Caring Headlines
December 19, 2013

# Where would we be...


# ...without innovation?

The newsletter for Patient Care Services
Massachusetts General Hospital

Jeanette Ives Erickson

# Innovation Units

## *a great idea, but will it fly?*

When Orville and Wilbur Wright lugged their primitive flying machine to the top of that rise in Kitty Hawk, North Carolina, on December 17, 1903, they may not have expected to alter the course of history. But with that flight that lasted all of 12 seconds and covered a mere 120 feet, they accomplished something that the greatest minds of their day had not been able to do. Their flying machine was more than an invention, it was the culmination of years of hard work, trial and error, and meticulous re-design. It was the translation of a simple idea into something that had never existed before. It was an innovation that changed the face of civilization forever.

Hard work. Trial and error. Re-design. Do those words sound familiar? They speak to me of the work we're doing on Innovation Units. And I would add to that list: creativity, commitment, and courage. Because that's what it takes to step away from the status quo and do something bold.

Like Orville and Wilbur, our work began with a simple idea—to make care more effective, efficient, and affordable. We knew that to achieve the kind of change we imagined, we would have to re-design the entire care process. We knew that transformational change of that magnitude could only be achieved by tapping into the wisdom, experience, and ingenuity of our incredible workforce. So that's exactly what we did.

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

We asked clinicians, leadership, and support staff throughout Patient Care Services (and the hospital at large) for their thoughts on how we could improve clinical outcomes, enhance patient- and staff-satisfaction, reduce costs, and decrease length of stay. Our decision-making was guided by the principles that:

- care is patient- and family-centered, evidence-based, accountable, autonomous, and continuous
- clinicians are highly present and know the patient
- care is provided by designated nurses and physicians who assume accountability to ensure continuity
- continuity of the team is a basic precept
- every novice team member is mentored by an experienced clinician
- Every patient has the opportunity to participate in the planning of his/her care
- Technological advancements create opportunities for improved communication and efficiency

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Innovation Units are testing grounds for change in a grand experiment to try to improve clinical outcomes, enhance patient- and staff-satisfaction, and reduce costs and length of stay. No one can dispute that Innovation Units are a great idea. But to expand on the Wright brothers metaphor, the question always was: 'Will they fly?'

Our goals were clear. We wanted to:

- increase continuity of care
- increase caregiver productivity
- increase inter-disciplinary teamwork
- re-design the physical environment of care
- focus on patient and family values
- increase time spent with patients
- focus on organizational goals and mission

Based on the feedback we received, we generated a number of interventions that we considered 'top-priority' actions to help us achieve the level of consistency, continuity, and efficiency we were looking for. Those interventions were:

- Adopt a philosophy of relationship-based care
- Implement attending nurse role to promote optimal coordination of care
- Have attending nurses use business cards to ensure optimal communication and continuity
- Enhance hand-over communication
- Articulate estimated discharge date and disposition upon admission
- Create a Welcome Packet
- Ensure across-the-board understanding of each discipline's domains of practice
- Implement daily inter-disciplinary rounds
- Introduce smart-phone technology on units
- Give staff access to wireless tablets or computers
- Implement quiet hours
- Implement hourly rounding with the Four Ps
- Install in-room white boards to enhance communication
- Install electronic white boards on units
- Conduct follow-up discharge phone-calls

Twelve Innovation Units were launched in March of 2012, and by September, 2013, all inpatient units had made the transition. Our methodology was to reduce variation wherever possible, implement evidence-based solutions, introduce and/or adapt technology to support practice, and foster exceptional care by ensuring that all members of the team practice to the full extent of their licensure.

We created a Patient Journey Framework (see page 12) to illustrate the process of care before, during, and after hospitalization. This framework became the blueprint for our work.

Innovation Units are testing grounds for change in a grand experiment to try to improve clinical outcomes, enhance patient- and staff-satisfaction, and reduce costs and length of stay. No one disputes that Innovation Units are a great idea. But to expand on the Wright brothers metaphor, the question has always been: 'Will it fly?'

I invite you to read the articles on the following pages of this special issue of *Caring Headlines*. They report on the work we're doing, the progress we're making, and the outcomes we're achieving. They tell of a workforce that has invested blood, sweat, and tears to try to accomplish something amazing for patients and families. Please, take a look. Then you tell me... are we flying?

## In this Issue



(Cover photo and other aviation pictures taken from *Flight: 100 Years of Aviation*, published by the Smithsonian Air and Space Museum, and *History of Flight*, by Riccardo Niccoli)

# Relationship-based care

—by Linda Lacke, senior project manager

Relationship-based care is a theory, a philosophy, and an intervention. It's the basis for the care we deliver to patients and families, the interactions we have with colleagues, and the way we think about ourselves as individuals and caregivers. In organizations that provide relationship-based care, every member of the team:

- knows the patient as a person and has access to information across the continuum
- participates in the coordination of care, knows who's responsible, and reviews the plan daily with the patient, family, and team
- builds the plan of care around the patient's goals and expectations
- coordinates care and patient-education and provides time to evaluate learning
- aligns support around patient populations rather than transactions

Since the launch of Innovation Units in 2012, the evolution and impact of relationship-based care has been visible throughout the hospital. Hourly rounding, one of the interventions introduced on Innovation Units, employs the 4 Ps approach: presence, pain, positioning, and personal hygiene. At the heart of hourly rounding is 'presence'—the purposeful connection with patients and families—the very essence of relationship-based care.

The Lunder 7 Neuroscience Unit recently implemented an initiative called, *Take 5* to help foster relationships with patients and families. Says nursing director, Sue Algieri, RN, "The nurse's presence is key to providing holistic care and improving the patient experience. Nurses and patient care associates are encouraged to spend at least five uninterrupted minutes each shift with patients to listen to their stories and answer any questions they may have in a relaxed and cordial way. It's not that staff isn't spending time with patients, it's that we don't want every interaction to be part of multi-tasking or to take place on the clinician's way to or from somewhere else. *Take 5* has been a fun and effective way to renew our commitment to relationship-based care."

Relationship-based care comes into play in our interactions with colleagues and other members of the team. One example is the way attending nurses support each

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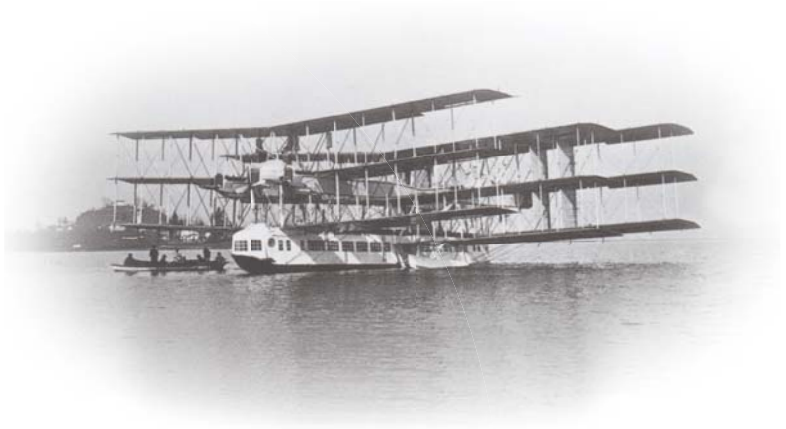
Relationship with patient: Above left, staff nurse, Christine Higgins, RN, with mom, Nicole Zalkin, and her new baby, Cooper.
Relationship with self: Above right: nursing student, Alexandria Delaney, spends a quiet moment in the Healing Garden on Yawkey 8.

other in their new role by sharing best practices and alerting one another to potential challenges so they can be better prepared if/when they arise. A chaplain provides guided meditation to a care team following the death of a patient. When staff members cover for a colleague so she can attend a collaborative governance meeting, take a break, or go to lunch—these are all examples of collegial relationship-based care.

Mary Hansen, RN, attending nurse in the Lunder 6 Neuroscience ICU, observes, "The most difficult relationship to embrace is the one with self. As caregivers, we often put our own needs aside to care for others. Relationship-based care has shone a spotlight on the importance of taking care of ourselves so we can better care for others."

Having a positive and meaningful relationship with self can take many forms. Getting to know and nurture your inner self is as important as any other facet of relationship-based care. Participating in wellness programs, resiliency training, or journaling are all ways to strengthen and expand self-knowledge. And having the support and encouragement of unit leadership is key to successfully embedding relationship-based care into the culture.

