

Caring

Headlines

November 1, 2012

Innovation



“There’s a way to do it better—find it.”

—Thomas Edison



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

Building on a history of innovative thinking

Thomas Edison, one of the most prolific inventors of all time, once said, “I have not failed. I’ve just found ten thousand ways that won’t work.” Think about that for a moment—the level of commitment and perseverance it took to try and fail *ten thousand* times before getting it right. Was it worth it? Among his record 1,093 patented inventions are the phonograph, the typewriter, sound recorders, storage batteries, and of course, the electric light bulb. I don’t know about you, but I’m glad Mr. Edison was willing to try and fail 10,000 times in his pursuit of new knowledge and ideas.

As with all advances, the road to change begins with innovative thinking. Without innovative thinking, MGH would still be the stark, pre-anesthesia hospital that was described in *Something in the Ether: a Bicentennial History of Massachusetts General Hospital*:

Of all the breakthroughs at Massachusetts General Hospital, the foremost occurred on Ether Day. Before October 16, 1846, patients had to endure excruciating pain under a surgeon’s knife, often with fatal results... early operators, wearing stained black frocks, often worked in rooms that had not been cleaned, let alone sterilized, using instruments only perfunctorily washed. Eventually, the importance of antisepsis was realized, and with the institution of asepsis, or sterile operating rooms, surgeons could conduct increasingly invasive procedures without losing patients to post-operative infections.

From the introduction of ether in 1846 to the ideas that influenced Massachusetts legislators to adopt the most progressive healthcare-reform bill in recent memory, MGH has a long history of innovative thinking. Clinicians and investigators from all disciplines have contributed to a body of knowledge that continues to advance the art and science of health care and health maintenance. This innovative thinking has led to ground-breaking discoveries, it has increased the efficiency and effectiveness of patient care, and it has inspired the engagement of a world-class workforce.

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

This is our mission; it guides every decision we make and every interaction we have with patients and families. But more than a mission statement, it is a sacred trust. And in keeping with that trust, the Accountable Care Act has given us an

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Our Vision

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

opportunity to transform the way we deliver care—to truly make care safer, more efficient, more timely, more effective, more equitable, and more patient- and family-centered.

This special issue of *Caring Headlines* describes our journey to test and implement new ways of providing care through interactive, inter-disciplinary teamwork. These innovations are the result of the hard work and creativity of a workforce dedicated to improving quality, reducing costs, and thinking outside the box to enhance the care experience for our patients. Our methodology has been to reduce variation wherever possible, implement evidence-based solutions, introduce and/or adapt technology to support practice, and foster exceptional care by ensuring that all members of the team practice to the full extent of their licensure.

Our strategic imperative is to meet the challenges of a changing healthcare environment in order to sustain and fulfill our vision. We believe in creating a practice environment that has no barriers, is built on a spirit of inquiry, and reflects a culturally-competent workforce that supports the values of this institution.

Through our professional practice model we make our vision a demonstrable truth. Our thoughts, decisions, and actions are at all times guided by our vision and values. As clinicians, we ensure that our practice is caring, innovative, scientific, empowering, and is based on a foundation of leadership and entrepreneurial teamwork.

Our innovative thinking is making a difference. We've created substantive change that has led to positive patient outcomes, enhanced teamwork, a safer environment of care, decreased lengths of stay, and increased patient-satisfaction. Our good work has been validated by feedback from patients and families, responses to the Staff Perceptions Survey, our recent very successful Joint Commission visit, and of course, by *US News & World Report* naming MGH #1 on their Best Hospitals Honor Roll. We are a Magnet hospital, and I'm confident the evidence we submitted October 1st will result in our re-designation as a Magnet hospital. We are leading the nation in re-designing health care.

Looking forward, we plan to roll out the interventions that are proving so successful on Innovation Units to all inpatient units. By sharing best practices and standardizing whenever possible, we'll continue to improve systems, refine care-delivery, and mine the creativity and innovative thinking that has brought us so far. I hope you enjoy this special issue of *Caring Headlines*. I look forward to hearing your feedback. And I look forward to working with you as we continue to strive for, as Thomas Edison put it, "a better way to do it."

