 Joint Commission  
National Patient Safety Goals

**Identify patients correctly**  
- Always use 2 patient identifiers  
- Two person verification for blood product administration

**Improve staff communication**  
- Report critical results on a timely basis

**Use medications safely**  
- Label all medications and solutions  
- Utilize and teach safe practices for anticoagulation therapy  
- Maintain and share accurate patient medication information

**Use alarms safely**  
- Respond promptly to every clinical alarm  
- Individualize parameter limits for the patient

**Prevent Infections**  
- Use hand hygiene  
- Adhere to Infection Control guidelines  
- Educate patients and families

**Identify safety risks**  
- Identify patients at risk for suicide or self-harm

**Universal Protocol**  
- Conduct a pre-procedure check, mark the site, and perform a Time Out/Pause to verify
Quality Assurance
Performance Improvement (QAPI)

Quality:

- Know your unit-specific Quality Data and Improvement Plans
- Prevent Falls, Pressure Injury and Hospital Acquired Infections
- Utilize IPASS for handovers

Speak Up for Safety:

- Share errors and near misses through narratives and filing of safety reports
- Keep suicidal patients in sight at all times. Use the suicide checklist and order set
- Scan all medications before administering
- Report eCare related safety concerns

Excellence Every Day:
Enhance the Patient Experience:

- Provide Efficient, Effective, Equitable, Timely, Safe, Patient-Centered Care
- Promote patients’ understanding of safe use and side-effects for medications
- Facilitate Quiet at Night
- Increase the use of Interpreter Services
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Patient Safety Goals</td>
<td>2</td>
</tr>
<tr>
<td>QAPI</td>
<td>3</td>
</tr>
<tr>
<td>Excellence Everyday</td>
<td>5</td>
</tr>
<tr>
<td>Resources for Patients, Families and Staff</td>
<td>6</td>
</tr>
<tr>
<td>Joint Commission Hospital Survey</td>
<td>8</td>
</tr>
<tr>
<td>Assuring Quality of Care</td>
<td>15</td>
</tr>
<tr>
<td>Nursing Sensitive Indicators - NSI</td>
<td>15</td>
</tr>
<tr>
<td>Falls</td>
<td>15</td>
</tr>
<tr>
<td>Pressure Injury</td>
<td>16</td>
</tr>
<tr>
<td>CAUTI</td>
<td>17</td>
</tr>
<tr>
<td>CLABSI</td>
<td>18</td>
</tr>
<tr>
<td>Restraints</td>
<td>19</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>20</td>
</tr>
<tr>
<td>PCS QAPI Initiatives - Patient Satisfaction</td>
<td>22</td>
</tr>
<tr>
<td>Culture of Safety</td>
<td>23</td>
</tr>
<tr>
<td>Assuring Patient Safety</td>
<td>24</td>
</tr>
<tr>
<td>Transfusion Therapy</td>
<td>24</td>
</tr>
<tr>
<td>Point of Care Testing (POCT)</td>
<td>26</td>
</tr>
<tr>
<td>Critical Results</td>
<td>28</td>
</tr>
<tr>
<td>Medication Safety</td>
<td>29</td>
</tr>
<tr>
<td>Alarm Safety</td>
<td>32</td>
</tr>
<tr>
<td>Antimicrobial Stewardship</td>
<td>32</td>
</tr>
<tr>
<td>Infection Control</td>
<td>33</td>
</tr>
<tr>
<td>At Risk Patients</td>
<td>39</td>
</tr>
<tr>
<td>Time Out /Universal Protocol</td>
<td>40</td>
</tr>
<tr>
<td>Preparing for Patient Emergencies</td>
<td>43</td>
</tr>
<tr>
<td>Environment of Care</td>
<td>46</td>
</tr>
<tr>
<td>Spills and MSDS</td>
<td>47</td>
</tr>
<tr>
<td>Clinical and Support Resources for Staff</td>
<td>50</td>
</tr>
</tbody>
</table>
EXCELLENCE EVERY DAY

At Massachusetts General Hospital, our Excellence Every Day philosophy means we commit to providing the best possible care to every patient and family in every moment of every day.

We are focused on meeting the needs of patients and families by creating systems that support the highest level of quality and safety. Our efforts to achieve Excellence Every Day include validation by the American Nurses Credentialing Center’s designation as a Magnet hospital and by external regulatory agencies in the form of on-site surveys.

MGH is visited by the Joint Commission every 3 years to validate that we are meeting standards and continuing to provide exemplary, safe care to our patients. Other important surveys we participate in are those that recognize excellence and/or are required to validate advanced, disease specific, certifications.

Examples include:

- Joint Commission Laboratory survey
- Joint Commission Comprehensive Stroke Certification survey
- Joint Commission Left Ventricular Assist Device (LVAD) Certification survey
- CMS End Stage Renal Disease licensure survey
- Massachusetts Department of Mental Health licensure survey
- Massachusetts Department of Public Health (DPH) Infection Control survey

Thank you for your contributions to our success in providing an environment where the EED philosophy comes alive for our patients, families and the entire MGH community.

You are Simply the Best!
RESOURCES FOR PATIENTS, FAMILIES AND STAFF

• Mass General Patient Guide ~ located on each inpatient unit

• Patient Rights and Responsibilities ~ located on each unit

• The Maxwell & Eleanor Blum Patient and Family Learning Center
  o A health information resource center available to Mass General patients, families and staff
  o The PFLC staff can help with information searches and provide a variety of pamphlets, periodicals, books and videos on many health- and disease-related topics
  o Computers with Internet access are available for on-site use.
  o White Building, 1st Floor, Room 110 • (617) 724-7352
  o PFLC@partners.org • www.massgeneral.org/pflc
  o Monday – Friday, 9am – 4:30pm; closed weekends and holidays

• Medical Interpreter Services
  o Provides professional interpreters for all limited English proficient (LEP), deaf and hard of heard (DHH) patients
  o Patients have a legal right to a professional medical interpreter 24/7 free of charge whether it is in person, over the phone or by video
  o Using family members or other staff to interpret is strongly discouraged Call 617-726-6966 for a professional interpreter
  o When a patient insists on using a family member, they must sign a waiver form
  o More information on MGH Interpreter and Translation services is available at: http://www.massgeneral.org/interpreters

• MGH Disability Program
  o Assists patients during their MGH visit
  o Helps patients with disabilities, and their caregivers, to plan visits
  o Responds to concerns and suggestions regarding access
• Provides support and services including but not limited to necessary accommodations:
  - Specialized Call Bells
  - Hearing Enhancers and Magnifiers
  - ASL interpreters or Communication Access Realtime Translation (CART) Services
  - Patient lifts
  - Wheelchair accessible scales
  - Large print documents, Braille
  - Portable Video phones for the Deaf
  - Wheelchair accessible shuttles
  - Accessible rooms and bathrooms (if one is not available at the time of admissions every effort will be made to transfer the patient when one becomes available)
  - Height adjustable accessible exam tables
  - Ambassador or volunteer wheelchair escort

For more information call the disability program manager at 617-726-3370 or check our webpage www.massgeneral.org/accessibility

• Optimum Care Committee
  o Representatives are available to clinicians, patients and families to help address ethical issues
  o Consults may be placed Monday – Friday from 8:00a - 4:00p (except on holidays observed by MGH)
  o Partners Telephone Directory → Ethics Support → PHS Page Status → You will find the phone # to call or person to page for consult intakes

• Office of Patient Advocacy
  o Supports patient’s rights and responsibilities
  o Serves as liaison to patients, family and staff to resolve healthcare concerns and grievances
- Provides accommodations and other services to patients with disabilities to ensure equitable care
- Serves as hospital civil rights officer
- (P) 617 726-3370
- Email: mghpatientadvocacy@partners.org

WHAT WILL THE JOINT COMMISSION SURVEYORS REVIEW DURING THE GENERAL HOSPITAL SURVEY?
The Joint Commission survey is designed to confirm that a hospital follows its own guidelines and policies as well as national standards. The JC general hospital survey will be 5 days in length. Using the patient’s medical record as a road map, surveyors will assess the care provided to patients in both inpatient and ambulatory sites. A surveyor will arrive at your practice area accompanied by MGH leadership. The surveyor will:
  - Review a patient’s record with caregivers
  - Observe care
  - Interview caregivers
  - Interview patients
  - Tour the unit
The nurse caring for the patient the Clinical Nurse Specialist / Nursing Practice Specialist and/or Nursing Director will participate in the record review. Because the surveyor will not know how to navigate the MGH patient record, they will ask you to help locate the documentation they want to review.
As the surveyor tours the unit and observes care, he or she may interview other members of the healthcare team including UCs, PCAs, NPs, PAs, physicians and allied health professionals.

Patient interview
The Joint Commission surveyors will ask the nurse caring for the patient if the patient is able to be interviewed. If yes, the JC surveyor will interview the patient and family without other members of the healthcare team present.
Questions to patients and families may include such topics as:

- Patient and family education
- Advance directives (Health Care Proxy)
- Patient and family participation in care planning
- Pain management
- Staff responsiveness
  - Help when they need it
  - Response to questions
- Continuity of care
- Understanding of medications
- Preparation for discharge
- Environment e.g. noise, cleanliness

Remember

- Surveyors know the standards, but YOU know your practice, your patients and their families
- Breathe and take your time answering the surveyor’s questions, be direct and to the point with your response
- You will not be alone, your Nursing Director, CNS/ NPS and others will be there to support you
- If you don’t know the answer to a question, it’s okay to say “I don’t know but I do know where to find the answer”.
- A full list of resources can be found at the end of this book
- Tell positive stories! If the surveyor asks you a question that relates to a special project on your unit or in the hospital talk about it!

How does the JC Surveyor “trace” a patient’s MGH experience?