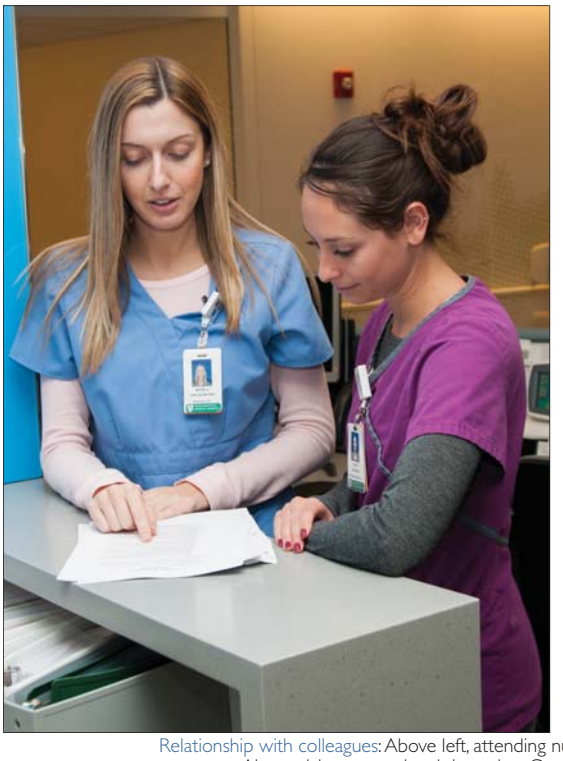


On October 17, 2013, MGH Nursing Grand Rounds featured Mary Koloroutis, RN, vice president of Creative Health Care Management, and Michael Trout, director of The Infant-Parent Institute, who presented, "Excellent Patient and Family Experiences: Authentic Connection is the Solution." Koloroutis and Trout examined the current state of the patient-family experience, describing a methodology that healthcare providers can use to cultivate authentic, therapeutic relationships with patients and families that involves:

- wondering—being curious in a patient's room; looking around, taking in what you observe, and asking questions; avoid making assumptions
- following—putting yourself in a position to be led by the patient; listening to what the patient and family have to say
- holding—being a sturdy presence for patients; holding leads to greater independence for patients; think of babies who are held frequently; they typically demonstrate more self-assurance and confidence. In health care, patients take the feeling of holding with them throughout their recovery

There is no end to the ways relationship-based care can be manifested, be it between clinicians and patients, clinicians and colleagues, or clinicians and their inner selves. Half the fun is exploring the possibilities.

For more information about relationship-based care, call Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development, at 617-643-6530.




Relationship with colleagues: Above left, attending nurses, Mikaela Arruda, RN (left), and Kristin Cina, RN, confer on Lunder 8 Neuroscience Unit. Above right, occupational therapists, Carol Mahony, OTR/L (left), and Julie MacLean, OTR/L, chat in the OT gym on Wang 1.

# The voice of the patient

—by Rick Evans, senior director of Service, and Robin Lipkis-Orlando, RN, director, Office of Patient Advocacy

A guiding principle of our work on Innovation Units has been the involvement of patients and families—both in their own care and in the on-going work of MGH to remain a world-class Magnet hospital. We constantly look for ways to incorporate the 'voice of the patient' into the care and services we provide.

Our care-delivery model is built on a philosophy of relationship-based care. Among other things, that means we seek to actively engage patients and families in the planning and delivery of care. One way we do this is with the Universal Patient Compact, a document that articulates our desire to partner with patients and families in the delivery of care. The Universal Patient Compact is approved by the National Patient Safety Foundation and outlines our pledge to provide the highest quality care. It includes what we need from patients and families in order to make good on that pledge. The compact is essentially about respect, describing what all members of the partnership can do to ensure optimal care and the best possible outcomes.

The patient's voice is also invaluable as we strive to improve services. For more than a decade, MGH has benefitted from the wisdom of patients and families through their participation in Patient and Family Advisory Councils (PFACs). PFACs provide a mechanism for patients, families, and staff to influence organizational decision-making and have a real impact on the patient experience. Currently, there are five active PFACs at MGH: The general PFAC; MassGeneral Hospital *for* Children (MGH*f*C), the Cancer Center; the Institute for Heart, Vascular and Stroke Care; and the Ambulatory Practice of the Future Care Alliance.

To give you an idea of some of the issues PFACs weigh in on, recently, the general PFAC provided feedback on the MGH Visitor Policy; helped develop a formal job description for patient advisors; and provided input on Innovation Units and Partners *e*Care. The MGH*f*C PFAC organized a Pediatric Grand Rounds and provided feedback on proposed renovations to the pediatric ED. The Cancer Center PFAC added 13 new members representing ten different cancers and helped launch the first patient-experience council. The Institute for Heart, Vascular, and Stroke Care PFAC contributed to re-naming MGH Telehealth, MGH Connect; recommended strategies for patient access; and participated in a recent Institute Nursing Conference. The Ambulatory Practice of the Future Care Alliance established guidelines for patient engagement; developed a Care Alliance web page; and designed and implemented a patient-experience survey.

New members are welcome; recommendations can be made by clinicians or self-referral. All candidates must have current healthcare experience at MGH or one of the MGH health centers and should be able to interact with a diverse group of people. For more information, e-mail: pcscpfac@partners.org.


Universal Patient Compact
Principles for Partnership

As your healthcare partner, we pledge to:

- Include you as a member of the team
- Treat you with respect, honesty and compassion
- Always tell you the truth
- Include your family or advocate when you would like us to
- Hold ourselves to the highest quality and safety standards
- Be responsible and timely with our care and information to you
- Help you to set goals for your healthcare and treatment plans
- Listen to you and answer your questions
- Provide information to you in a way you can understand
- Respect your right to your own medical information
- Respect your privacy and the privacy of your medical information
- Communicate openly about benefits and risks associated with any treatments
- Provide you with information to help you make informed decisions about your healthcare and treatment options
- Work with you, and other partners who treat you, in the coordination of your care

As a patient I pledge to:

- Be a responsible and active member of my healthcare team
- Treat you with respect, honesty and consideration
- Always tell you the truth
- Respect the commitment you have made to healthcare and healing
- Give you the information that you need to treat me
- Learn all that I can about my condition
- Participate in decisions about my care
- Understand my care plan to the best of my ability
- Tell you what medications I am taking
- Ask questions when I do not understand and until I do understand
- Communicate any problems I have with the plan for my care
- Tell you if something about my health changes
- Tell you if I have trouble reading
- Let you know if I have family, friends or an advocate to help me with my healthcare

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If there are other ways you would like us to work with you and your family, please let us know:


At left, David Finn, MD, and at right, patient Susanne Goldstein, address recent joint meeting of Patient and Family Advisory Councils. Above center: the Patient Compact.

# The patient experience

—by Rick Evans, senior director of Service

When we began our Innovation-Unit journey, our goal was to make care more efficient while ensuring the highest standards of quality, safety, and patient- and staff-satisfaction. We wanted to provide superior care while keeping both staff and patients engaged.

We're fortunate to have mechanisms in place to harvest feedback from patients through surveys, letters, and the Office of Patient Advocacy. One survey, the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), is required for all hospitals across the country. It asks about key elements of the patient experience—nurse and physician communication, staff responsiveness, pain-management, cleanliness, quietness, and how well we prepare patients for discharge, among other things. HCAHPS results are publicly reported and impact the hospital's reimbursement.

A key aspect of the survey is the rating scale. The survey asks patients to rate the care they received based on the frequency with which they experienced high quality service. For example, patients are asked: "How often did nurses or physicians listen carefully to you?" Or, "After you pressed the call button, how often did you get help as soon as you wanted it?" The highest response a patient can give is: 'Always.' So a high rating is linked to the *consistency* with which their needs were met. Getting an 'Always' rating can be challenging, especially when the hospital is as big and busy as MGH. But consistency is also a goal for our work on Innovation Units.

Generally, MGH does very well on HCAHPS surveys. Some of our scores, including Nurse Communication, Discharge Instruction, Overall Rating of Care, and Likelihood to Recommend, are among the highest in the country. There's always room to improve; many of our efforts now are focused on responsiveness, pain-management, and quietness.

The work we're doing on Innovation Units and the interventions we've introduced have had an incredible impact on the patient experience and our survey results. Since the launch of Innovation Units in 2012, the hospital's scores for every HCAHPS domain have improved, and the majority of our results have improved at a significant rate, outpacing most other hospitals in the country. Of note, our scores for cleanliness and quietness are up five points. Nursing Communication scores, which were already high, are up more than two points. Discharge Information, already well above the 90th percentile nationwide, has come up another 1.5 points. And the hospital's already high Overall Rating and Likelihood to Recommend scores have also improved.

These numbers are more than just scores on a data sheet. They represent a message from our patients that the interventions we introduced on Innovation Units are working. Our efforts to improve coordination and collaboration, the new attending-nurse role, the launch of inter-disciplinary rounds, post-discharge phone calls, quiet times—these interventions are being well received by patients and families, and that was our goal from the outset.