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(Cover graphic courtesy of idowns.net; graphic on page 20 courtesy of teachers.usd497.org)

About Innovation Units

Earlier this year, 12 inpatient units were selected to serve as Innovation Units—testing grounds for change—in an ambitious attempt to make care more efficient, affordable, and patient- and family-centered. The units selected were: Bigelow 14, Vascular; White 7, Surgical; Lunder 9, Oncology; Ellison 16, Medical; White 6, Orthopaedics; Ellison 17 and 18, Pediatrics; Blake 13, Obstetrics; Blake 10, Neonatal ICU; Blake 11, Psychiatry; Ellison 9, Cardiac ICU; and the Blake 12 ICU.

Work on Innovation Units is geared toward improving clinical outcomes, enhancing patient- and staff-satisfaction, and reducing costs and lengths of stay. The work is guided by the principles that:

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

The Patient Journey diagram on the opposite page illustrates the process of care before, during, and after hospitalization. Continuity is enhanced by standardization wherever possible. At the heart of the Innovation-Unit model is a series of interventions generated by discussions with staff and leadership throughout Patient Care Services (and the hospital at large). These interventions represent ‘top-priority’ actions aimed at achieving the highest level of consistency, continuity, and efficiency. The interventions include:

- Building relationship-based care into educational curriculum
- Implementing the new attending nurse role
- Enhancing hand-over communication
- Enhancing pre-admission data-collection with a revised Admitting Face Sheet
- Creating a Welcome Packet for patients
- Re-visiting domains of practice to ensure across-the-board understanding of each discipline’s scope of practice
- Implementing inter-disciplinary team rounds
- Making use of supporting technology
- Being proactive in discharge-planning; implementing new Discharge Checklist
- Implementing Discharge Follow-up Phone-Call Program

Relationship-based care

Relationship-based care is more than an intervention; it’s a philosophy, a way of thinking about care-delivery. Relationship-based care stresses: the caregiver’s relationship with the patient and family; the caregiver’s relationship with his or her colleagues; and the caregiver’s relationship with him- or herself (self-awareness). In an organization that provides relationship-based care, every member of the team:

- knows the patient and has access to information across the continuum
- plays a part in coordination of care, knows who’s responsible, and reviews the plan daily
- builds the plan of care around the patient
- aligns patient care and teaching
- aligns support around patient populations rather than transactions
- learns lessons from the past

The attending nurse role

Expanding on the staff nurse role, the attending nurse is accountable, along with the attending physician, for ensuring that patient care meets clinical standards and for the continuity and timely progression of care from admission to discharge.

Enhancing hand-over communication

This has to do with passing patient information from caregiver to caregiver; from caregiver to patients and families; and from MGH to other organizations or to patients’ homes. It relies on the SBAR (Situation, Background, Assessment, and

continued on next page

Innovation Units

Recommendations) communication tool that prompts caregivers to provide complete information during hand-overs.

Enhancing pre-admission data-collection

To ensure continuity and accurate information-gathering for all patient populations, an inter-disciplinary Tiger Team created a new Admitting Face Sheet that includes anticipated discharge date and disposition to better inform inter-disciplinary care-planning.

Welcome packets

A new Welcome Packet provides patients and families with relevant information, invites feedback for improvement, and helps set expectations and preparation for discharge.

Domains of practice

With the implementation of inter-disciplinary rounds, having a greater understanding of the domains of practice of colleagues in other disciplines is key. Each discipline within Patient Care Services updated their domains of practice and shared them in various forums, including the Excellence Every Day web portal.

Inter-disciplinary team rounds

Inter-disciplinary rounds bring all members of the team together on a daily basis to identify obstacles to

the progression of care, create a more holistic approach to care-delivery, and ensure that issues are shared and addressed in a timely manner.

Supporting technology

Efficient, well-coordinated care depends on staff's ability to communicate effectively. Staff on Innovation Units are equipped with specially programmed cell phones and portable, wireless laptops to make access to, and dissemination of, information more efficient. In-room white boards and electronic white boards at nurses' stations enhance staff's ability to know patients and coordinate care.