The surveyor will ask you to navigate your patient’s electronic medical record in order to trace the patient’s care via associated documentation. The surveyor will ask you to show them documentation in the electronic record including:
• Admission overview and assessment (Initial Nursing Assessment)
• Advance directives/health care proxy available or documentation regarding a discussion about HCP is present in record.
  1. The HCP is found in the maroon book if it has been provided during the current admission
  2. It is found in the Advanced Care Planning module or the Media tab if it has been previously scanned
• Accurate and up-to-date allergies
• Consent for surgery/procedures (found in the maroon book for current admission)
• Timeout/Universal Protocol completed for every invasive procedure that requires an informed consent
• Progress Note
  o Provides a synthesis of the patient’s overall progress
  o Focuses on problems that are not progressing in the Plan of Care (POC)
  o Documents assessments that need to be captured outside of flowsheet
• Transfer of care
  o Note should be a synthesis, the same as a progress note
  o Reviews the POC, problems should be up-to-date and resolved if no longer active
  o Review and update the Education activity
• Plan of Care (POC) Activity
  o Individualized for the patient
  o Based on assessment and re-assessment of the patient’s specific risk factors
  o Progression of problems toward end goals is up-to-date (progressing, not progressing, resolved)
  o Patients at risk for falls, pressure injury, suicide or self-harm have these problems documented in the POC activity and flowsheet
  o Discharge planning
• Educational Activity
  o Patient and family preferred learning style is identified
  o Patient and family education has been implemented
  o Patient/family understanding of educational content has been evaluated
  o Patient and / or family understands medications and side effects

• Flow Sheet Activity
  o Timeout flowsheet (aka Universal Protocol)
  o VS, Intake/Output
  o Safety risks including suicide, self-harm, falls, pressure injury are documented on the Screening Flowsheet
  o Restrain flowsheet – documentation reflects the restraint in use for the patient or discontinued
  o Provider notification of critical lab values is documented in the Assessment Flowsheet
  o Blood Admin flowsheet – Transfusions are stopped and all VS are present
  o Accurate documentation of items (e.g., infusions, restraints) that need to be “stopped” to indicate that they have been discontinued

• Utilize these flowsheet tools

  “Go To Date” takes you directly to a specific date on the flowsheet

  “Last Filed” takes you to the last filed information

  “Hide Completed” allows you to organize Flowsheets. Remember to deselect this when you are searching for specific information
• Other documentation reviewed
  o Evidence of implementation of Provider orders
  o The interdisciplinary plan of care and follow through is evident through summary activity including overview, patient story, and index tabs
  o Documentation that nurse-driven consults have been completed
  o Assessments by Provider-ordered consultants (e.g., PT, OT, SLP, Social Work) are documented
  o Handover/transfer of care is careful and systematic (IPASS, transfer note)
  o OR and Anesthesia notes are accessible in: chart review → encounter → anesthesia event/surgery
  o Discharge planning is documented in progress notes
  o No unapproved abbreviations are used

The Patient Header provides easy access to select patient information

<table>
<thead>
<tr>
<th>Allergy: Heparin An...</th>
<th>Language: English</th>
<th>Wt: 129.3 kg...</th>
<th>Isolation: Contact</th>
<th>Acute Care P...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code: Full (Presum)</td>
<td>Need Interp: No</td>
<td>BMI: 43.33 k...</td>
<td>Precautions: Seizure precau...</td>
<td>MOLST NOT...</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>FYI: No Draw Left Arm</td>
<td>Patient Gate...</td>
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<td></td>
<td></td>
<td></td>
<td>Special Needs: Speech Imp...</td>
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</tr>
</tbody>
</table>

such as:
  o Preferred language
  o Isolation details
  o Precautions
  o Selecting either the MOLST or Code Status headings will bring you to the Advanced Care Planning Module. The Health Care Proxy / Advanced Directive can be found here or in the Media tab
  o “FYI” shows you important patient-specific information that has been flagged by staff
  o Acute care plan (if activated)
Competency, Scope of Practice, Checking Credentials

The surveyor may ask you:

How are you competent to do your job?
Staff are competent through completion of an accredited program, professional licensure, MGH onboarding, continuing education, in-service education, annual training, and validation of performance. Specialty certification is encouraged.

What is the scope of your job?
The ANA defines the legal scope of nursing practice related to medications, therapeutics, and treatments this way:
Nurses make clinical decisions in order to assist in the development and implementation of a strategy of care to accomplish defined goals. Nurses also evaluate the patient’s response to care and treatment. A duly authorized prescriber (MD, APRN, PA) order is required for all medications and all medical therapeutics and treatments. Examples may include blood tests, oxygen, urinary catheter irrigations, EKGs, and point of care testing.

If a provider that you don’t know shows up on your unit to do a procedure, how do you know he or she is privileged to perform the procedure?
I can look the provider up through the MGH Delineation of Privileges Intranet site: Partners Application ► Clinical References ► MGH Delineation of Privileges Intranet Site

How is patient information completely and safely communicated?
Communication of the ongoing plan of care among nurses and between interdisciplinary team members is accomplished through one-on-one discussions and a variety of other means:

- The IPASS framework is one tool employed by clinicians
  - I - illness severity
  - P - patient summary
Electronic health record is accessed to review the patient summary / patient story

Warm Handover: A conversation between caregivers at the time of transition of care from one clinician to another allows staff to synthesize and discuss
  - Patient history
  - Active problems
  - Interventions
  - Patient responses
  - Next steps
  - Information regarding family/significant others
  - Questions & concerns

Interdisciplinary rounds highlight
  - Ongoing plan of care
  - Current problems and interventions
  - Changes to plan of care
  - Changes to treatment strategies
  - Plan for safe discharge

Huddles provide an opportunity to address patient and unit-specific concerns

When a patient goes to a test or procedural area, how is clinical information provided to staff in those areas?

1. A “Ticket to Ride” (aka the Internal Patient Transfer form) is sent with the patient. The Ticket to Ride” contains relevant information, pulled from the EHR, that the receiving area needs upon arrival of the patient.
2. Warm handovers are encouraged to address specific patient needs or concerns
HOW DO WE ASSURE QUALITY FOR OUR PATIENTS?
Nursing-Sensitive Indicators (NSIs) are measures and indicators that reflect the structure, processes and outcomes of nursing care (American Nurses Association, 2004). They showcase the impact of nursing care. Surveyors may ask about Quality Assurance and Performance Improvement (QAPI) initiatives on your unit and throughout the hospital

• Most inpatient units monitor patient falls, pressure injuries, restraint use, Catheter-Associated Urinary Tract Infections (CAUTI) and Central Line-Associated Bloodstream Infections (CLABSI)
• Know your unit-specific NSI Quality Data and Performance Improvement Plans
• Reference your unit-specific Excellence Everyday Quality Board
• Describe Practice Improvement projects in place on your unit and how they have benefitted your patients

Clinical Quality NSIs

Fall Prevention
http://www.mghpcs.org/eed_portal/EED_fallprevention.asp

The falls prevention program at MGH is referred to as the LEAF program (Let’s Eliminate All Falls). The program has 3 components:

1. Identification of patients at risk
   • Every patient is screened on admission, daily, and with any change in status using the Morse Falls scale (adults) or Graf PIF (pediatrics). This helps inform a customized plan of care and patient/family education.
2. Fall risk communication
   • If the patient is at risk, the nurse initiates a fall prevention plan and documents specifics in the POC activity and flowsheet.
   • Information is provided through patient handovers, hourly rounding, signage, or other unit-based strategies
• The patient and family are instructed about fall risk and interventions.
• When a patient is going off the floor, the Internal Patient Transfer form (aka “Ticket to Ride”) is sent with patients to inform the receiving clinician of the patient’s risk.
• The review of unit-specific fall trends is posted on the Excellence Every Day bulletin board.

3. Interventions

• Some interventions apply to all patients, regardless of risk
  o Call light is within reach
  o Room is clear of clutter
  o Teaching is done regarding the side effects of medications

• Interventions are customized or added for patients at moderate or high risk then documented in the plan of care. These interventions may include:
  o Use of bed alarms with customized sensitivity setting 1-3
  o Patient placement near nursing station
  o Patient kept within arm’s length during ambulation and assisted toileting
  o Consults to PT or OT and use of assistive devices
  o Each unit monitors rate of falls and falls with injury quarterly
  o Unit-specific performance improvement plans for reducing and/or eliminating falls are re-assessed and modified based on unit-specific trends.
  o Rates and plans are posted on unit-based bulletin boards

Pressure Injury Prevention
http://www.mghpcs.org/eed_portal/EED_skin.asp

Skin integrity is evaluated as a part of the initial nursing assessment. The Braden scale, which is completed on admission, daily, and with any changes, is used to gauge the patient’s level of risk for development of a pressure injury. As shown in the Skin Care Guideline, interventions are guided by the subscale scores for sensory perception, moisture, activity,
mobility, nutrition, friction or sheer. If the score is one or two, there’s something to do!

If a pressure injury is present:
- Consult CNS/NPS for pressure injuries Stage 3 and above
- Treat patients at risk for, and patients with, pressure injury per Skin Care Guideline and provide wound care as ordered
- Document pressure injury measurements on admission, weekly, or whenever acute changes are noted
- Document location and condition of the wound bed (tissue type and type/amount of exudate) and peri-wound margin
- Document the patient’s response to treatment
- File a safety report

**Catheter-Associated Urinary Tract Infections (CAUTI) Prevention**

http://www.mghpcs.org/eed_portal/EED_CAUTI.asp

The most effective means to prevent a CAUTI is to remove the catheter.

**A.R.M. your patients against CAUTI by:**

- **Avoid** the use of catheters (except for hospital-approved indications)
  - Consider alternatives (straight catheter, condom catheter, etc.)
  - Ask: “what is the indication for the catheter?”
  - **Never** use a catheter for the management of incontinence
- **Reduce** the number of days a catheter is in place by:
  - Use of the Nurse Driven Protocol for Catheter Removal
  - Regularly assess ongoing need for catheter
- **Maintain** the catheter below the level of the bladder and avoid dependent loops
  - Perform daily catheter care using warm soap and water
  - Maintain a closed system and avoid disconnecting the catheter from the drainage bag
  - Use only the sterile port to obtain urine specimens
  - Secure the catheter to prevent urethral trauma and traction
o Insert catheters using aseptic technique
o Use hand hygiene before touching catheter
o Use a separate, patient-labeled container for emptying collection systems
o Do not routinely replace catheters

Central Line-Associated Bloodstream Infections (CLABSI) Prevention
http://www.mghpcs.org/eed_portal/EED_centrallines.asp

The following actions are taken to prevent Central Line-Associated Bloodstream Infections (CLABSI) during insertion and line access (NPSG)
- A standardized kit and protocol are used
- During insertion, a qualified individual monitors for breaks in sterile technique and stops the procedure if breaks are noted
- Hand hygiene is performed with antimicrobial soap or alcohol-based hand sanitizer prior to donning sterile gloves for catheter insertion
- Maximal sterile barrier precautions are followed during insertion, including:
  o head to toe sterile drape
  o sterile gown
  o masks and hair covers worn by everyone in the room
- After insertion:
  o the Provider and the Monitor complete and sign the Central Line Checklist in Epic
  o a Chlorhexidine impregnated sponge dressing is applied at the insertion site to prevent introduction of skin microorganisms into the blood stream.
  o a disinfecting alcohol port protector is used to keep access points on IV tubing continuously disinfected.
  o patients and families are educated about prevention of infection
A restraint is any manual, physical or mechanical device, material or equipment that immobilizes or reduces the ability to move arms, legs, head or body freely. Document details of restraint use in the restraint flowsheet.