For more information about the patient experience at MGH or how to interpret HCAHPS scores, contact Rick Evans at 617-724-2838.

| Measure | 2011 | 2012 | 2013 YTD | Change (2011 - 2013 YTD) |
|---|---|---|---|---|
| Nurse Communication Composite | 79.4 | 81.0 | 81.8 | +2.4 |
| Doctor Communication Composite | 81.9 | 81.6 | 82.4 | +0.5 |
| Room Clean | 69.8 | 72.9 | 74.6 | +4.8 |
| Quiet at Night | 45.2 | 48.5 | 50.4 | +5.2 |
| Cleanliness/Quiet Composite | 57.5 | 60.7 | 62.5 | +5.0 |
| Staff Responsiveness Composite | 63.6 | 64.9 | 64.6 | +1.0 |
| Pain Management Composite | 71.5 | 71.9 | 72.1 | +0.6 |
| Communication About Meds Composite | 62.7 | 64.0 | 65.2 | +2.5 |
| Discharge Information Composite | 89.8 | 91.2 | 91.6 | +1.8 |
| Overall Rating | 79.1 | 80.1 | 81.1 | +2.0 |
| Likelihood to Recommend | 89.4 | 90.5 | 90.4 | +1.0 |

HCAHPS results reflecting progress from 2011 through 2013.

# Inter-disciplinary care

—by Ann Jampel, PT; Mary Ellin Smith, RN; Sharon Bouvier, RN; Kevin Whitney, RN; Carmen Vega-Barachowitz, SLP; Theresa Gallivan, RN; and Chris Annese, RN

Inter-disciplinary collaboration is a patient-centered approach to care-delivery that maximizes the strengths and skills of all members of the care team. At MGH, teamwork, collaboration, and inter-disciplinary practice are core values. Following, are just a few examples of how inter-disciplinary practice dovetails with the innovative work we're doing to make care more efficient, affordable, and patient- and family-focused.

*Inter-Disciplinary Rounds*

While rounds had always been part of the daily routine on the Bigelow 14 Vascular Unit, in preparing to become a Phase I Innovation Unit, it became clear that there was an opportunity to enhance the rounding process. Staff identified factors that contributed to rounds being inefficient and not well-attended. Rounds had always been scheduled for 7:15am and typically included the resident or physician assistant, the case manager, and the resource nurse. Key members of the team, such as physical therapists and dieticians, often weren't available at that hour. Many care plans hadn't yet been reviewed by the attending physician, which made it difficult to move forward and made meaningful communication a challenge.

As a unit, staff brainstormed ideas to improve the rounding process. Meetings were held with clinicians from each disciplines so that everyone's interests and perspectives could be considered. All agreed that rounds would be more productive if all members of the team attended and care plans had been reviewed. There was immediate buy-in from the team to have rounds start at 8:30am.

Rounds are led by attending nurses. Kathy Hurley, RN, attending nurse, says, "It makes such a difference having everyone together to share observations, ask questions, and hear the same information at the same time. Care is better coordinated and we've moved from focusing on discharge planning to a more comprehensive care-plan approach. We focus on quality indicators such as skin care, fall-prevention, and early removal of Foley catheters. Having the participation of the whole team is key."

Physical therapist, Kirstie Hinsman, PT, observes, "Inter-disciplinary rounds are incredibly helpful. They allow you to plan your day and identify priorities based on the patient's needs and the plan of care."

On the White 7 Dedicated Education Unit, (l-r): staff nurse, Lisa Rattner, RN; dietitian, Caitlin Albano, RD; physical therapist, Lena Rabideau, PT (leaning toward patient); and case manager, Christine Rothwell, RN, with patient, Linda Coughlin.

*The Inter-Professional Dedicated Education Unit*

Since September of 2011, MGH and the MGH Institute of Health Professions (IHP) have partnered in an innovative, clinical education model to enhance inter-professional collaboration and patient outcomes. MGH staff and IHP students in Nursing, Physical Therapy, and Speech-Language Pathology participate in this program on the Ellison 8 and Bigelow 11 Inter-Professional Designated Education Units. Students are paired inter-professionally, and learning is focused on understanding each team member's role and responsibilities and role-modeling effective

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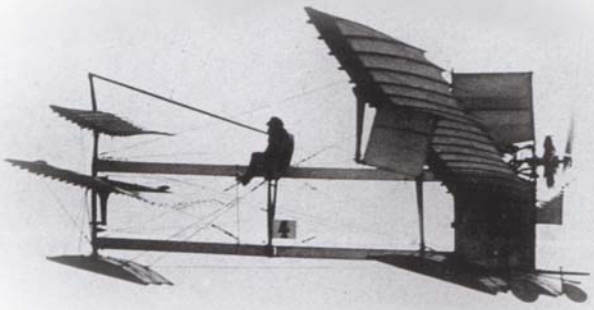


inter-professional communication and teamwork. Debriefings are held each week to review successes and challenges; these sessions are attended by students, MGH instructors from all three disciplines, and IHP faculty. This approach prepares students to fully participate in the teamwork and knowledge-sharing they'll encounter in professional practice.

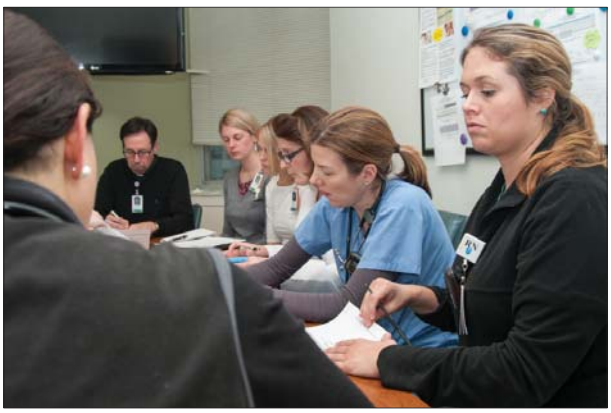
*Inter-Disciplinary Staff Advisory Committee*

The success of inter-disciplinary rounds and the success of the Staff Nurse Advisory Committee triggered a discussion at a recent meeting of the Patient Care Services Executive Committee: Why not create an *inter-disciplinary* staff advisory committee? The idea was soon a reality with a committee composed of representatives from all roles and disciplines within Patient Care Services (including associate chief nurses and department directors). The committee meets quarterly and is charged with:

- promoting and invigorating inter-disciplinary collaboration and effectiveness
- providing a forum for communication about organizational changes affecting staff
- participating in planning and communication of initiatives to promote and sustain regulatory readiness
- serving as liaison between units/departments and PCS leadership regarding issues of quality, clinical care, and work-life balance
- identifying opportunities for efficiency in care-delivery and cost savings

Even in the short time the committee has been in existence, they've had an impact on inter-disciplinary communication and advancing the understanding of each discipline's domains of practice. These are only some of the efforts underway to promote seamless, inter-disciplinary care and teamwork.

Participating in inter-disciplinary rounds on the Bigelow 11 Medical Unit are (top row, l-r): social worker, Berney Graham, LICSW; physician, Ricardo Cigarroa, MD; case manager, Jill Harmer, RN; staff nurse, Aislinn Doherty, RN; and attending nurse, Lore Innamorati, RN.



And below on White 8: Karen Blumenthal, MD, junior medical resident; Renee Reynolds, RD, dietitian; Margaret McKinney, RN, attending nurse; Nora Arbeene, RN, case manager; Father John Kearns, chaplain; Caitlin Laidlaw, LICSW, social worker; Katie Murphy, LICSW, social worker; Jean Conti, RN, case manager; Laura Tikonkoff, PT, physical therapist; and Valerie Cyr, RN resource nurse.

# The attending nurse role

—by Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development

The 2010 Institute of Medicine's report, *The Future of Nursing: Leading Change, Advancing Health*, observed that, "The United States has the opportunity to transform its healthcare system, and nurses can and should play a fundamental role in this transformation." One recommendation of the report was that nurses practice to the full extent of their education and training; another was that nurses should be full partners with physicians and other healthcare professionals in re-designing health care.

At MGH, we've turned those words into action with the work we're doing on Innovation Units. A key intervention on Innovation Units has been the introduction of the attending nurse role (ARN). Attending nurses function as clinical leaders, managing the care of patients on a single unit from admission through discharge. Attending nurses interact with the inter-disciplinary team, the patient, and the family to ensure continuity and efficient care in a safe and responsive environment.

Attending nurses share best practices to promote optimal family-centered care, identify and resolve barriers, and promote trans-discplinary collaboration among the entire team.