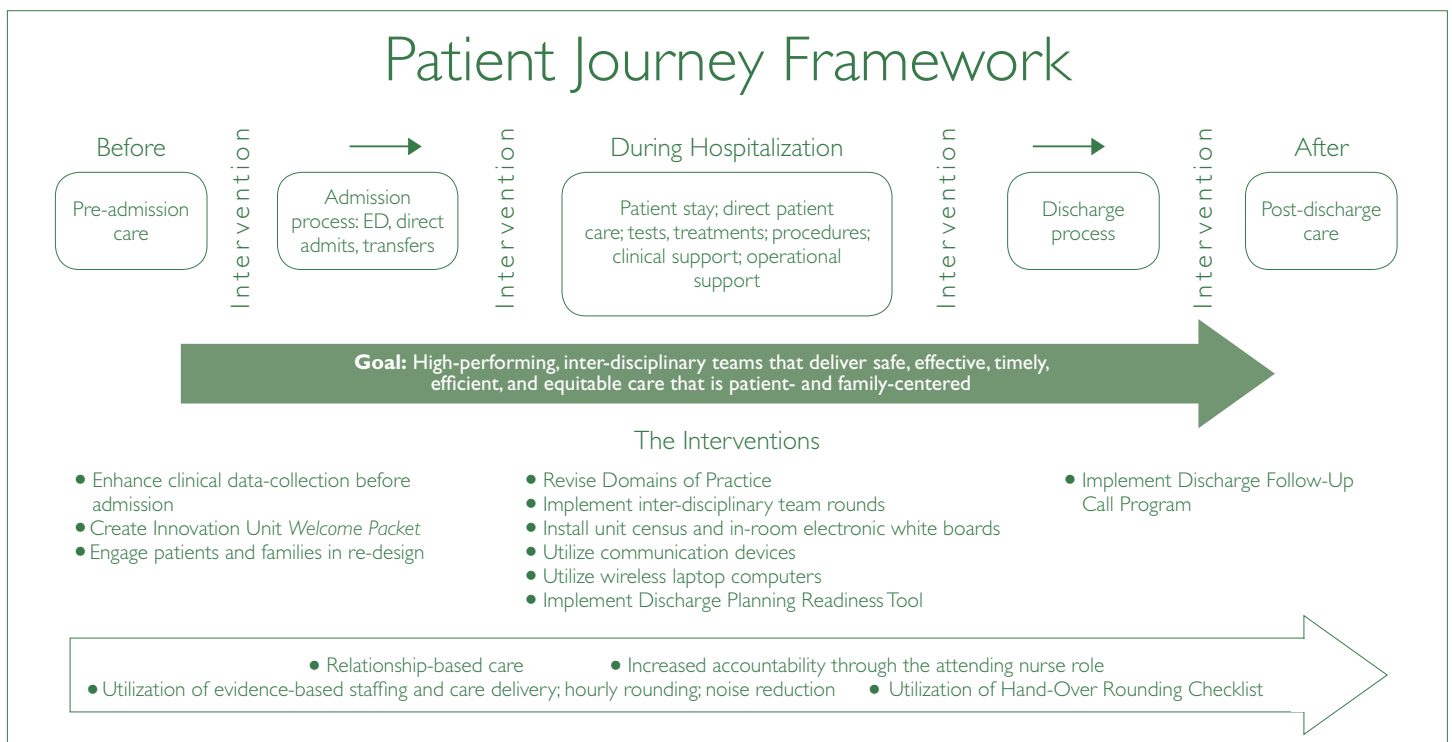
Discharge planning and readiness

A new Discharge Checklist is being developed.

Discharge Follow-up Phone Call Program

To reduce hospital re-admissions and ensure patients understand discharge instructions, a Discharge Follow-up Phone Call Program is being implemented. All patients will be eligible to participate. A questionnaire, guidelines, and training curriculum are currently being developed.

See articles on pages 6–17 for stories about Innovation Units. And for more information, see the February 16, 2012, and May 10, 2012, issues of *Caring Headlines*; chapter 7, "Innovations in Care Delivery," in the new book, *Fostering Nurse-Led Care: Professional Practice for the Bedside Leader from Massachusetts General Hospital*, by Jeanette Ives Erickson, RN, Dorothy Jones, RN, and Marianne Ditomassi, RN; the article in *Nursing Economics* entitled, "Attending Registered Nurse: an Innovative Role to Manage Between the Spaces," by Jeanette Ives Erickson, RN, Marianne Ditomassi, RN, and Jeffrey Adams, RN; or visit the Innovation Unit section of the Excellence Every Day portal: www.mghpcs.org/Innovation_Units/.