- Customize restraint use to specific patient needs
- Always attempt least restrictive measures before applying restraints
- Medications are not used to involuntarily restrain patients
- Removing restraints for a “trial period” should not be done
- If the patient is taken out of restraints and needs to be put back in, this is a new episode of restraint and a new order is required. This is true even if the patient has only been out of restraints a short time
- Removing restraints to deliver care is acceptable provided they are reapplied once specific care has been completed
- Siderails are not considered restraint: When used to prevent a patient from sliding or rolling out of bed; this includes padded side rails for seizure precautions. When used in conjunction with another restraint, they are treated as a safety precaution
- Siderails are considered a restraint: When the intent is to restrict the patient from getting out of bed; this is true even if using fewer than 4 siderails
The restraint grid can be found with the Restraint and Seclusion policy in Ellucid https://hospitalpolicies.ellucid.com/documents/view/1378

Pain Assessment and Re-assessment
http://www.mghpcs.org/eed_portal/EED_pain.asp

A pain treatment plan including stated problem, goals, interventions and individual response is noted in the Plan of Care Activity. Goals that are not progressing should also be documented in the progress note.

- Pain is assessed and documented on admission and every 8 hours throughout hospitalization
- Pain is assessed before administering analgesic medications then re-assessed after administering analgesic medications
Pain is assessed using an appropriate method, based on age and verbal ability.

Examples of validated tools include, but are not limited to:

- **Adults**: Numeric Pain Scale, Simple Descriptive Scale, Functional Pain Scale
- **Pediatrics**: The Neonatal Pain, Agitation & Sedation Scale (NPASS), Faces Pain Scale, and the revised-Face, Legs, Activity, Cry, Consolability (r-FLACC) scale
- **Critical Care or Non-verbal**: Critical Care Pain Observation Tool (CPOT), The Checklist of Non-Verbal Pain Indicators (CNPI).
- **Patients with Delirium or Dementia**: Pain Assessment in Advanced Dementia (PAINAD)
- **Comatose or minimally conscious state**: Nociception Coma Scale (NCS)

PCS QAPI initiatives
Patient satisfaction reflects the patient’s perception of the quality of care received during the hospitalization. Nurses have great influence on all aspects of the patient experience especially related to coordination of care, ensuring patient’s comfort, patient education and respectful professional interactions. Some tips to improve patient satisfaction include:

**Courtesy and Respect**
- Introduce yourself and your role when meeting patient for first time
- Greet patient by name
- Knock on patients’ room before entering
- Apologize for delays
- Include family members in the discussion when appropriate
- Pay attention to patients’ physical comforts when leaving the room – pull up the covers, make sure they can access the call button and their tray
- Close interactions with: “What other questions do you have for me?”; “Is there anything else I can do for you now?”

**Listening**
- Don’t rush
- Make eye contact especially when asking a question
- Listen to patient’s perspective – try not to interrupt
- Use short summaries to demonstrate you understand what patient is telling you
- Use non-verbal language – lean forward, nod, use facial expression and posture to provide encouragement

**Care Coordination**
- Include patient and family in care plan; Involve interpreters for LEP patients
- Foster good communication among the members of the interdisciplinary care team
- Use IPASS
- Document in EHR in real time
Discharge Information

- Provide written information including symptoms or health problems for patients to be aware of after discharge
- Nurses follow up through discharge phone calls allowing the patient to ask additional questions and the nurse to verify that adequate post discharge follow-up is in place. This is the last step in the patient hospital journey.

Partners QAPI initiatives - Patient Satisfaction

Quiet at Night

- Educate patients and family members on Quiet Times upon admission
- Encourage visitors to take a break during designated Quiet Times
- Bundle night shift care across role groups
- Ensure signage is in place in patient rooms and around unit
- Reduce environmental noise

Staff Responsiveness

- Promote responsiveness with all role groups
- Purposeful safety rounding
- Leave the patient room in the same way you found it or better
- Use VOALTE to close loop with colleagues

Medication Communication

- Start patient education early during patients’ admission
- Utilize “teach back” method
- Review medications on day of discharge & include family in discussion
- Explain each new medication’s purpose and check for understanding
- Describe the possible side effects of new medications and check for understanding

CULTURE of SAFETY

Safety culture reflects the behaviors, beliefs and values within and across all levels of an organization as they relate to safety and clinical excellence. All culture is local and every unit, or specific work setting, has its own unique culture that may or may not be exactly the same as the organizational culture.
There are the 3 major components of a Safety Culture
1. Just culture- staff feel safe raising questions and concerns and reporting safety events in an environment that emphasizes a non-punitive response to errors and near misses
2. Reporting culture-staff realize errors are inevitable and are encouraged to speak up for safety by reporting errors and near misses
3. Learning culture- staff regularly collect and learn from defects and successes, openly sharing data and information, applying best evidence to improve work processes and patient outcomes

HOW DO WE ASSURE SAFETY FOR OUR PATIENTS?

The National Patient Safety Goals represent areas of risk identified by the Joint Commission as requiring high priority focus. Surveyors may ask about measures to ensure patient safety on your unit and throughout the hospital. Describe unit specific as well as hospital-wide initiatives guided by the National Patient Safety Goals and Nursing Sensitive Indicators (NSI)

Submit Safety Reports
Report “near misses” as well as adverse events through the Safety Reporting System.

Identify Patients Correctly (NPSG)

• Always use 2 patient identifiers. Inpatient: Name and MRN. Outpatient: Name and Date of Birth.
• Use an active identification process; encourage patient participation when possible by asking them to tell you their name and date of birth while you are checking their ID band

Provide transfusion therapy safely (NPSG)

Q How do you verify the identity of a patient who is receiving a transfusion?
A In the presence of the patient two qualified clinicians, one of whom is the transfuser, positively identify the patient and match the blood component to the patient.
Patient ID:
- One clinician checks the name and MRN on the patient ID band
- The clinician verifying confirms the name and MRN on the blood component
- The patient’s ID band is scanned

Blood component match:
- One clinician checks the label on the patient information side of the blood component for product number, expiration date and blood type
- The clinician verifying views the label on “donor” information side of the blood component to confirm the product number, expiration date and blood type
- The blood component is scanned

Q  What is your procedure for monitoring vital signs before and after transfusion of blood products.

A  Stay with patient for at least the first 5 minutes after the patient begins receiving the blood product.
Obtain temperature and vital signs at the:
Start of the infusion; 0-60 minutes prior to start
During the infusion if > 30 minutes (recommended @ 5-30 minutes)
End of the infusion; 0-30 minutes after stopping

Note:
1. Scanning the blood product defines the start time and documents “new bag” on the blood admin flowsheet
2. “Stopping” the transfusion in the flowsheet defines the “end time”. If not stopped the documentation is incomplete
3. Blood pressure, heart rate, respiratory rate, and temperature must all be documented in the same flowsheet column
**Q** What are the signs of a transfusion reaction? What would you do if you suspected one was occurring?

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

**Collect specimens and perform Point of Care Testing (POCT) safely**

Specimens are collected using appropriate procedures and precautions

- Specimens labeled in the presence of the patient
- Doctor’s order present for all specimens

Staff should be able to easily locate lab-related policies and procedures

For more information refer to the MGH Laboratory handbook

http://mghlabtest.partners.org/poct.htm

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

**A** Match the patient’s name and MRN on the label with the name and MRN on the patient’s wristband. Label the specimens in the presence of the patient. Label the container, not the cap.

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

**A** Units vary. Examples include blood glucose, stool for occult blood and urine dipstick.

**Q** How are you competent to perform POCTs?

**A** I demonstrate competency during orientation and as part of annual required training. Annually I complete a training module in HealthStream and complete the required quiz. I also successfully perform a quality control test at least once a year.
Q  **Who performs phlebotomy on your unit? When and how are they trained? How is competency evaluated?**
A  Patient Care Associates (PCAs) perform phlebotomy. During orientation, PCAs receive classroom training, and complete a precepted practicum during which they demonstrate competencies on the skills checklist. Competency is maintained through frequent performance of blood draws.

Q  **How do you prevent spread of infections while performing POCTs?**
A  Glucometers are wiped between patients with a hospital-approved disinfectant such as Super Sani-cloth. Appropriate precautions are used depending on the patient.

Q  **How do you know the glucometer is working properly?**
A  A hi/lo control test is performed every 24 hours by either an RN or PCA. If a PCA performs the test and the repeat result is out of range, he or she reports to the RN. The RN arranges for the meter to be replaced.

Q  **How long are glucometer controls and strips good for?**
A  Both Hi and Lo controls are labeled with the manufacturer’s expiration date. However, once a bottle is open it is good for 90 days. Strips are good for 180 days once opened. Vials must be labeled with the date of opening.

Q  **What do you do if a glucometer result is 462?**
A  Results above 400 are considered a critical value. If the procedure was performed by a PCA, he or she notifies the RN immediately. The RN notifies the physician who then orders a venous specimen.

Q  **What do you do if a glucometer result is 42?**
A  Results below 50 are considered a critical value. Same as above.
What is a hemoccult slide used for?
A To check for blood in the stool. It is not designed to check for blood in other specimens such as gastric contents.

How do you ensure that the hemoccult slides perform correctly?
A By storing them away from moisture and light, and by conducting the performance monitor (QC) with each test; QC’s are documented in the log.

Where do you document results of a hemoccult test?
A In the Hemoccult QC log and in EPIC using Enter/Edit.