To facilitate the growth and development of nurses in this new role, The Norman Knight Nursing Center for Clinical & Professional Development offers weekly meetings with attending nurses. These meetings give attending nurses a supportive place to debrief, support one another, and talk about developing the role.

Says attending nurse, Jean Stewart, RN, "It's so important to have uninterrupted time to sit and talk with patients about what *they* want to talk about. Attending nurses have a broader view of care; we make sure all the loose ends are tied up and that the home plan is safe before the patient is discharged. Sometimes it's nice to just have the opportunity to do the simple things that make patients happy."

Sandy Masiello, RN, Maureen Tully, RN, and Margo Wilson, RN, agree that the attending nurse role has had an incredible impact on continuity of care. "We see patients every day; they know the same person is going to be there to advocate for them. This is the best thing for the patients. We're seeing results. The longer we do it, the more positive the feedback is from staff and patients."

Perhaps attending nurse, Donna Slicis, RN, put it most succinctly when she said: "My job is to pause, look, question, connect, communicate, and improve. Sometimes, I feel like my role is to be the punctuation mark in our daily work caring for patients."

Because there's so much interest in this new role, *Caring Headlines* invited two attending nurses to talk about their practice in an attempt to shed light on how this role works on a day-to-day basis. Following are their narratives.

Attending nurse, Sandra Kelly, RN (right), with colleagues, Michelle Allen, RN (left) and Kitman Tsang, RN, with patient, Linda Ayers.

*Sandra Kelly, RN, attending nurse, White 11 Medical Telemetry Unit.*

A 'typical' day as an ARN varies greatly from day to day. On Mondays, I meet patients who were admitted over the weekend and begin to prioritize their needs. After rounding with the medical team, I look at who's scheduled to be discharged, especially patients scheduled for pre-noon departure who may require patient education before leaving or help with paperwork. I work closely with the resource nurse and all the nurses on the unit to identify specific patient needs, such as education around diabetes, medications, or CHF (congestive heart failure). I work with social workers to ensure any home services are in place before they go.

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Early in the week, I make a lot of post-discharge phone calls to patients. I answer questions about medications, or home regimens, or follow-up appointments.

I'm available to the resource nurse and staff (who may rotate from day to day). But since I'm on the unit every day, I'm familiar with what's happening and can provide continuity.

I think of the role as the 'nucleus' of patient care for the inter-disciplinary team. Patients know me and feel comfortable asking questions or voicing concerns. I'm in a good position to advocate for their needs. I think the role of attending nurse is valued by nurses and patients alike. Staff utilize the role in ways that best fit the needs of the patient and the unit.

One memorable call involved a complex medical patient who'd been discharged the day before. She was being followed by a visiting nurse. When I called, she was home alone and experiencing pain she described as 10 out of 10. She had vomited several times. Her son wouldn't be home until later that afternoon. I pulled up her list of medications and saw that she had Zofran. I explained that the Zofran would help her nausea and told her which medications would help ease her pain. I advised her to take the Zofran first, and then the pain medications. I called the visiting nurse agency and advised them of the situation. I called her PCP and informed him of her condition. And I called the patient's daughter who left work to go over and check on her. I let the patient know I'd call back later to see how she was doing. When I called back that afternoon, her vomiting had resolved, she'd been able to eat lunch, and her pain had improved.

*Grace Aylesbury, RN, attending nurse, White 11 General Medical Unit*

As I educate myself about the difference between bedside nurse and attending nurse, I realize that being an attending nurse has a great impact on post-hospital care and preventing unnecessary re-admissions.

I recently made a post-discharge phone call to Mr. H and noted he sounded anxious because he couldn't get a follow-up appointment at the West End Clinic (an outpatient facility for patients with mental-health and substance-abuse issues). It was imperative for him to have follow-up care to prevent a relapse of his alcoholism. I facilitated the call for him and found that there had been a miscommunication in his trajectory of care. I directed him to the right physician who was able to see him immediately. Mr. H was very appreciative, knowing he had a solid plan in place to maintain his sobriety.

Providing individualized education to patients with COPD, congestive heart failure, and diabetes helps them better understand their disease processes. Attending nurses have time to answer questions and encourage patients to actively participate in their care. One patient on anti-coagulation therapy for a blood clot thought it was okay to miss a few doses of his medication when he travelled. This led to a deep-vein thrombosis and re-admission to the hospital. During his re-admission, I spent time with him, stressing the importance of rigorous adherence to his treatment and making sure he understood why it was so crucial to adhere to the plan. I took the time to understand his lifestyle, what was important to him, and made sure he understood everything he needed to know to manage his illness.

I assisted in the care of Mrs. C, an 88-year-old woman from the Philippines who'd had multiple small strokes and a complicated hospitalization. According to her chart, she had become aphasic, 'non-verbal, and confused.' I happen to speak her language, so I stopped by several times to see her. During our cordial conversations, I discovered she wasn't confused or non-verbal, she was actually showing signs of recovery. I communicated my observations to the team. They were pleasantly surprised by her progress. With this new assessment, Mrs. C's discharge trajectory was changed to a more appropriate, acute-care rehabilitation setting.

Attending nurse, Grace Aylesbury, RN, reviews patient-education materials with patient, Stanislav Voronov

In addition to direct patient care, the attending nurse role gives me the opportunity to help my colleagues in their daily work. Sometimes just knowing there's another person available when the unit gets busy contributes to the overall smooth functioning of the unit and helps with morale. I find the role very fulfilling and am happy I made the decision to take on this new challenge in my career.

For more information about the attending-nurse role, call Gino Chisari, RN, director, The Knight Center for Clinical & Professional Development at 617-643-6530.

# The Patient Jou

## Before

Pre-admission care

Intervention

Admission process: ED, direct admits, transfers

Intervention

## During Ho

Patie
direct p
tests, treatme
clinical
operatio

**Goal:** High-performing, inter-disciplinary
efficient, and equitable care that

## The Inter

- Articulate estimated discharge date and disposition upon admission
- Create Welcome Packet (that includes notebook and discharge envelope

- Ensure across-the-board understanding of each discipline's domain of practice
- Implement daily inter-disciplinary team rounds
- Install electronic unit white boards
- Install in-room white boards to enhance communication
- Introduce smart-phone technology for unit staff

## Throughout

- Relationship-based care
- The attending nurse

# rney Framework

spitalization

nt stay;
atient care;
nts; procedures;
support;
nal support

Intervention

Discharge process

Intervention

After

Post-discharge care

**teams that deliver safe, effective, timely, is patient- and family-centered**

## ventions

- Provide staff with access to portable wireless tablets or computers
- Equip attending nurses with business cards to ensure optimal communication and continuity
- Implement hourly rounding with the Four Ps (presence, pain, positioning, and personal hygiene)
- Implement quiet hours
- Implement discharge follow-up phone-calls

hospitalization:

role

- Consistent hand-over communication

# Hourly rounding

—by Patricia Shanteler, RN, staff specialist

Ask any nurse about the importance of hourly rounding, and he or she will tell you it's a vital part of patient care. Research shows that certain aspects of care, certain needs, can be anticipated. Those needs are frequently the reason patients use their call lights. Proactively meeting those needs before patients call for assistance can go a long way toward keeping patients safe and comfortable.

By bundling, or clustering, specific interventions together and performing them at regular intervals, nurses can reduce call-light utilization and enhance time-management, making care at once more efficient *and* responsive to patients' needs.

Hourly rounding is one of the 15 interventions introduced as part of the care model on Innovation-Units. At MGH, hourly rounding consists of four important aspects of care, referred to as the Four Ps:

- *Presence*
  The impact of staff's presence on the patient journey cannot be overstated. Presence is more than stepping into a patient's room. It's conveying a sense of connection and interest, as if that patient is the only thing on your mind in that moment. When patients feel that staff listen to them and care about them, that's a factor of presence
- *Pain*
  Anticipating and actively managing pain means intervening before pain becomes severe. Hourly rounding gives clinicians an opportunity to assess and treat pain at regular intervals to ensure optimal pain-management
- *Positioning*
  Studies show that frequent position changes contribute to a decrease in hospital-acquired pressure ulcers. Positioning also means checking the environment to make sure personal necessities are within reach for patient
- *Personal Hygiene*
  Assisting patients in attending to their personal needs (toileting, grooming, etc.) leads to fewer falls. Patients are less likely to get out of bed and attempt something beyond their means if they know someone is going to check on them at regular intervals

Though the framework of hourly rounding is standardized, the power of this intervention is in customizing each interaction to meet the individual needs of each patient. Creativity and teamwork are critical components of successful rounding.