Relationship-based care

—by Marianne Ditomassi, RN, executive director, PCS Operations

Relationship-based care is more than an intervention—it's a philosophy. Relationship-based care stresses three basic tenets: the caregiver's relationship with the patient and family; the caregiver's relationship with his or her colleagues; and the caregiver's relationship with him/herself (self-awareness). In organizations that provide relationship-based care, every member of the team:

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

- has the opportunity to reflect on care and learns from past experience

According to Mary Koloroutis, RN, and colleagues in their book, *Relationship-based care: a model for transforming practice*, "We experience the essence of care in the moment when one human being connects to another. When compassion and care are conveyed through touch, a kind act, through competent clinical interventions, or through listening and seeking to understand the other's experience, a healing relationship is created. This is the heart of relationship-based care."

Since the launch of the Innovation Units in March, 2012, the impact of relationship-based care has been keenly felt. Says Colleen Snyderman, RN, nursing director for the Ellison 9 Cardiac ICU, "Relationship-based care has deepened the connection staff have with patients and families. Their clinical narratives tell of interactions that go above and beyond expectations. That level of care requires resiliency and rejuvenation. So caring for ourselves and each other has become more important than ever. Relationship-based care has helped us fill a need I didn't even know existed."

Lori Pugsley, RN, nursing director for the Blake 13 Newborn Unit, says, "Staff are excited when they feel they know their patient. Their care is focused more on their patients and not the tasks of the day. And staff have really engaged in devel-

oping a deeper understanding of enhancing their relationship with themselves (taking care of themselves, lunch breaks and off-unit breaks) and their relationship with colleagues (caring for each other). We have one nurse who provides monthly massages to our nurses—hand, foot, or head, in a holistic environment. Staff appreciate her support in helping them care for themselves. When relationships with self and colleagues are cultivated, people feel more satisfied with their work, which contributes to their ability to provide better, more meaningful patient care."

Mary McAuley, RN, nursing director for the Blake 12 ICU says, "Patients and families want to be known and respected. We believe those values transcend the professional practice of the entire team. Natalie, an operations associate on our unit, saw a husband slowly losing his wife. She met this man every day and made time to listen to his story. When his wife died, he sought Natalie out for support. It is an honor that patients and families allow us into their lives."

For more information, call Gino Chisari, RN, director, The Norman Knight Nursing Center, at 617-643-6530.



Staff nurse, Nicole Uhrig, RN (left), and new physical therapist, Lena Rabideau, PT, visit with patient, Horace 'Les' Ruddock, on the White 6 Orthopedics (Innovation) Unit.

The Patient Compact

—by Brian French, RN, and Linda Lacke

Interventions currently being piloted on Innovation Units support relationship-based care. The *Patient & Family Notebook*, for example, promotes communication between patients and caregivers, and a key element of the Notebook is The Universal Patient Compact.

The Universal Patient Compact was developed by the National Patient Safety Foundation to help foster partnerships between providers and patients. Though patients and families may already think of our relationship with them as a partnership, it's important to have a document that explicitly explains what that means. The Universal Patient Compact describes our commitment to protect patients' rights, respect their wishes, and include them in decisions that affect their care. The compact enumerates behaviors that promote collaboration and communication in the hope that effective partnerships will result and realistic expectations will be set. Our commitment to the principles outlined in the compact is demonstrated every day through the care we provide to patients and families.

Patients and families receive a copy of the *Patient & Family Notebook* upon admission. As the attending (or admitting) nurse reviews the Notebook with patients and families, including the Universal Compact, the groundwork is laid for a relationship built on mutual respect, communication, cooperation, and a clear understanding of the patient's health goals.

For more information, contact Brian French, RN, at 617-724-7843.

Universal Patient Compact Principles for Partnership

As your healthcare partner, we pledge to:

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

As a patient I pledge to:

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

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

_____	_____
_____	_____
_____	_____

The attending nurse role

—by Marianne Ditomassi, RN, executive director, PCS Operations

At the heart of the Innovation Unit model is the introduction of the new attending nurse role. Within the context of the MGH care-delivery model, attending nurses function as clinical leaders, managing the care of patients on a single unit from admission to discharge. The attending nurse interacts with the inter-disciplinary team, the patient, and the family to foster continuity, responsiveness, quality, safety, effectiveness, and efficiency.

