership and participation in majority and minority professional organizations.  
- Participation in community health efforts with particular attention to the underserved.  
- Serves as an ambassador for the organization and its commitment to diversity.  
- Teaches, writes, and speaks in institutional, academic and community settings.  
- Maintains clinical and cultural competency.

Resources: Sr. VP for Patient Care, Chief Nurse Executive  
Patient Care Services Executive Committee Members
6. **Leadership and Diversity (1 week)**

- Establishes personal leadership style and recognizes those of others.
- Develops ability to articulate organizational commitment to diversity as context for personal leadership.
- Enhances decision making skills and ability to take calculated risks within the context of leadership and diversity at MGH and within PCS.
- Develops a reliable and valid picture of organizational and interpersonal perceptions as they relate to leadership and diversity.
- Commits to mentoring a “rising star” from a diverse background.
- Learns to identify advocates and supporters as resources to process perceptions of diversity at MGH.

**Practicum**

Following the 13-week learning experience, the Diversity Leadership Fellow will rotate through relevant areas of practice within PCS as a Diversity Leadership Resident, working with a mentor-leader who will provide performance coaching.
Hi all:

We are scheduled to meet tomorrow, Wednesday, 2/2 from 2-3pm in the FND 343 Conference Room to continue our discussion on the Education Project Charter. We have two items for the agenda:

1) Compare and contrast current orientation content across disciplines
2) Discuss ideas for efficiencies and interdisciplinary collaboration

I am attaching my analysis of the collated survey responses for your review. The first part captures my broad thinking about the survey responses. Recognize that in my doing so, much of the detail is lost, but it is a more succinct way to present the information. The second section includes my ideas for potential areas of efficiencies and/or collaborations.

Please bring your departmental orientation record-keeping form and/or outline so that we can review content that might be taught across all or a few of the disciplines. Also, please bring your analysis of the survey responses and suggestions for efficiencies/collaborations. In terms of our timeline, our draft recommendations are due by 2/19/11.

Brian

Brian M. French, RN, PhD(c), BC
Simulation Program Manager
Interim Manager, Blum Patient Family Learning Center
The Institute for Patient Care
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POB 445
275 Cambridge Street
Boston, MA 02114
617-724-7843
**Tactic # 14: PCS Education Project Charter Committee**

**Executive Sponsor:**
Gaurdia Banister, RN, PhD, Executive Director, PCS Institute for Patient Care

**Team Leads:**
Gino Chisari, RN, MSN, DNP, Director, The Norman Knight Nursing Center for Clinical and Professional Development

Brian French, RN, PhD(c)
Manager, The Knight Simulation Program and Blum Patient and Family Learning Center

**Team Members:**
Tom Elliott, RN, MHSA, Director, Patient Care Services Management Systems

Marie Elena Gioiella, LICSW, Oncology Social Worker Clinical Director, Social Services

Ann Jampel, PT, MS, Education Coordinator, Physical & Occupational Services

Nancy McCarthy, RN, MSN, Staff Specialist, Patient Care Services Management Systems

Carmen Vega-Barachowitz, MS, CCC-SLP, Director, Speech, Language and Swallowing Disorders

Purris Williams, BS, RRT, Staff Respiratory Therapist, Respiratory Care Services
Patient Care Services Orientation

MGH Credo

- The first priority at MGH is the well being of our patients. All of our work, including research, teaching and improving the health of the community, should contribute to that goal.
- Our primary focus is to give the highest quality care to each patient delivered in a culturally sensitive, compassionate and respectful manner.
- Employees are MGH’s greatest asset
- Teamwork and clear communication are essential to providing exceptional care.

Proud History of Patient Care

Welcome to Patient Care Services

“We employ the best and the brightest so we can provide the highest quality care to a diverse and complex patient population”
Ives Erickson, J. (2009), What Does responsiveness mean to you?, Caring Headlines, (10), 2.

Patient Care Services (PCS) 2012 Strategic Goals

- Always meet or exceed expectations of patients and families
- Enhance care delivery by improving the efficiency and effectiveness of systems
- Ensure staff have a strong voice in the design

Journey through MGH and Patient Care Services
Massachusetts General Hospital
Patient Care Services Courses/In-services

2010:
Six courses were published by Nursing and shared with PCS colleagues. These include:
- Safe Transport: Respiratory Compromised Patients/Artificial Airway Patients
- H1N1 Clinical and Non-Clinical
- Rapid Response Team
- Universal Protocol
- Preliminary MGH Self Assessment: National Standard on Cultural and Linguistic Appropriate Services (CLAS)
- OR Patient Positioning

2011 through 2012 (as a result of the Tiger Team) Nursing extended use of 17 courses with PCS colleagues. These included:
- Autism Care
- Leaf Fall Prevention
- Lunder Building Overview
- Inpatient Stemi
- Aspiration Preventative Care of Patients with Dysphagia
- Radiation Safety in the OR
- Global Health: Cholera
- Voalte Training
- MGH Swallow Screening Tool
- The Patient Can't Sleep: Is it Insomnia or Delirium?
- The Joint Commission is Coming
- 2012 MGH Safe Handling of Hazardous Drugs Beyond Chemotherapy
- MGH Competency Unit-Based Safety Program: Cardiac Surgery Process Improvement
- MRI Safety: Level 1
- MRI Safety: Level 2
- Benson Henry Institute: Relaxation Response
- MGH Mission Credo Boundaries
Massachusetts General Hospital
Patient Care Services

PCS Strategic Goals
Performance Report
As of September 2011

Meet or Exceed Expectations of Patients & Families

1) Enhance staff communication & responsiveness to patients & families
2) Implement hourly safety rounds
3) Ensure equitable care for patients
   • Create Patient Family Advisory Council
   • Implement Disabilities Program plan
   • Improve communication with efficient use of resources and technology (e.g. V-POP,)
4) Reduce hospital acquired pressure ulcers
5) Improve hospital cleanliness

Enhance Care Delivery by Improving the Efficiency & Effectiveness of

6) Increase documentation efficiency and quality
   • ACD UAT design & integration testing
   • Continue process improvement
7) Revise the payroll system so that non-exempt employees are paid according to HR policies. Begin revising scheduling policies & practices to more precisely meet workload demands.
8) Increase direct care time
   • Supplies at the bedside
9) Learn about strategies to prevent unnecessary readmissions
10) Execute a successful move into the Lunder Building
11) Reduce non-salary expenses

Ensure Staff Have a Strong Voice in Design of

12) Enhance staff input in decision-making that influences care delivery
   • Implement re-designed Collaborative Governance model
13) Create & implement a diversity leadership fellowship
14) Increase efficiency & effectiveness of educational offerings across PCS

Overall Performance

Baseline 2010
YTD Sep 2011