What do you do if a hemoccult test is positive?
A Report the result to the Provider.

How frequently is urine dipstick QC performed?
A When bottle is initially opened and every 30 days it is still in use. Bottle must be dated after QC passes with “QC OK” and date. Documentation is put on the urine dipstick QC log.

Where are urine dipstick results documented?
A In EPIC using the Enter/Edit function

Critical Results (NPSG)
- A “read back” of the critical result, using 2 patient identifiers, occurs between the clinician (MD, NP, PA, RN) receiving the result and lab staff reporting the result
- When the RN receives the critical result, it is communicated promptly to the responding provider
- The exact time of communication, mode of communication, name and title of the responding provider are documented in the Provider Notification section of the Assessment Flowsheet
Use Medications Safely (NPSG)

A. Anticoagulation Therapy (NPSG)

Anticoagulants are high risk medications, careful attention to orders and administration is necessary. Examples of anticoagulants used at MGH include:

- Heparin
- Warfarin
- Low Molecular Weight Heparin (LMWH)
- Direct Oral Anticoagulants (DOACs)
- Direct Thrombin inhibitors
- 2b3a inhibitor

- Know the anticoagulants used in your patient population.
- Refer questions to your pharmacy colleagues and our educational resources (e.g., Lexicomp, EED portal: http://www.mghpcs.org/eed_portal/EED_anticoag.asp)
- Program infusion pumps using the drug library
- Monitor lab values pertinent to anticoagulation therapy: Hct, PT/INR, PTT, platelets kidney & liver function
- Communication regarding brief interruptions to anticoagulation therapy should include the Prescriber, the patient, and those involved in the care of the patient related to these events (e.g., surgery, invasive procedures)
- Educate patients and their families about:
  - Who to contact regarding management of their anticoagulation
  - Signs and symptoms of complications and subsequent actions to take
  - Daily dose regimen
  - Importance of follow-up with anticoagulation management
  - Importance of periodic blood testing (INR) for patients taking warfarin
  - Food, drug, and herbal interactions
  - Importance of communication with Prescriber to manage brief
interruptions in anticoagulation therapy such as when having
- procedures/ surgery.

- Patients on LMWH or DOACs should receive printed information from Epic, Partners Handbook (MGH Patient Education Documents) or the EED anticoagulation site
- Patients on warfarin should receive a copy of the “Guide to Using Warfarin”

B. Medication Reconciliation (NPSG)
Nursing, Pharmacy and Providers should collaborate to assure that patient med lists are accurate throughout admission and for discharge
- Review of Prior To Admission (PTA) medication list is performed by the nurse to determine accuracy and to flag medications no longer taken by the patient
- The Provider reviews and edits the PTA med list and performs Medication Reconciliation. This is the documentation of the decision to order, continue, modify or discontinue medications.
- At discharge, the provider reconciles each medication, including PTA medications and active orders, by reviewing and editing the discharge orders which generates the medication list in the After Visit Summary (AVS).
- The nurse reviews the medication list, and gives the patient a copy of his/her After Visit Summary (AVS) which includes medications instructions the patient should follow when discharged from the hospital.
- The AVS is saved as part of the electronic record and is sent to the next healthcare facility when the patient is discharged to another healthcare facility.

C. Medication labeling
Medications and solutions must be labeled when they are removed from their original, labeled container and not immediately administered. This applies both on and off the sterile field. If there is an intermediate step or the
medication leaves the clinician’s hand before administering a medication, it must be labeled, even if it is the only medication being given at that time. When the person who labels the medication is not the one administering it, two individuals, including the one who will administer the medication, must verify the medication label both verbally and visually.

D. Medication Administration Safety

- Before administration, verify the 5 rights, visually inspect the medication and make sure that it is not expired and no contraindications exist.
- Scan barcodes on all medication and continuous infusions before administration.
- Administer IV infusions using a smart pump drug library with minimum and maximum limits.
- Before administering a new medication, inform the patient/family about any potential clinically significant adverse reactions or other concerns.
- Error prevention strategies have been put in place for high risk medications. Example: Different types of insulins are physically separated in Omnicell to prevent wrong insulin errors.
- Tall man lettering or labels are used to prevent errors with sound-alike/look-alike drugs (SALAD). Examples include HYDROcodone and oxyCODONE; dilTIAZem and diazepam.

E. Medication Storage and Security

- Medications are not stored at the bedside (with rare exceptions such as inhalers stored in drawer when not in use. see policy https://hospitalpolicies.ellucid.com/documents/view/1690).
- Medications not under direct observation of the RN are secured in approved locked medication closets/storage areas, Omnicells, code carts, etc., this includes insulin and IV solutions.
- Different types of insulin are stored separately in Omnicell.
- All medications, especially those requiring refrigeration, are promptly put away.
• Tuberculin and Insulin are the only multi-dose vials approved for multiple patient use; *Pharmacy places expiration date label on Tuberculin and Insulin vials when issued; Expiration is 28 days after issue by Pharmacy*
• Pill cutters are individual, labeled and stored in patient specific bin
• Date of the first medication to expire in the code cart is noted on the outside of the cart, to ensure that none of the medications are expired.

**Use Alarms Safely (NPSG)**
Using the following guidelines can help eliminate non-actionable alarms and reduce alarm fatigue.

A - Assess DAILY monitoring needs  
L - Learn proper electrode care and O₂ Sat probe placement  
A - Admit the patient to the monitor  
R - Respond to all alarms immediately - Review history/events every 4 hours  
M - Minimize irrelevant alarms by individualizing parameter limits e.g., HR, SPO₂  
S - Standby mode for interruptions in monitoring and/or transport

For more information refer to the physiologic monitoring resources webpage in PCS clinical resources:  
[http://intranet.massgeneral.org/pcs/PhysMon.asp](http://intranet.massgeneral.org/pcs/PhysMon.asp)

**Prevent Infections (NPSG)**  
**Antimicrobial Stewardship (NEW)**
The Joint Commission has developed “Antimicrobial Stewardship” standards for hospital staff and providers. Staff involved in antimicrobial ordering, dispensing, administration, and monitoring must be educated about antimicrobial resistance and antimicrobial stewardship practices. Patients and family are educated regarding the appropriate use of antimicrobial medications including antibiotics.
Infection Control

What type of questions will the surveyor ask?

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

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

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

A  There are several ways that I find out:

- I review laboratory reports
- Infection Control or Microbiology laboratory notifies the nursing unit
- Physicians also inform us
- Patients known to have these organisms are identified in Epic with an Infection Status banner in the header of the electronic medical record. When an order is written for Isolation, the type of Isolation required is displayed in the Isolation banner, also in the header
- When patients are transferred from another hospital, I read the history. When I transfer a patient or send them for a test, I pass on the information regarding Isolation

Q  *What type of Isolation is required for patients with MRSA or VRE or an MDRO Gram-negative organism? (NPSG)*

A  Patients with known or suspected MRSA, VRE or an MDRO are placed on **Contact Isolation**.

- They’re placed in a private room or cohorted in a semi-private room with another patient infected or colonized with the same organism. Patients with an MDRO may NOT be cohorted in the same room.
• Gloves are worn on entry into the room and gowns are worn when there is anticipated contact with the patient, surfaces, and equipment.
• Equipment is dedicated to the patient if possible. If equipment is shared, it is cleaned and disinfected with hospital-approved disinfectant (Virex Plus or Super Sani-Cloth).

Q *What type of Isolation do you use with patients who have C. diff?* (NPSG)
A Patients with known or suspected *C. diff* are placed on Contact Isolation PLUS. This is similar to Contact Isolation with two primary differences. After contact with the patient or the environment, hands must be washed with soap and water first, then disinfected with Cal Stat. Patient rooms and equipment are cleaned daily with bleach-based disinfectant. If equipment is shared, it is cleaned and disinfected with hospital-approved bleach-based disinfectant.

Q *Describe the procedure for donning and removing gown and gloves.*
A The steps are: perform hand hygiene, place the isolation gown over the shoulders, and tie the gown at both the neck and waist. Ensure that the gown provides full coverage of clothing (both front and back). Put on gloves, pulling them up and over the cuffs of the gown. When leaving the room, take gloves off first, then gown, and then perform appropriate hand hygiene. Note: Disposable gowns may require a different technique.

Q *If a patient on Isolation is leaving the unit to go to x-ray, how does the transporter know the patient is on Isolation. How does radiology know?* (NPSG)
A The isolation status is entered as an order in Epic and appears in the patient header for all care team members to view and the isolation status is also included in the transport request. In addition, the transporter is informed by the sign on the door or by talking
with the nurse. The Epic Internal Patient Transport report also known as “Ticket to Ride” includes Isolation and Precaution orders. This report is auto-printed and placed in the record sent with the patient.

Q  **What training have you received regarding infection control and what does it include?** (NPSG)
A  I’ve received training about general infection control practices such as hand hygiene, blood borne pathogens, tuberculosis guidelines, and other MGH practices to prevent healthcare-associated infections such as MRSA, VRE, C. diff, central line-associated blood stream infections, surgical site infections, and catheter-associated urinary tract infections.

Q  **When did you receive this training?** (NPSG)
A  During orientation and it is repeated each year as part of required annual training. We also discuss the need for urinary catheters and central lines in daily rounds on the unit.

Q  **Describe the steps that are taken to prevent infection when inserting a central line.** (NPSG)
A  Hand hygiene is performed prior to donning sterile gloves for catheter insertion.
Maximal sterile barriers are maintained during insertion.
A qualified individual monitors for breaks in sterile technique during insertion and completes the Central Line Checklist in Epic.
A standardized kit and protocol are used.
Patients and families are educated about prevention of infection.
A disinfecting alcohol port protector is also used to keep access points on IV tubing continuously disinfected.
**Q** Describes steps that are taken to prevent surgical site infections. (NPSG)

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

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

**A**
- Limit the use of urinary catheters to the MGH-approved indications for use and remove them as soon as possible.
- Follow the Nurse-driven protocol for removal when ordered.
- Insert using sterile technique and equipment
- Perform meatal care per procedure, secure the catheter, do not disconnect the catheter from the drainage tube unless necessary to irrigate and avoid routine irrigations
- Obtain specimens through the specimen port.
- Avoid kinking of the tube, keep the urine bag lower than the bladder, and off the floor

**Q** How do you prevent hospital-acquired pneumonia?

**A**
- Take steps to prevent aspiration
- Use hand hygiene and other appropriate measures to prevent cross-contamination
- Ensure that the respiratory equipment is appropriately cleaned and disinfected.
- Administer vaccines against influenza, pneumococcal pneumonia and educate patients/families about infection
- For ventilated patients, implement the prevention bundle including oral care, HOB elevation and daily assessment for readiness to wean.
Q: **What do you do if a patient is suspected of having TB?**
A: The patient is placed on Airborne Isolation. Staff entering the room must wear an N-95 mask. The patient is placed in a private room with negative air pressure. The negative air pressure is checked every day either by performing the tissue test or looking at the ping-pong ball.