For more information about hourly rounding, or to learn more about the Four Ps, call associate chief nurse, Kevin Whitney, RN, at 617-724-6317.

Lunder 8 staff nurse, Sara Bourassa, RN, checks in on patient, Marilyn Adamski, during hourly rounds.

# Warm hand-overs

—by Kevin Whitney, RN, associate chief nurse

A key intervention embedded in the Patient Journey is the hand-over communication process (see Patient Journey diagram on page 12). The primary purpose of hand-overs is to enhance communication among caregivers during each care transition to ensure all members of the team have a clear understanding of the patient's current condition, medical history, and care plan. Having a structured, reliable hand-over process improves quality of care, efficiency, and outcomes.

A Joint Commission study found that the most common cause of sentinel events involves a breakdown in communication between caregivers. In addition to written communication, best practice includes verbal communication, or 'warm hand-overs.' With warm hand-overs, the sending clinician has an opportunity to communicate pertinent information, and the receiving clinician has an opportunity to ask clarifying questions. Warm hand-overs have the added benefit of improved patient- and family-satisfaction, shorter lengths of stay, and fewer re-admissions.

MGH and Partners HealthCare are always looking for ways to improve the hand-over process. Developing efficient and effective warm-hand-over communication also helps us prepare for implementation of Partners *e*Care.

This past year, a workgroup was formed to review warm-hand-over options, including SBAR (Situation, Background, Assessment, Recommendation) and I-PASS (Illness severity, Patient summary, Action list, Situation awareness, and Synthesis). SBAR was originally implemented as part of our Innovation Unit interventions, but I-PASS is a relatively new framework. A key advantage of I-PASS is the final step, Synthesis, that emphasizes warm hand-overs, including the opportunity for the receiving clinician to summarize what was heard, ask questions, and re-state actions and to-do items. I-PASS is flexible and can be adapted to different situations, including shift-to-shift, unit-to-unit, provider-to-provider, and acute-care to post-acute-care transfers.

Following the workgroup's recommendation, the Partners Chief Nurse Council and Partners Chief Medical Officer Council have endorsed I-PASS as the preferred method for future hand-over communication throughout Partners HealthCare. At MGH, the effort to advance I-PASS as the preferred hand-over process is being led by David Shahian, MD, vice president of the MGH Center for Quality & Safety. Shahian has formed an inter-disciplinary team to make recommendations on how best to incorporate I-PASS into the current workflow and develop a hospital-wide educational campaign.

The transition from SBAR to I-PASS will begin in early 2014. For more information, call David Shahian at 617-643-4335.

## I-PASS

- *Illness severity*
  - stable, watcher, (unstable, likely not applicable for transfer)
- *Patient summary*
  - Demographic data
    - name, date of birth, date of admission, date of transfer, attending physician of record during stay
    - code status
    - doctor or nurse to contact for hand-over
  - Facility course by active issues
    - problem #1, problem #2, problem #3, etc.
    - medication changes
  - Common elements
    - diet
    - activity
    - precautions
    - physical therapy, occupational therapy, nutrition, speech, social work consults or recommendations
- *Action plan*
  - remaining tasks
  - pending studies that require follow-up
  - contact for pending studies
- *Situational awareness and contingency planning*
  - potential complications
  - HCP, family contact
  - PCP contact
  - provider to contact regarding hospital stay
- *Synthesis*
  - summary statement

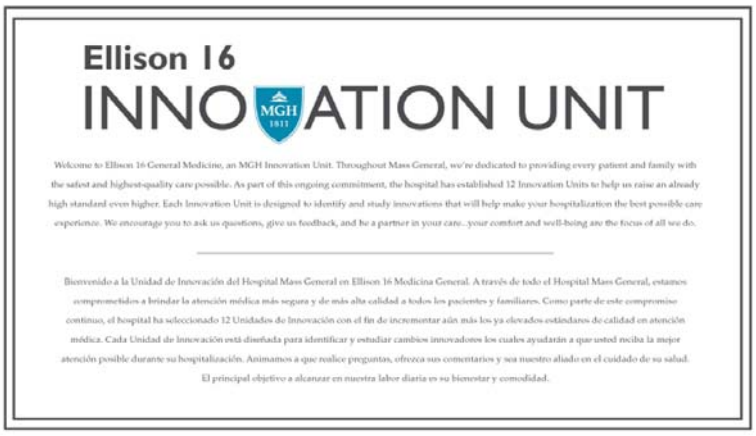
# Communication

—by Georgia Peirce, project manager

When it comes to health care, it's especially important to give the right information to the right people at the right time and in the right way. In a rapidly changing healthcare environment, clear, timely, accurate communication is crucial.

As Innovation Units went 'live' at MGH and began introducing new interventions, it was important for patients, families, and staff to be on the same page. Everyone needed to know that something new and different was happening and be assured that care would continue to be safe, attentive, and patient-focused. And everyone needed to know that they were part of the process.

The Innovation-Unit communication plan was designed to raise awareness and share information through highly visible signage and educational materials. Step one was creating an Innovation-Unit logo with a clean, forward-thinking look that would mirror the work being done and be readily recognizable to staff and visitors. Step two was creating a visual of the Patient Journey Framework that would serve as a blueprint for the work (see diagram on page 12).


Ellison 16

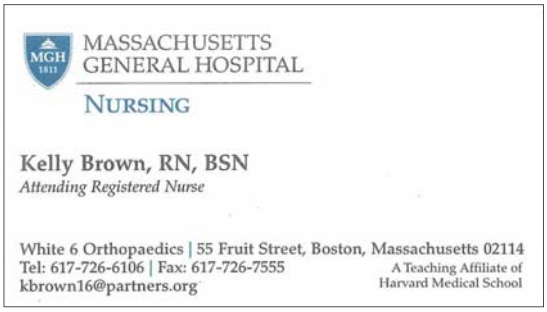
INNOVATION UNIT

Welcome to Ellison 16 General Medicine, an MGH Innovation Unit. Throughout Mass General, we're dedicated to providing every patient and family with the safest and highest-quality care possible. As part of this ongoing commitment, the hospital has established 12 Innovation Units to help us raise an already high standard even higher. Each Innovation Unit is designed to identify and study innovations that will help make your hospitalization the best possible care experience. We encourage you to ask us questions, give us feedback, and be a partner in your care...your comfort and well-being are the focus of all we do.

Bienvenido a la Unidad de Innovación del Hospital Mass General en Ellison 16 Medicina General. A través de todo el Hospital Mass General, estamos comprometidos a brindar la atención médica más segura y de más alta calidad a todos los pacientes y familiares. Como parte de este compromiso continuo, el hospital ha seleccionado 12 Unidades de Innovación con el fin de incrementar aún más los ya elevados estándares de calidad en atención médica. Cada Unidad de Innovación está diseñada para identificar y estudiar cambios innovadores los cuales ayudarán a que usted reciba la mejor atención posible durante su hospitalización. Animamos a que realice preguntas, ofrezca sus comentarios y sea nuestro aliado en el cuidado de su salud. El principal objetivo a alcanzar en nuestra labor diaria es su bienestar y comodidad.

Several Innovation-Unit retreats were held. Leadership forums, educational programs; e-bulletins and articles, and a web portal reflecting our progress were all useful tools in educating the MGH community about our work. This is the third issue of *Caring Headlines* dedicated to our work on Innovation Units.

Multi-lingual signage was posted at the entrance to each unit notifying patients, visitors, and staff that they're on an Innovation Unit and explaining what that means. Bi-lingual signage in visitor lounges provided additional visibility. A Patient & Family Notebook and companion Discharge Envelope were developed and given to patients and families upon admission. These documents provided information about the Innovation-Unit initiative, what to expect while hospitalized, and tools to help prepare for a safe and seamless discharge. Attending-nurse business cards offered a contact name and telephone number for patients and families to use if they had questions during or after hospitalization.


MASSACHUSETTS GENERAL HOSPITAL

NURSING

**Kelly Brown, RN, BSN**

*Attending Registered Nurse*

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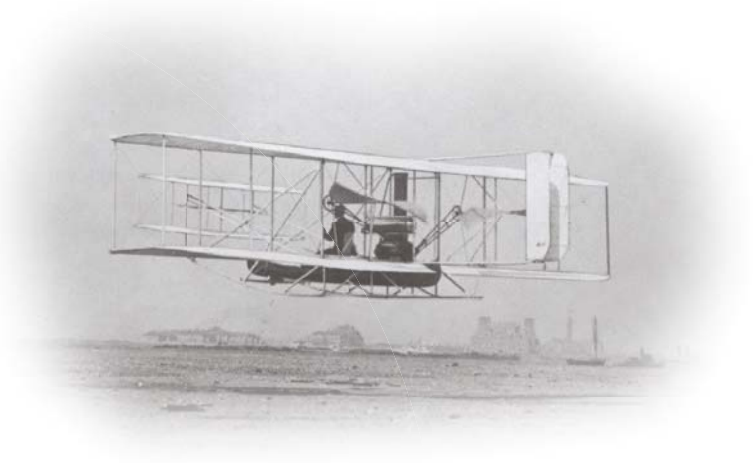
kbrown16@partners.org

A Teaching Affiliate of Harvard Medical School

Inter-disciplinary rounds, team huddles, hand-held communication devices, warm hand-overs, in-room white boards, electronic white boards at nurses stations, and other interventions enhanced communication and the exchange of information as Innovation Units went live.