Q: **What other precautions do you take when caring for patients on Airborne Isolation?**
A: I wear an N-95 respirator that I have been fit-tested for when in the room. I perform a fit-check every time I use an N-95 respirator. Patients leaving the room must wear a surgical mask and should leave only for necessary procedures.

Q: **When must you wash your hands with soap and water?**
A: When my hands are visibly soiled, after using the toilet and before eating. Hands must also be washed with soap and water after caring for a patient on isolation for *C. diff* or *Norovirus*.

Q: **When are gloves worn?**
A: Clean, non-sterile gloves must be worn when touching blood, body fluids, secretions, excretions, mucous membranes, and contaminated medical equipment.

Q: **Where are infection control policies located?**
A: Infection Control Policies are available online in the *ellucid* policy management system under MGH MGPO Hospital-Wide Policies.

Q: **What is your policy regarding employees and volunteers who have symptoms of, or have been exposed to, infectious disease/illness?**
A: Employees and volunteers must contact Occupational Health Service if they have: skin lesions and/or rash, especially if lesions are weeping or fever is present; non-intact skin or dermatitis;
conjunctivitis or “pink eye”; diarrheal illness; cough of more than two weeks (unless explained by a non-infectious disease); new onset of jaundice; exposure to chickenpox, TB, or other contagious condition or when their primary diagnoses is a communicable disease such as chickenpox, staph skin infections, and influenza. Employees and volunteers should not come to work if they have a fever of 100.5°F or more and one or more of the following symptoms:

- Runny nose or nasal congestion
- Sore throat
- Cough
- Body aches

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

A  Centrally-managed equipment is located on the LEAN cart and is tagged as clean by Materials Management. Equipment that is cleaned on the unit is kept in a clean equipment storage room or another designated clean equipment storage area. Items that are stored in the hallway are covered with a clear bag to indicate they have been cleaned. Dirty equipment is kept in the soiled utility room until it can be cleaned and disinfected. If I am not sure about the status of a piece of equipment, I assume it’s dirty and clean it prior to patient use.

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

A  Eating is restricted to the staff lounge, conference room, or private offices. Drinks are allowed at the nurses’ station on low, interior surfaces only. Drinks are not allowed in the hallway such as on WOWs, bedside tables, counters between patient rooms, and portable chart racks.
Q  What are the contact times (i.e. how long the surface should remain wet) for cleaning products to assure effective disinfection?
A  The contact times for hospital-approved disinfectants are:
- Virex Plus - 3 minutes
- Clorox Bleach Germicidal Cleaner - 3 minutes
- Dispatch Bleach wipes - 3 minutes
- Super Sani-Cloth wipes - 2 minutes
- Sani-Cloth HB wipes - 10 minutes

Identify Safety Risks (NPSG)
Identify patient populations at high risk, such as those with Limited English Proficiency (LEP), Substance Use Disorder (SUD), and those at risk for falls. Implement appropriate interventions for patients with positive screening.
On admission patients are:
- Interviewed about language proficiency and preferences
- Screened for SUD
- Screened for fall risk

Identify patients at risk for suicide and self-harm
- All inpatients are screened as part of the initial nursing assessment to identify those who may be at risk for suicide
- When a nurse assesses a patient to be at immediate risk for suicide, he or she assures the patient is in the view of an observer at all times
- Handoff information about the patient’s safety needs is exchanged between the observer and the RN
- Patients in settings other than inpatient (e.g. ambulatory, ED) are assessed for suicide risk if factors suggest that suicide may be a significant clinical concern
- Suicide checklists are available to help guide staff as they implement safety precautions
There are 4 unique suicide checklists in Ellucid as appendices to the policy. Also available to order from The Allied Group:

- Inpatient (#89696)
- PCA / Observers (#89709)
- Ambulatory (#89695)
- ED (#89697)

**Time Out** also known as **Universal Protocol (NPSG)**

Required for all invasive procedures that require an informed consent in order to verify:

- Correct patient: Use two patient identifiers and have patient actively participate when possible
- Correct procedure: Verify that the procedure planned matches what the patient expects and/or the procedure consent
- Correct site; the site should be marked and the marking should be visible after the patient is prepped and draped
- Correct equipment
Document the “Time Out” by completing the checklist in Epic. The “Time Out” checklists are found:

- Bedside procedures performed on the care unit: The time out flowsheet is found in the facility preference list
- Procedural areas: The “time out” tab is found within the procedure log or sedation narrator specific to that procedural area
- Procedures in the OR: The Peri-op Checklist is found on the Intra Op Navigator. There are three sections: Huddle, Time Out, Debrief

Time Out checklist for bedside procedures performed on the care unit:
Peri-Op checklist for Procedures in the OR

The **Huddle** is to discuss the anticipated needs of the patient ahead of time to assure all are prepared for any unexpected challenges.

<table>
<thead>
<tr>
<th>Huddle</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Has the patient been identified with 2 identifiers?</td>
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<td>Has the Procedure (including Side, Site and Level) been verified?</td>
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<td>Is the site marked?</td>
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<td>Consents verified?</td>
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<td>H&amp;P verified?</td>
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<td>Position verified?</td>
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<td>Correct laterality?</td>
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<td>Team concerns discussed?</td>
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<td>Difficult airway?</td>
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<td>Risk of blood loss discussed and preparations made?</td>
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<td>Imaging, implants and equipment available?</td>
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<td>VTE Prophylaxis discussed?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Allergies discussed?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

The **Time Out** is a complete pause taken by all team members just before skin incision or start of procedure to do the final safety check.
The **Debrief** is to discuss key concerns for recovery and management of the patient. This is completed at the conclusion of the procedure, prior to the patient leaving the OR.

### PREPARING FOR PATIENT EMERGENCIES

**Response To Change In Patient Condition**

Rapid Response Teams provide patients with a timely clinical evaluation during an unexpected decline in clinical condition:

- **Warning signs** may appear before a critical event by an average of 6 to 8 hours. Early recognition may prevent further deterioration helping to avoid a critical event, decreasing cardiopulmonary arrests and patient mortality.

- **Patients and families** should be encouraged to ask questions about care and to let staff know if they are concerned about any change in condition.

- **Rapid Response Teams** are meant to support, NOT replace, current existing emergency responses such as: Code Blue Teams, Airway Consult (RICU), Surgical Airway, Acute Stroke Team.
Code Cart
The Code Cart / Defibrillator Checklist must be completed every day. The lock numbers on the cart and tracking form MUST match. If they are different or if the lock is not red call the code cart exchange room @ x 64602. These checklists are kept for 3 months in the Nurse Director’s files before being discarded. The Joint Commission surveyor will review 3 months of checklists which must be perfectly complete.
Defibrillator
A Code Readiness test is automatically performed every night at 2am on all Zoll defibrillators

Q. How do you assure that the defibrillator is ready for this test?
A. Paddles or One Step Pads must always be connected to ensure that the device is set up for the Code Readiness test. Always Turn device off and plug into power source when not in use

Q. How does staff know that the Code Readiness test was successful?
A. Success is designated by display of a green check mark.
   A failed test is designated by:
   1. Display of a red X
   2. A failed message on the defibrillator screen
   3. A paper printout displaying the time of the test and the reason for the failure

Q. What are some reason the test may fail?
A. Reasons that the Code Readiness test may fail include:
   1. Pads or paddles are NOT connected
2. The translucent Propadz are attached
3. The power cable is not plugged in
4. There may be a system problem

Q. What do you do when a red X is displayed as the test result?
A. Call Biomed (x41333) to check the device

Q. What happens if the machine is in use when the Code Readiness test is performed?
A. The Code Readiness test will be deferred until the next 2am test

ENVIRONMENT OF CARE TOUR
Who will be involved? The JC surveyor will tour the unit or department accompanied by MGH escorts and unit or department leadership. During the tour, the surveyor will observe practice and will ask staff questions about the work environment and fire safety.

What will the surveyor observe?
In addition to the environmental items mentioned in the Infection Control Section of this booklet the surveyors will observe:

- Compliance with HIPAA regulations
- Security of medications and IVs (med carts, med and IV closets locked)
- Code Cart locks checked daily (see checklist page 31)
- Fire extinguisher not blocked by equipment, inspection up to date
- Oxygen tanks secured and stored per standards, storage racks labeled with proper signage
- Access to exit doorways not blocked
- Corridors kept clear (all equipment on one side of hallway)
- Response to clinical alarms and call lights
- Patient food refrigerator checked; out of range actions noted; patient food dated
- No food or drink in patient care areas, clean supply or soiled areas, or where specimens collected

46
• MED gas zone shut off valves labeled and not blocked
• Stairways kept clear
• 18 inch Rule - Nothing, include shelving, racks, storage, etc., can be within 18-inches of the sprinkler head discharge plane unless against a perimeter wall
• Electric/equipment rooms not blocked
• Linen chute doors not blocked or propped open

WHAT WILL THE SURVEYOR ASK WHILE TOURING THE AREA?

Equipment

Q  What do you do if a piece of medical equipment malfunctions or fails?
A  Remove the device, sequester, call Biomedical Engineering to report; submit a safety report, complete a yellow tag.

Q  How do you know a medical device is safe to use?
A  Each piece of equipment has a sticker which shows when it was inspected by Biomedical Engineering.

Q  What is the process if there is a recall or hazard alert on a piece of equipment?
A  MGH has a recall officer; Biomed and Materials Management work together to act on the alert.

Spills

Q  What do you do if there is a chemo spill on this unit?
A  The chemo spill kit, which is available on the unit, is used to clean it up. The materials used to clean it up are placed in the chemo bucket.

Q  Show me your SDS (Safety Data) sheets.
SDS sheets for drugs are available through pharmacy. SDS sheets for other chemicals are available on the (Partners Applications→Utilities→SDS Safety Data Sheets). The User Name and Password are both MGH.

![MSDS Source Login Page]

Disaster and Fire Safety

Q **What is your role in a disaster that results in an influx of patients to your organization?**
A Follow directions of my nursing director, resource nurse, or Clinical Nursing Supervisor.

Q **What would you do if you saw smoke coming out of a patient’s room?**
A I would implement the hospital’s fire plan which, is R.A.C.E., by "R"escuing the patient, sounding the "A"larm, "C"ontaining the fire by closing the door to the room after the patient has been evacuated, and, finally, if it is safe to do so, "E"xtinguish the fire.

Q **Show me the fire extinguishers and fire alarm pull stations on this unit.**
A Fire alarm pull stations are usually located by exit doors and by the
nurses station. One fire extinguisher is usually located near nurses station and each unit has others located appropriately based on the unit floor plan. All fire extinguishers are clearly marked.

Q  Where are the oxygen shut off valves? Under what circumstances would you turn off the oxygen supply?
A  If a patient is on oxygen in the room where the fire is and I couldn’t get in the room safely to turn off the bedside oxygen flowmeter. Know where the shut off valve is for your unit

Cardboard
Q  How should cardboard be handled in patient card areas?
A  Cardboard must not be stored anywhere it can get wet. Cardboard outer shipping boxes cannot be stored, they must be discarded

Q  How should cardboard be disposed of?
A  All cardboard must be disposed of in a separate dumpster or receptacle for recycling cardboard

Unit Refrigerators
Q  How long can patient food remain in the refrigerator before you must throw it away?
A  Three days.

Q  What do you do if you find out that the temperature in the refrigerator has been out of range?
A  Call Buildings and Grounds and/or notify the OM.
CLINICAL AND SUPPORT RESOURCES FOR STAFF

- Ellucid
- Excellence Everyday Portal
- Excellence Everyday Quality Boards – Quality data and PI Plans
- Partners Handbook
- PCS Clinical Resources webpages
- Badge Tags
- Nursing Director
- Clinical Nurse Specialist
- Resource Nurses
- Operations Managers
- Collaborative Governance Champions
- Infection Control Liaison
- Staff of the PCS Office of Quality and Safety (ext. 3-0140)
- Staff of the PCS Clinical Informatics team (ext. 3-4082)
- Staff of the MGH/ MGPO Compliance office (ext. 6-9169)
2017-2018 Magnet Recognition Journey Resource Guide
Background: The Magnet Recognition® Program formally acknowledges healthcare organizations for quality patient care, nursing excellence and innovations in professional nursing practice. Developed by the American Nurses Credentialing Center (ANCC) – a division of the American Nurses Association (ANA) – the Magnet Recognition® Program is considered the leading resource for identifying efficient and effective nursing practices.

The Science Behind Magnet: The Magnet Recognition® Program is grounded in research. A landmark study titled Magnet Hospitals: Attraction and Retention of Professional Nurses (McClure, et al., 1983) identified specific characteristics that contributed to the success of certain hospitals in attracting and retaining quality nursing staff. These characteristics became known as the “Forces of Magnetism” and provided the original framework for the ANCC Magnet Recognition® Program. In 2008, the ANCC introduced the next generation Magnet Model which is designed to provide a framework for nursing practice and research in the future. Though the 14 Forces of Magnetism are still foundational to the program, the new model has a new, simpler look and reflects a greater focus on measuring outcomes related to nursing practice.
The Magnet Model Components

**Transformational Leadership:** The organization’s leadership team creates the vision for the future, and the systems and environment necessary to achieve that vision. Nurses at all levels of the organization are transformational leaders.

**Structural Empowerment:** Innovative environments support strong professional practice that flourishes and where mission, vision and values come to life. Patient outcomes are improved from strong relationships and partnerships across the organization and the MGH community. Examples include Collaborative Governance and the Clinical Recognition Program.

**Exemplary Professional Practice:** The true essence of a Magnet organization is exemplary professional nursing practice. This component is more than the establishment of strong professional practice – it is what nursing can achieve. Examples include MGH's Professional Practice Model, patient care delivery system, ethical decision-making processes and professional development opportunities.

**New Knowledge, Innovation, and Improvements:** Magnet organizations promote foster and encourage new models of care, application of existing evidence, creation of new evidence and visible contributions to the science of nursing.

**Empirical Quality Outcomes:** Historically, the Magnet survey focused on “process and structure.” Now, the Magnet survey focuses heavily on outcomes. Outcomes are categorized in terms of clinical outcomes related to patient care; workforce outcomes; nursing sensitive indicators (NSIs) and patient and staff satisfaction. All outcomes are compared to benchmark data and used to describe the organizational commitment to excellence.
## Crosswalk: ANCC Model Components and 14 Forces of Magnetism

(Source: ANCC)

<table>
<thead>
<tr>
<th>Model Elements</th>
<th>Overview</th>
<th>Forces of Magnetism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transformational Leadership</td>
<td>Transformational leadership is essential to meet the demands of the future. Leaders are visionary, and strategic.</td>
<td>Quality of Leadership Management Style</td>
</tr>
<tr>
<td>Structured Empowerment</td>
<td>Structures and processes provide an innovative environment in which professional practice flourishes. The organization needs to develop and empower staff in order to identify best practices and achieve desired outcomes.</td>
<td>Organizational Structure Personnel Policies and Programs Community Professional Development Image of Nursing</td>
</tr>
<tr>
<td>Exemplary Professional Practice</td>
<td>The essence of a Magnet organization is exemplary professional practice which drives better outcomes.</td>
<td>Models of Care Autonomy Nurses as Teachers Interdisciplinary Relations Resources/Consultation</td>
</tr>
<tr>
<td>New Knowledge, Innovation &amp; Improvement</td>
<td>Magnet organizations contribute to the organization and profession new knowledge and innovative models of care and contribute new evidence to the science of nursing.</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>Empirical Quality Results</td>
<td>Magnet organizations must use quality data to measure outcomes and demonstrate improvements in care delivery.</td>
<td>Quality of Care</td>
</tr>
</tbody>
</table>
Nursing “Gold Standard”: The ANCC has awarded Magnet recognition to approximately 9% of all registered US hospitals. In 2003, Massachusetts General Hospital (MGH) became the state’s first hospital to earn this distinction and in 2008 and 2013 was re-designated a Magnet hospital. Research demonstrates that Magnet facilities have better patient outcomes, patient satisfaction and nursing satisfaction, as well as lower RN turnover. Magnet-hospital designation (and re-designation) is considered the “Gold Standard” for nursing practice in all settings.

The Magnet Redesignation Process: Nurses throughout MGH conducted a comprehensive process of gathering evidence to demonstrate the hospital’s achievement of ANCC Magnet standards. MGH’s evidence, submitted to the ANCC on June 1, 2017 is being reviewed by a team of four Magnet Appraisers who will determine advancement to the site survey phase. The same team of four appraisers will conduct a site visit at MGH to ensure the practice environment accurately reflects the evidence submitted. The role of the Magnet Appraiser is to verify, clarify and amplify the evidence.

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

Magnet Appraisers will visit as many patient care units and practice sites as possible. Appraisers will speak directly with staff nurses about verifying, clarifying and amplifying the submitted evidence. The visit will also involve all members of the healthcare team as well as patients and families regarding how clinical practice is delivered and supported. They may also speak with staff from other departments to discuss how they work with nurses to ensure patients get the equipment and services they need. Lastly, there will also be other forums throughout the site visit where nurses will have the opportunity to interact with appraisers.
What will Appraisers Look for During Unit Visits? Examples of:

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

Take a minute and jot down examples of what you’re most proud of on your unit?
What Types of Questions will the Appraisers Ask? Below are examples organized by the Magnet Model Components:

**Transformational Leadership**

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

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

**Massachusetts General Hospital**

**Mission**

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

**Nursing & Patient Care Services**

**Vision & Values**

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 healing environment – an environment that is safe, has no barriers, and is built on a spirit of inquiry – an environment that reflects a diverse, inclusive, and culturally-competent workforce reflective of the patient-focused values of this institution.

It is through our professional practice model that we make our vision a demonstrable truth everyday by letting our thoughts, decisions, and actions be guided by our values. As clinicians, we ensure that our practice is **caring, innovative, scientific, and empowering,** and is based on a foundation of **leadership and entrepreneurial teamwork.**
Nursing & Patient Care Services
Guiding Principles

Maintaining the highest standards of patient care delivery is a never-ending process that involves the patient, family, nurse, all healthcare providers, and the community-at-large.

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

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

Q What are Nursing’s strategic goals?
A Every year, the MGH Nursing & Patient Care Services Executive Team sets strategic goals based on an assessment of organizational priorities and input from patients, families, staff. Goals focus on enhancing the patient experience; continually improving care delivery through increasing the efficiency and effectiveness of systems; and, creating and sustaining a strong, supportive practice environment in which staff have a strong voice in the design of care and services. Each of these goals has tactics with defined measures of success.
The annual strategic plan is vetted with nurses at all levels in the organization before finalization.

2017-2018 Nursing Strategic Goals

Goal 1: Workforce – Maintain MGH’s Position as Employer of Choice
Goal 2: Lead and Participate in Partners 2.0 Initiatives to Realize Targeted Cost Savings
Goal 3: Implement and Support MGH Diversity Goals and Strategies
Goal 4: Maximize Capacity through ED Targeted Initiatives
Goal 5: Sustain and/or Improve Select Quality, Safety and Patient Experience Indicator Performance

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

A Our Chief Nurse is visible and accessible to staff through formal nursing presentations, monthly Collaborative Governance Staff Nurse Advisory Committee, and unit rounds. She is accessible to staff anytime via telephone, e-mail and face-to-face with her open-door-policy.