When our evaluation of Innovation-Unit work began to show positive outcomes, news was shared more broadly. Updates were distributed to MGH leadership, trustees, and Partners leadership. *Fostering Nurse-Led Care*, written by Jeanette Ives Erickson, RN; Dorothy Jones, RN; and Marianne Ditomassi, RN, featured our Innovation-Unit work in the chapter, "Innovations in Care Delivery." The October, 2012, issue of *Nursing Economics* featured the article, "Attending Registered Nurse: an Innovative Role to Manage Between the Spaces," by Ives Erickson, Ditomassi, and Jeff Adams, RN. On October 11, 2012, MGH Innovation Units were featured in the world premiere of the movie, *If Florence Could See Us Now*. And our Innovation in Care Delivery Symposium in October attracted an international audience.

For more information about the Innovation-Unit communication strategy or creation of the Patient Journey Framework, call Georgia Peirce, project manager, at 617-724-9865.



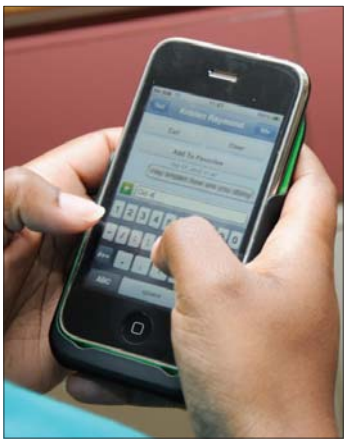
# Supporting technology

—by George Reardon, director, Clinical Support Services

Organizational success occurs most readily when workflow and clinical processes intersect with technology. But technology in and of itself does not constitute improvement. Technology is a tool intended to support organizational processes with the ultimate goal of improving patient care.

On Innovation Units, the marriage between process-improvement and technology has been a resounding success. The introduction of smart phones came about as a result of clinical and support staff identifying the need for a better *tool* to support intra-unit communication. The goal was to improve patient satisfaction through improved responsiveness and quiet, both of which could be achieved with smart phones.

Patient Care Services partnered with IS to identify options. A number of devices were piloted on two inpatient units, and staff recommended the one they felt best supported unit quiet, responsiveness, and ease of use. The device is a combination cell phone and desktop web application. Staff can send and receive instant messages and voice-call using the hospital's secure wireless network so all communications are private and secure. Customized, pre-set messages and commands make it easy to send and receive information to an individual or group.

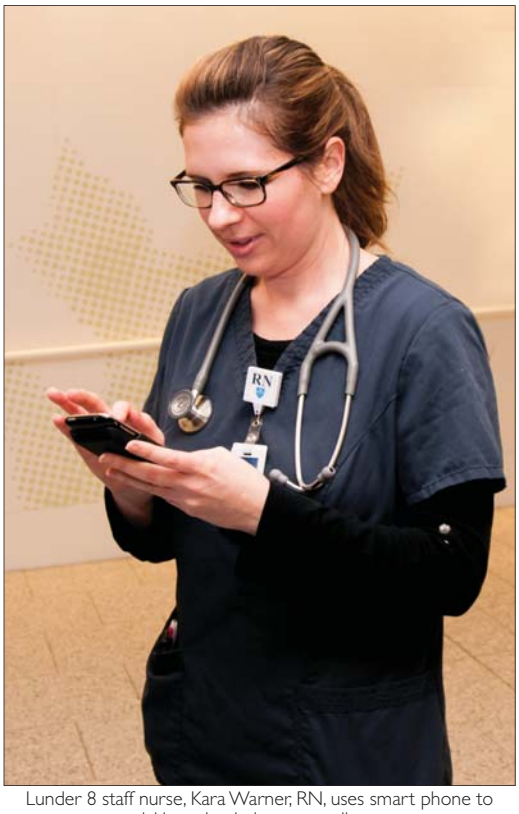


The ease with which two-way, instant messaging can be achieved was the feature that most persuaded staff to choose this device. It's fast and quiet regardless of whether the user is sending a message to other clinicians or to the operations associate at the front desk, or both.

These mobile devices have really taken off. Last month there were 976 smart phones in use at MGH. At any given time, there's an average of 750 concurrent users. And more than 5,000 staff members are using either the smart phone or the desktop applications.

Says staff nurse, Kara Warner, RN, "Smart phones have made communication among nurses and other staff so much more efficient while also reducing the overall noise level by eliminating the need for overhead pages and call bells."

For more information about how smart phones have impacted practice on Innovation Units, call George Reardon, director of Clinical Support Services, at 617-726-5392.




Lunder 8 staff nurse, Kara Warner, RN, uses smart phone to quickly and quietly text a colleague.

# Equitable care

—by Deborah Washington, RN; John Polk, DMin; Anabela Nunes; and Marianne Ditomassi, RN

The Institute of Medicine's 2001 report, *Crossing the Quality Chasm*, noted that the US healthcare-delivery system does not provide consistent, high-quality health care to all people. That's why 'equity' is one of the six Aims for Improvement in addressing the divide between what we know to be good health care and the care that people may actually receive. In response to the Institute of Medicine's report, the language of health care has changed. In addition to the thinking and procedures that go along with standard models of care, there's increased attention on fair and equal delivery of care and how patients experience that care. We call this approach to caring for a diverse patient population, cultural sensitivity, cultural humility, or cultural competence. And it involves eliminating disparities wherever they exist in the spectrum of care-delivery.

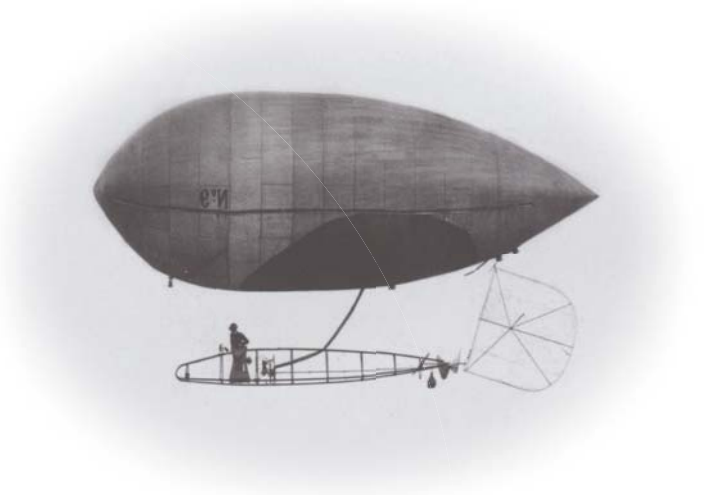
Through education and experience, we understand that in order to take care of a multi-cultural, multi-lingual patient population, our skill set needs to change. Culturally sensitive care requires clinicians capable of complex thinking; clinicians who find the unfamiliar customs, traditions, and practices of those in our care appealing and interesting. These clinicians seek a wider social experience and are characterized by a specific type of skillfulness. These clinicians manage care with consistent use of resources such as interpreters, inter-faith chaplains, The Blum Patient & Family Learning Center, and other sources of cultural knowledge and insight. Care delivered in this way ensures that excellence is maintained across all cultures for all patients.

Culturegrams and Cultural Rounds are two resources designed to help make care more equitable. Culturegrams are written materials that provide information about a specific cultural group. What distinguishes culturegrams designed by Nursing and Patient Care Services is the focus on 'community.' Cultural groups are considered within the context of their neighborhood characteristics, including cultural life, geographical challenges (such as transportation), and vulnerabilities (such as chronic diseases and social determinants of health). This new format for disseminating cultural information will be fea-

*continued on next page*

Pediatric chaplain, Kate Gerne, (right) visits with baby Ana; mom, Dianne Vazquez; and dad, Reinaldo Martinez

Spanish-Portuguese interpreter, Ines Kasper, staffs video interpreter station in the Interpreter Services office.



tured on the PCS portal page beginning in January, 2014.