These strategies are also used by the Associate Chief Nurses and Nursing Directors. All nurse leaders carry their pagers/cell phones 24 hours a day, seven days a week. Staff has the ability to page or call these leaders at any time to address a need on the unit or personal issue. It is common for Nursing Directors to work on evenings, nights or weekends to support staff during routine operations, special projects and for emergency situations. Clinical Nursing Supervisors augment the unit Nursing Director’s leadership presence and accessibility, particularly on the off-shift and weekends.
Q Describe ways in which your nursing leadership has improved the work environment?
A Some examples of ways in which nursing leadership has improved the work environment include the installment of ceiling lifts and new beds in all patient rooms; establishment of tiger teams (ad-hoc groups) to address issues such as workplace violence; incorporation of peer review in the performance evaluation process; as well as, provision of education and support for conflict resolution.

Q Give examples of how the input of nurses has affected the work environment?
A Input from the nursing staff has influenced many aspects of the work environment. A major example is the myriad of ways nurses were involved in the design, implementation and evaluation of the new eCare electronic patient record system. This is also an example of a major planned change that required keen communication.

Structural Empowerment

Q How do nurses participate in decision-making (individually and through groups)?
A Nurses participate in decision-making through their involvement in unit-based activities, interdisciplinary rounds, as a member of a Collaborative Governance committee, and in the role of resource or attending nurse.

Q Give examples of how participation in decision-making has resulted in improvements on the unit (e.g. through participation in collaborative governance, tiger teams, unit-based committees, etc.).
A (Varies by unit; cite unit-based examples)
How does MGH support nurses’ participation in professional organizations and pursuit of formal education and certification?

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

The MGH Department of Nursing supports professional certification by providing reimbursement for certification and recertification exams for nationally-recognized professional and specialty nursing organizations. The Norman Knight Nursing Center provides on-site educational preparation programs for many types of certification.
Q. Describe improvements on your unit that resulted from participation in professional organizations?
A. (Varies by unit; cite unit-based examples)

Q. Describe how MGH supports continuing education/professional development (internal and external)?
A. The MGH and The Norman Knight Nursing Center provide hospital-based continuing education programs that provide continuing education units (CEUs) to staff in attendance. The Norman Knight Nursing Center for Clinical & Professional Development offers over 150 programs each year in addition to the availability of hundreds of online and web-based educational opportunities as well.

Although funds are limited, the Department of Nursing also financially supports staff attendance at strategic conferences and seminars outside the MGH. Paid educational time and flexible scheduling practices ensure staff nurses are able to attend professional development opportunities.

Q. How do Magnet Hospitals view workforce and career development efforts?
A. Nurse leaders and other leaders at Magnet hospitals recognize the importance of a well-educated, diverse workforce and the role that lifelong learning and workplace satisfaction play in the provision of safe, effective, high quality, patient-centered care. In addition, there is a commitment to developing the workforce of the future through collaborations and support with area schools and community entities.

Multiple structures and processes support workforce and career development efforts for MGH nurses, other employees, students and visitors.

The Institute for Patient Care and its many programs, among them:
- **Award and Recognition Program**: financial support for education through vouchers, grants, scholarships and fellowships.
- **Clinical Affiliations Program**: teaching and mentoring of nursing students at baccalaureate, masters and doctoral levels.
Clinical Recognition Program: recognizes clinical knowledge and decision-making (understanding attained through formal and experiential learning) as one of three themes of practice that distinguishes each level (Entry, Clinicians, Advanced Clinician, Clinical Scholar).

Workforce Development Program: Job Shadowing experiences

The Norman Knight Nursing Center for Clinical & Professional Development (Knight Center): offers continuing education, inservice education and training initiatives that are open to nurses throughout the MGH healthcare system.

Diversity Initiatives: PCS Diversity Program; Collaborative Governance Diversity Committee, Association of Multicultural Member of Partners (AMMP) scholarship and committee; Hausman Fellowship.

MGH Workforce Development Initiatives: MGH/James P. Timilty Middle School Partnership; MGH Summer Jobs for Youth Program; Youth and Bicentennial Scholars Program; Support Service Grants.

Support for attendance at external local, regional, national, and international conferences or meetings negotiated with manager/director.

Flexible unit scheduling practices to promote time to attend classes.

Q How do MGH nurses support the education of undergraduate and graduate students?
A Education is an integral part of our mission. MGH holds more than 170 contracts with schools from around the world, encompassing all disciplines across Patient Care Services. Within nursing, every year approximately 30 schools place more than 2500 students for clinical practicum experiences or 1:1 clinical preceptorship. MGH nurse preceptors provide education and clinical experiences for nursing students for a required number of hours and assist the student in
meeting course objectives. Preceptors provide role modeling for students, as well as clinical and professional guidance.

On White 7 and Ellison 7 Surgical Units, a Designated Education Unit model is in place. In this case, the MGH has a collaborative relationship with the University of Massachusetts, Boston, and staff nurses serve in the role of clinical instructor and are responsible for on-unit clinical education for 1-2 nursing students. A faculty member from UMASS, Boston, oversees and guides the staff clinical instructors. In partnership with the MGH Institute of Health Professions, MGH also houses Interprofessional Dedicated Education Units (IPDEU) on Bigelow 11, Ellison 8 and Ellison 12. Focusing on collaborative practice and team-based, patient-centered care in the acute care setting, IPDEU students are precepted by and interact with clinicians from various professions to learn firsthand about the importance of interprofessional practice.

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

A  MGH nurses regularly participate in health-related community activities including, but not limited to, health fairs, a variety of information sessions in the MGH Lobby, Blum Center Patient & Family Education Lecture Series, Senior HealthWISE Series, the Boston Health Care Expo, Center for Global Health initiatives, the community volunteerism, and national and international disaster response teams.

PCS has established guidelines to address the pay and benefits for employees embarking on domestic and/or international service work. Beyond formal compensation policies, MGH encourages participation in community activities by communicating opportunities through E-mail and hospital publications. In addition, staffs’ participation is supported through flexible scheduling.

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

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

Exemplary Professional Practice

**Describe the professional practice model?**

A The Massachusetts General Hospital Nursing & Patient Care Services (N&PCS) Professional Practice Model (PPM) is the framework that guides professional practice across multiple disciplines including the profession of nursing. The intent of the model is to provide clinicians the opportunity to explore, develop, learn and articulate their contributions to patient care. Originally crafted and launched in 1996 and revised several times (2006, 2012 and 2016) in the past 21 years, the PPM is comprised of nine interlocking components. Every element of the PPM “interlocks” to ensure the delivery of seamless, knowledge-based patient care.

- **Relationship-Based Care**: N&PCS’s primary core value is patient-centeredness and we believe that the patient/family-nurse relationship is critical to the delivery of safe, quality care. Through relationship-based care, we cultivate relationships with: our patients & families; our colleagues; and, with ourselves.

- **Vision and Values**: N&PCS’s vision is articulated through each component our PPM. It reflects that our patients are out primary focus, and the way we deliver care reflects that focus every day. Our values ensure that our practice is caring, innovative, scientific, and empowering and is based on a foundation of leadership and entrepreneurial teamwork.

- **Standards of Practice**: Standards of practice exist to ensure that the highest quality of care is consistently maintained across practice settings.

- **Narrative Culture**: Narratives provide an opportunity to share stories that have meaning to clinicians and at the same time
describe concerns, inner dialogue and the evolving understanding of the situation.

**MGH Professional Practice Model**

- **Professional Development and Life-Long Learning**: Creating an environment for professional development and life-long learning is essential to our ability to provide quality care, to achieve personal and professional satisfaction, and to advance our careers.
- **Clinical Recognition and Advancement**: Using Dr. Patricia Benner’s “novice to expert” framework, clinicians have the opportunity to advance their clinical practice and career at the bedside through the Clinical Recognition Program. Our robust awards and recognition program celebrates excellence and supports professional advancement.
• Collaborative Decision-Making: Collaborative governance is the communication and decision-making structure framework that ensures decisions are made by those closest to the patient and family.

• Innovation and Entrepreneurial Teamwork: Through interdisciplinary teamwork and innovation, opportunities are created to ensure the delivery of patient care and the structures that support it.

• Research and Evidence-Based Practice: The possession of a body of knowledge from research is the hallmark of a profession. Research and evidence-based practice are the bridges that translate academic knowledge and constructed theories into direct clinical practice.

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

A The Staff Perceptions of the Professional Practice Environment Survey is an evaluation of our professional practice model at the MGH. It is administered to clinicians throughout Patient Care Services every 2 years. Feedback from this survey is critically reviewed and used to influence changes that are made. Examples of this would be the redesign of our Collaborative Governance model and development of conflict-resolution education programs.

Q **What is MGH’s patient care delivery model?**

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

The Nursing & Patient Care Services (N&PCS) Patient Care Delivery Model has **relationship-based care** at its center as it’s at the center of N&PCS’s Professional Practice Model. This speaks to the importance of “knowing” patients in order to provide the highest quality care and service.
Sharing the center of the model are the **six aims for quality improvement** from the Institute of Medicine ensuring that care is patient-centered; safe; efficient; effective; timely; and equitable. These objectives have become the pillars of our care-delivery model and the mainstay of our culture at Mass General.

The **Domains of Practice** hearken back to an earlier iteration of the model and speak to the importance of “doing for” and “being with” the
patient. “Doing for” includes assessment, diagnosis, planning, intervention and evaluation of outcomes. “Being with” refers to behaviors that create an environment where patients can heal. The nurse-patient relationship occurs within and across each dimension of the patient’s experience including coming to know the patient and family, their changing health responses, and the dynamic and interactive response of the nurse to the patient’s experience.

Finally, **Empirical Outcomes** refer to the critically important function of how we measure the impact of our work encompassing clinical outcomes, patient and staff satisfaction, the environment of care and quality of work life. As represented by the model, these four central components are symbiotically related, each one vital to the effectiveness of care and each one inter-dependent on all the others.

**Donabedian’s Structure-Process-Outcomes cycle** circles the model. Care Delivery is influenced by factors in both the internal and external health care environments including professional standards, credentialing and privileging processes, regulatory structures and reimbursement practices.

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**Donebedian’s Structure-Process-Outcomes Model**

![Diagram of the Structure-Process-Outcomes Model](image-url)
Q **What’s an example of using the Structure, Process, Outcomes model?**
A. Issue: Pressure ulcer prevalence was trending upward.

**Structure:** The Nursing and Patient Care Services Strategic Plan included a goal of reducing hospital-acquired pressure ulcers and an interdisciplinary Tiger Team was formed.