Unit-based Cultural Rounds are informal sessions where staff come together to discuss educational needs related to cultural diversity or concerns about equitable care. Cultural Rounds are available for any unit or role group. These learning sessions can be integrated into regularly scheduled staff meetings or requested as separate educational sessions. Cultural Rounds could also be structured as a job-shadow experience between a nurse and the director of Diversity for a more focused look at care based in culture. Another iteration of Cultural Rounds is to have documentation reviewed with an eye toward culturally-informed clinical practice.

Another component of equitable care is the ability to ensure that the same high-quality care is afforded to patients who speak other languages or who have limited English proficiency (LEP). Fully engaging LEP patients and families in healthcare decisions and plans of care is essential; that means establishing meaningful two-way communication between patients and caregivers. Providing professional medical interpreters to LEP patients and families is a best practice that yields undeniably positive results. In addition to bedside interpreters, MGH has leveraged advances in technology to maximize interpreter services by utilizing VPOPs (Video Phones on Poles), and IPOPs (Interpreter Phones on Poles). These devices that are widely available on inpatient units and in many ambulatory practices provide immediate access to professional medical interpreters in more than 200 languages. This allows clinicians to connect with patients and families in a timely and effective manner and engage in meaningful discussions about their care regardless of what language they speak.

Spiritual care is another factor we must consider when talking about equitable care. Research shows that failing to address patients' spiritual needs can impact their well-being, satisfaction with care, perceived quality of care, and can be associated with higher healthcare costs. On Innovation Units, staff chaplains actively participate in inter-disciplinary rounds, keeping awareness of spiritual and religious needs at the forefront of the patient's care plan. Inter-disciplinary rounds are an opportunity to educate members of the team about the patient's belief system and how it may impact the delivery of care.

The Chaplaincy Department's Clinical Pastoral Education Program for Health Care Providers welcomes healthcare providers (nurses, social workers, physicians, etc.) into a learning experience alongside those studying to become professional chaplains. This inter-disciplinary program focuses on developing skills and competence in addressing patients and families' existential, spiritual, and religious concerns in a hospital setting. Upon completion of the program, clinicians remain in the practice of their own disciplines but can contribute new knowledge about spiritual care to their clinical practice and their colleagues.

Director of PCS Diversity, Deborah Washington, RN (right), facilitates Cultural Rounds on White 9

Equitable care is an extension of good communication, cultural sensitivity, and relationship-based care. With more effective inter-personal communication comes greater awareness, respect, and engagement. This is how gaps are bridged; this is how relationships are forged; this is how positive outcomes are achieved—one patient at time.

For more information about equitable care, call director of PCS Diversity, Deborah Washington, RN, at 617-724-7469. For information about interpreter services, call director of Interpreter Services, Anabela Nunes, at 617-726-3298. And for information about spiritual care, call director of the MGH Chaplaincy, John Polk, DMin, at 617-724-3226.

# Evaluation

—by Dottie Jones, RN; Jeff Adams, RN; Amy Giuliano, RN; and Marianne Ditomassi, RN

In today's dynamic healthcare environment, MGH has taken a leadership role in re-defining care-delivery and, just as important, articulating how the new care-delivery system impacts key outcomes. The MGH Innovation-Unit evaluation strategy is structured to quickly identify trends and support either acceleration or rapid-cycle course correction as appropriate.

*Innovation Unit Evaluation Schema*

The evaluation structure is clearly delineated in the schema below. The areas of focus (column 1) help define the innovation interventions (depicted in column 2). In turn, patients and staff are continually educated about the innovation interventions (column 3). Then (column 4), using a mixed-method data-collection approach, we're able to gather quantitative and qualitative measures from focus groups, surveys, observations, and analysis of data with input from patients, direct-care staff, and administrators.

Data was collected both pre-Innovation-Unit launch and at specified intervals so we could see where success and opportunities for improvement existed. Qualitative feedback from focus groups and surveys with staff highlighted certain themes:

- The palpable change in organizational culture to respond to health reform needs
- The value of the new attending nurse role in care-delivery
- Although the work has been challenging, the impact on patient care is worth it

With focused observations and interviews conducted with patients and staff, it's clear that Innovation-Unit interventions are becoming part of the culture. Every clinician surveyed was able to speak to the role of attending nurse; more than 92% were able to share an example of relationship-based care; and 92% reported that inter-disciplinary rounds are occurring at scheduled times on their units.

Opportunities to improve were also identified. Crucial data such as anticipated discharge date and discharge disposition originally intended to be articulated upon admission have proven challenging to capture.

More than 95% of patients surveyed reported feeling included as part of the care team. Patients reported that their call bells were answered promptly 88% of the time; they were asked about pain during hourly rounding 93% of the time; and if anything else was needed 96% of the time.

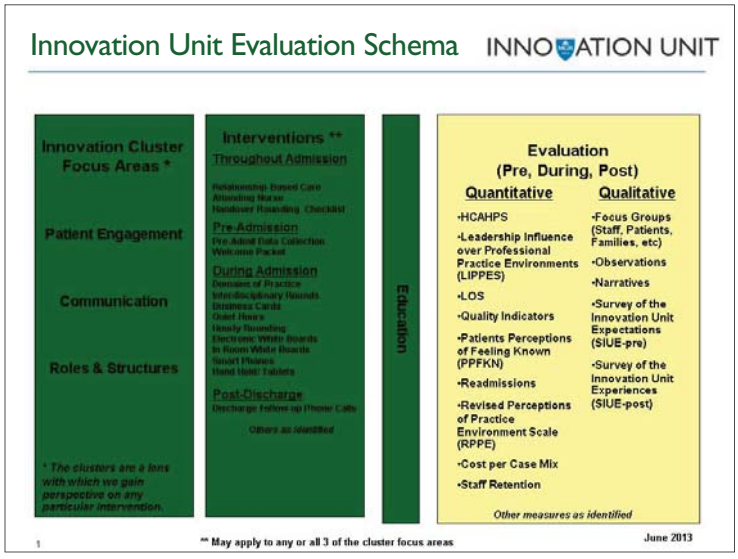
*Innovation Unit Dashboard*

The Innovation Unit Dashboard is an integral component of the evaluation plan and an effective tool for measuring the impact of Innovation-Unit interventions. Categories of the dashboard include:

- Quality and Safety, including Nursing Sensitive Indicators
- Infection Control
- ALOS and Re-Admissions
- Patient-Satisfaction
- Staff-Satisfaction
- Throughput and Efficiency (patient volume and financial metrics)

Quantitative data are organized in an easy-to-read format using Microsoft Excel (see dashboard on opposite page). Visual displays using colors and shading help demonstrate favorable (or unfavorable) performance and progress toward achieving specific goals. A Notes feature is available for unit-specific information, if necessary. The latest version of the Innovation Unit Dashboard is available on the Innovation Unit portal page at: http://www.mghpcs.org/Innovation_Units/index.asp.

While we have a robust plan to assess the impact of Innovation-Unit interventions, we also have mechanisms in place to assess the strength of our professional practice environment: the

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# Innovation Units

bi-annual Staff Perceptions of the Professional Practice Environment Survey, and the rigorous triennial Magnet Recognition process.

*Staff Perceptions of the Professional Practice Environment Survey*

The Staff Perceptions of the Professional Practice Environment Survey reports the perceptions of PCS clinicians about the strengths and weaknesses of the clinical practice environment at MGH. It is essentially a 'report card' designed to evaluate clinicians' overall satisfaction with the environment in which they practice. Results of the survey are used to celebrate strengths and guide efforts to improve the practice environment.

The 2013 survey contained five sections:

- Demographic Information
- Revised Professional Practice Environment Scale
- NDNQI-Adapted Job Enjoyment Scale
- Overall Satisfaction with Working in their Department/Primary Unit
- An open-ended question asking for additional comments about the professional practice environment at MGH

More than 1,830 individuals or 42.3% of staff completed the survey. Clinicians continue to agree that the professional practice environment characteristics of Autonomy/Leadership, Control over Practice, Clinician-MD Relations, Communication about Patients, Teamwork, Handling Disagreement and Conflict, Internal Work Motivation, and Cultural Sensitivity, are important elements within the MGH practice environment. Overall, 86% of staff reported that they were satisfied or very satisfied working at MGH.

More than 31% of clinicians (580) who responded to the survey provided additional written responses. In general, respondents reported that they enjoy working at MGH; are proud of their contributions to patient care; want increased standardization around innovation strategies; value supportive leadership, teamwork, and effective communication; and are satisfied with their personal development and voice in advancing patient care.