**Process:** The Tiger team conducted a comprehensive review and identified that the Dolphin Mat is a best practice. They developed and implemented a hospital-wide pressure ulcer prevention program and incorporated the use of Dolphin Mats, in addition to other measures.

**Outcome:** Dolphin Mats were purchased and deployed in adult intensive care units and in the ORs. The comprehensive pressure ulcer prevention plan was implemented. The prevalence of pressure ulcers subsequently trended downward.

Q **Give an example of how you involved a patient and family in the plan of care.**
A (Cite personal example: Possible answers to this would include goal setting, identifying priorities, family meetings, and obtaining health information through the Patient / Family Learning Center).

Q **Describe an example of how you’ve advocated for your patients?**
A (Varies by unit; cite unit-based examples)

Q **Who are your expert resources? How do you access them?**
A Expert resources include: Nursing Directors, Clinical Nurse Specialists, Resource Nurses, Attending Nurses, The Institute for Patient Care (comprised of The Norman Knight Nursing Center for Clinical & Professional Development, The Yvonne L. Munn Center for Nursing Research, The Blum Patient and Family Learning Center and The Center for Innovations in Care Delivery), the PCS Office of Quality and Safety, etc. Resource contacts are available by email, phone or in person.
How do nurses influence recruitment and retention?

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

How do nurses impact their staffing budget?

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

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

Direct care staffing requirements occurs at three levels: long term projections for the Fiscal Year, near-term scheduling for successive four-week cycles, and daily shift to shift requirements. Staff decisions are: made at the unit level, based on patient acuity and based on the competency of available staff.

Daily and shift-to-shift decisions regarding staffing are made at the unit level by Nursing Directors and/or their designees, such as staff and Resource Nurses. In the event that additional staff are needed for a particular shift there are several options available including: calling in staff scheduled for “on call” or standby, negotiating changes in scheduled time among the unit staff, utilizing cross-trained staff from other units, using staff from the Central Resource Team, accessing per diem staff, using part-time staff to work beyond their standard hours and/or working long-week/short-week hours.

In addition, the Department of Nursing is committed to providing clinical support to all nurses providing direct care. Resources such
as the Clinical Nursing Supervisors, The Central Resource Team Staff Nurses, Unit Resource Nurses, Clinical Nurse Specialists and expert Advanced Practice Nurses are available to assist all nurses regardless of years of experience or competence in a clinical specialty.

Q **Give examples of interdisciplinary performance improvement activities.**

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

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

A Examples include nurses’ involvement on the Collaborative Governance Informatics Committee, piloting all new equipment and technology, and participating in the design and testing for eCare electronic patient record.

Q **What is the Nurse Practice Act and how can it be accessed?**

A **Nurse Practice acts (NPAs)** are laws in each state that are instrumental in defining the scope of nursing practice. NPAs protect public health, safety, and welfare. This protection includes shielding the public from unqualified and unsafe nurses. In each state, statutory law directs entry into nursing practice, defines the scope of practice, and establishes disciplinary procedures. State boards of nursing oversee this statutory law. They have the responsibility and authority to protect the public by determining who is competent to practice nursing. In Massachusetts, the NPA can be accessed on the Massachusetts Board of Registration in Nursing website. It provides the following information: definition of a registered nurse; responsibilities and functions of registered nurses and delegation and supervision of selected nursing activities by licensed nurses to unlicensed personnel.
Q What are the five rights for delegation?
A The five rights that guide your judgement and decision to delegate a task are:
- Right task
- Right person
- Right circumstances
- Right communication and direction
- Right supervision

Q What are the key components of the annual performance appraisal process?
A Self-Reflection: The performance appraisal process provides the nurse with an opportunity for self-reflection as a way to improve practice. In addition to completing the self-evaluation too, the annual clinical narrative allows the staff nurse to reflect on his/her practice by writing about an event that they feel best exemplifies their current clinical practice.

Peer Review: Nurses in every role at MGH, seek peer feedback during the performance appraisal process. This feedback allows for additional insight and collective learning. The peer review tool for each role group is based on the domains of practice within the group.

Manager Review: During the review process the nurses’ manager shared his/her assessment of the nurses’s performance and professional development opportunities.

Mutual Goal Setting: Together, the manager and the nurse review the performance appraisal including the self-evaluation, management and peer feedback and develop goals that provide a road map for professional development.

Q How do nurses use external standards and resources such as the ANA Code of Ethics?
A Resources to guide ethical decision-making at MGH include: Collaborative Governance Ethics in Clinical Practice Committee, Optimum Care Committee, Advance Care Planning Task Force, MGH Ethics Task Force, Pediatrics Bioethics Committee, Harvard Ethics
Leaders Council, Interdisciplinary Ethics Resource Program, Unit-Based Ethics Rounds, MGH Employee Assistance Program and individual consultation with the Ethics Clinical Nurse Specialist.

The ANA Code of Ethics is a key document and is shared and discussed at Ethics Forums each year.

Q  **What does MGH do to meet the needs of such a diverse patient population?**  
A  MGH has a number of resources including our Culturally-Competent Care Program, Disabilities Awareness Initiative, Medical Interpreters Services, Patient Care Services Diversity Program, etc.

Q  **How are problems managed related to unsafe or unprofessional conduct?**  
A  Unsafe or unprofessional conduct can be reported through our MGH Safety Reporting System, and directly to Unit Directors. There is also a confidential compliance hotline where staff can report issues. Employees are expected to adhere to the behaviors outlined in the organization’s Credo and Boundary Statement.

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

**New Knowledge, Innovation & Improvement**

Q  **Describe difference between research, evidence-based practice and performance improvement.**  
A  **Research** is the analysis of data collected from a homogenous group of subjects who meet study inclusion and exclusion criteria for the purpose of answering specific research questions or testing specific hypotheses.
Evidence-Based Practice is the practice of applying knowledge (research findings, expert opinion, case reports) to a particular patient’s situation as well as considering the patient’s preferences and values as well as the clinician’s expertise. At Mass General, we use the Johns Hopkins Model of Evidence-Based Practice (Dearholt & Dang, 2012) and utilize their EBP toolkit to guide the process.

Performance improvement is the concept of measuring the output of a particular process or procedure, then modifying the process or procedure to increase the output, increase efficiency, or increase the effectiveness of the process or procedure. Remember the steps (PDCA): 1) Plan (identify and opportunity and gather information and measure the current situation), 2) Do (design and improve and implement the change, 3) Check (measure again to see if the plan worked), and 4) Act (sustain the change).
Q: **Give an example of a practice you implemented based on research findings?**
A: Examples include: hourly safety rounding to influence patient outcomes and satisfaction; development of sensory cart to decrease restraint use, and using wound care research findings to identify skin care and pressure ulcer prevention strategies. *(Cite unit-based examples)*

Q: **What processes are in place to promote evidence-based practice at MGH?**
A: The Yvonne L. Munn Center for Nursing Center is the organizational structure that supports and promotes nursing research. Research components include: Collaborative Governance Research and Evidence-Based Practice Committee, the Clinical Nurse Specialist Research Task Force, the Norman Knight Visiting Scholar Program, the Yvonne L. Munn Nursing Research Awards, the Yvonne L. Munn Post-Doctoral Fellowship, and the Doctoral Forum. Internal consultation is also widely available through the Munn Center’s Nurse Scientists, MGH doctorally-prepared staff and the Mongan Institute for Health Policy. The unit-based CNSs actively promote evidence-based practice at MGH.

Q: **How is research disseminated at MGH?**
A: Examples of how nursing research is disseminated at MGH include: Did You Know posters designed by the Research and Evidence-Based Practice Committee, Journal Club, research poster display during Nurse Recognition Week, presentations at conferences and through publications.

Q: **What is innovation and how is innovation supported at MGH?**
A: Clinicians are challenged every day to find solutions to problems in care delivery. The Center for Innovation in Care Delivery’s (part of The MGH Institute for Patient Care) focus is to bring teams together to identify opportunities, to estimate the impact of change (including workforce demographics, new technologies and regulatory change) and to construct innovations. The Center works to provide clinicians with knowledge, skills and opportunities to solve problems at the bedside and within the system.
In service delivery and organizations, innovation is defined as a novel set of behaviors, routines and ways of working that are directed at improving: health outcomes; administrative efficiency; cost effectiveness; or patient and family experience, and that are implemented by planned and coordinated actions (Greenhalgh, 2004).

IDEA grants were launched in 2016 to support clinician innovation initiatives. Examples included a proposal to design and install bathroom safety harnesses to prevent patient falls and an initiative to assess the impact of a central-line-associated blood-stream infection (CLABSI) flip board on staff engagement with the CLABSI-prevention process via qualitative analysis.

**Empirical Quality Results**

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

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

**Quality NSIs Submitted in 2017 Evidence**

- Inpatient Falls with Injury
- Inpatient Hospital-Aquired Pressure Injury stage 2 or greater
- Inpatient CLABSI
- Inpatient CAUTI
- ED: Ischemic stroke patients who received IV tPA within 60 minutes of arrival in ED
- Ambulatory: Falls with Injury
Q Give examples of strategies used on your unit to improve outcomes related to nurse-sensitive indicators?
A (Cite unit-based initiatives to improve nurse-sensitive outcomes; refer to unit-based performance improvement plans).

Q How do nurses get results about nurse satisfaction data and patient satisfaction data? In what ways are the findings discussed and analyzed? Describe the results for your unit?
A Nurse and patient satisfaction results are shared with nurses through staff meetings, bulletin board postings, quarterly email distributions, and presentations from the Chief Nurse and leadership in various meeting forums. (Cite unit-based examples)

Nurse Satisfaction Indicators Submitted in 2017 Evidence (Measured by NDNQI RN Survey)
- Autonomy
- Interprofessional relationships (all disciplines)
- Quality of nursing care
- Adequacy of resources and staffing

Patient Experience Indicators Submitted in 2017 Evidence
- Courtesy & Respect
- Careful Listening
- Patient Education
- Care Coordination

Q Give examples of other improvement projects on your unit? What were the strategies and how do you know they have been effective?
A (Cite unit-based initiatives).

For Additional Resources
Regarding Magnet Recognition® Program
Visit MGH Excellence Every Day Portal – Magnet Page
mghpcs.org/PCS/Magnet
This ends the Magnet Redesignation Section of the Resource Guide.
For information about the Regulatory Surveys, close the guide and flip over.