*Magnet Recognition*

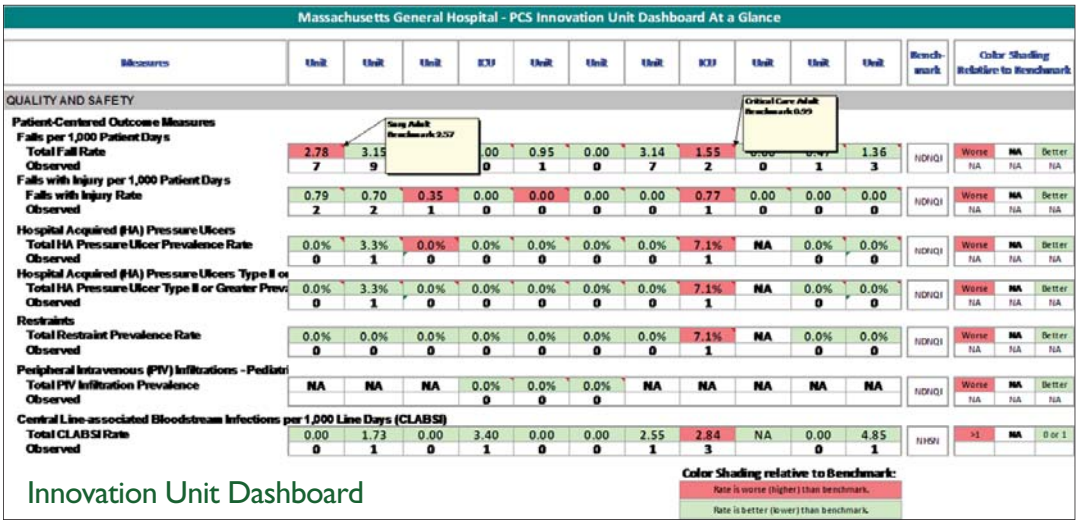
Magnet Recognition is the highest honor bestowed on a healthcare institution by the American Nurses Credentialing Center (ANCC). On May 6, 2013, MGH was re-designated a Magnet Hospital. After four Magnet appraisers critically reviewed MGH evidence and conducted a four-day site visit, no deficiencies were identified, and appraisers identified four exemplars:

- MGH nurses report a higher level of nurse satisfaction than the national mean
- Strong structures and processes are in place to advance nursing research
- MGH has demonstrated innovations in care delivery (the Intra-Professional Dedicated Education Unit and Innovation Units)
- Nurses are highly valued by the healthcare community internally and externally

Appraisers commended MGH for the array of resources available to address complex ethical issues.

Our evaluation efforts have helped us better understand the needs of our patients, families, and colleagues and how to better meet those needs; identify objectives that are achievable and measurable; monitor progress more effectively and efficiently; and identify best practices.

For more information about our evaluation processes, call Jeff Adams, RN, director of The Center for Innovations in Care Delivery, at 617-643-7092.


Massachusetts General Hospital - PCS Innovation Unit Dashboard At a Glance

| Measures | Unit | Unit | Unit | ICU | Unit | Unit | Unit | ICU | Unit | Unit | Unit | Bench-mark | Color Shading Relative to Benchmark | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| QUALITY AND SAFETY | | | | | | | | | | | | | | | |
| Patient-Centered Outcome Measures | | | | | | | | | | | | | | | |
| Falls per 1,000 Patient Days | | | | | | | | | | | | | | | |
| Total Fall Rate | 2.78 | 3.15 | | .00 | 0.95 | 0.00 | 3.14 | 1.55 | | | 1.36 | NDNQI | Worse | NA | Better |
| Observed | 7 | 9 | | 0 | 1 | 0 | 7 | 2 | 0 | 1 | 3 | | NA | NA | NA |
| Falls with Injury per 1,000 Patient Days | | | | | | | | | | | | | | | |
| Falls with Injury Rate | 0.79 | 0.70 | 0.35 | 0.00 | 0.00 | 0.00 | 0.00 | 0.77 | 0.00 | 0.00 | 0.00 | NDNQI | Worse | NA | Better |
| Observed | 2 | 2 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | NA | NA | NA |
| Hospital Acquired (HA) Pressure Ulcers | | | | | | | | | | | | | | | |
| Total HA Pressure Ulcer Prevalence Rate | 0.0% | 3.3% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 7.1% | NA | 0.0% | 0.0% | NDNQI | Worse | NA | Better |
| Observed | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 | 0 | | NA | NA | NA |
| Hospital Acquired (HA) Pressure Ulcers Type II or | | | | | | | | | | | | | | | |
| Total HA Pressure Ulcer Type II or Greater Prev | 0.0% | 3.3% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 7.1% | NA | 0.0% | 0.0% | NDNQI | Worse | NA | Better |
| Observed | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 | 0 | | NA | NA | NA |
| Restraints | | | | | | | | | | | | | | | |
| Total Restraint Prevalence Rate | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 7.1% | NA | 0.0% | 0.0% | NDNQI | Worse | NA | Better |
| Observed | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 | 0 | | NA | NA | NA |
| Peripheral Intravenous (PIV) Infiltrations - Pediatr | | | | | | | | | | | | | | | |
| Total PIV Infiltration Prevalence | NA | NA | NA | 0.0% | 0.0% | 0.0% | NA | NA | NA | NA | NA | NDNQI | Worse | NA | Better |
| Observed | | | | 0 | 0 | 0 | | | | | | | NA | NA | NA |
| Central Line-associated Bloodstream Infections per 1,000 Line Days (CLABSI) | | | | | | | | | | | | | | | |
| Total CLABSI Rate | 0.00 | 1.73 | 0.00 | 3.40 | 0.00 | 0.00 | 2.55 | 2.84 | NA | 0.00 | 4.85 | NHSN | >1 | NA | 0 or 1 |
| Observed | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 3 | | 0 | 1 | | | | |

Color Shading relative to Benchmark:
Rate is worse (higher) than benchmark.
Rate is better (lower) than benchmark.

Innovation Unit Dashboard

# Life-long learning

—by Mary Ellin Smith, RN, professional development manager

When talking about transformational change, it would be easy to focus solely on positive outcomes and forget that in order for change to occur, new learning must take place. As staff and leadership discussed how to improve the patient experience, they recognized that all members of the team would need new skills, new knowledge, and on-going support.

In developing an outline for educational programs, we were guided by observations offered by participants at innovation retreats, and a curriculum for all members of the inter-disciplinary team was created. That curriculum includes:

*Appreciating Differences*, a program offered by MGH Training & Workforce Development that helps participants gain new understanding and identify opportunities to create an environment that is welcoming to people of all beliefs and cultures.

*Conflict Engagement in Complex Healthcare Systems*, is a two-day program for staff and leadership focused on developing skills to effectively engage in conflict and still produce a positive outcome.

*HCAHPS Training* allows members of the team to understand what HCAHPS is and how it's used to improve the patient experience. Training was offered to leaders on how to access their unit's data using the hospital's portal.

*Leadership Coaching* provides facilitated sessions to nursing directors and clinical nurse specialists on leading staff through change.

*Leadership Development and Resiliency Training for ARNs* focuses on developing leadership skills needed by attending nurses as they work with the team to transform care on their unit and across departments

*Owning the Role and Communicating Confidently* focuses on the attending-nurse role, developing skill and confidence in articulating the work and scope of the role, and building leadership skills.

*continued on next page*

# Innovation Units

*Patient Experience, Best Practice Training Sessions* focus on a number of Innovation-Unit initiatives such as post-discharge phone calls, quiet times, and hourly rounding, to name a few. Each best practice includes training for both staff and leaders.

*Resiliency Training* assists team members to foster self-care with strategies such as learning to stay present, developing insight into how to handle people and situations that deplete your energy, and developing positive ways to react to unexpected situations.

*Relationship-Based Care Program* brought a nationally recognized expert for a one-day workshop with leaders of Innovation Units and attending nurses. The program helped reinforce a relationship-based-care approach as part of the new culture.

*Studer Sessions* brought coaches from the Studer Group, an organization devoted to teaching institutions how to create and sustain service excellence. Coaches from Studer Group presented at an Innovation-Unit retreat, and subsequent coaching sessions are planned for the fall.

*Hand-Over Training* provides on-going education to the team on a consistent and systematic approach to hand-over communication.

A commitment to life-long learning goes hand-in-hand with our philosophy of Excellence Every Day. Health care is a dynamic, perpetually changing arena that demands an academically nimble workforce able and willing to stay abreast of new thinking and new ideas. The spirit of life-long learning is embedded in the Patient Care Services vision statement:

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

We believe in creating a practice environment that has no barriers, that is built on a spirit of inquiry, and reflects a culturally-competent workforce supportive of the patient-focused values of this institution."

For more information about any of the educational programs listed here, call Mary Ellin Smith, RN, professional development manager, at 617-724-5801.

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