Influenced by trends in the literature such as the patient care facilitator role at the Baptist Hospital of Miami and the faculty attending nurse role at New York University, we wanted to ensure that our attending nurses were experienced, highly regarded, inquisitive nurses willing to put themselves forward in order to advance change in care-delivery. While operating within the evidence-based framework of this new role, Innovation Units were given the freedom to implement the role according to the individual needs of each unit, including the number of attending nurses, the number of patients within the attending nurse's scope of responsibility, and the number of hours per day the attending nurse works. The role does not alter the full-time-equivalent (FTE) nursing allocation on any unit. And attending nurses make a commitment to work five eight-hour days to promote continuity and relationship-based care.

The attending nurse:

- facilitates care with the entire healthcare team. Is a consistent contact for patients, families, and the healthcare team throughout the patient's care
- identifies and resolves barriers to promote seamless hand-overs, inter-disciplinary collaboration, and efficient patient throughput
- coordinates meetings for timely, clinical decision-making and optimal hand-overs across the continuum of care

- ensures that the team and process of care sustain continuous, caring relationships with patients and families that may begin before admission and continue after discharge
- develops a comprehensive patient-care assessment and plan using the principles of relationship-based care
- communicates with patients and families around the plan of care, answers questions, teaches and coaches
- develops and revises patient-care goals with the clinical team daily
- organizes team huddles that include the attending nurse and physician, staff nurses, house staff, and other disciplines
- serves as a role model for inter-disciplinary problem-solving
- meets with families on a continuous basis regarding the plan of care, disposition, goals of treatment, palliative care, and end-of-life issues

Recently, Terry Fulmer, RN, professor and dean of the Bouvé College of Health Sciences at Northeastern University, served as a visiting faculty scholar on the Ellison 16 Innovation Unit (a medical unit). Says Fulmer, "In my view, the MGH attending nurse model is of exceptional importance to the delivery of humane, efficient, effective care. It's also a big factor in cost-containment. The attending-nurse model is linked to your ability to establish metrics related to length of stay, re-admission, patient-satisfaction, and discharge before noon. I had an opportunity to work with the attending nurses as they reviewed records in the morning and prepared for the day. The complexity of care is daunting, but the nurses are engaged and excited about contributing to the overall care on the unit. I took the liberty of rounding with the medical team and could readily see the value of attending nurses and attending physicians rounding together. Knowledge of the patient is rapidly transmitted, which is so important to the delivery of optimal care."

In the words of the attending nurses themselves:

Jean Stewart, RN, attending nurse on the White 6 Orthopaedics Unit, says, "I describe my role as, the 'constant' nurse. I'm the one who'll be there every day assisting patients and families with whatever is on their minds. I'm the glue that keeps the patient's hospitalization cohesive and moving forward. I not only assist patients while they're here, I check on them at home through follow-up phone calls. I continue to assist them if needed."

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Karen Rosenblum, RN, attending nurse on the Blake 11 Psychiatry Unit, says, “The attending-nurse role combines the functions of navigator, advocate, educator, and discharge nurse, and gives patients and families a consistent presence throughout their hospitalization. Attending nurses are available for any questions or concerns patients may have about their treatment plan.”

Jean Masiello, RN, and Stacey Kabat, RN, attending nurses on the Blake 13 Family Newborn Unit, say, “Our colleagues refer to our role as, ‘the resource nurse on steroids.’ Attending nurses are totally familiar with each patient—their needs, issues, goals, and plans for discharge.”

Says Rosenblum, “There is no ‘typical day’ for an attending nurse. We’re involved in inter-disciplinary

rounds throughout the day. We introduce ourselves to each patient as they arrive on the unit, letting them know about the Innovation Unit concept and reviewing the *Patient & Family Notebook*. We reference the *Notebook* throughout the patient’s stay and remind them to write down any questions or concerns they may have for the team. It’s a great way to be sure all their questions are answered. We also introduce the role to families and let them know there’s a consistent contact person available if they need one. Attending nurses coordinate the details of discharge, including making sure that prescriptions are written and reviewed with patients and, if necessary, filled at our outpatient pharmacy before the patient leaves. We start coordinating the discharge plan the day before, so patients are ready for discharge by 10:00am the next day, if possible.”

Attending nurse, Donna Slicis, RN, of the Blake 12 ICU, says, “My day is focused on rounding, learning, setting goals, then rounding again to assess the progress made related to earlier goals. My job is to ensure that the goals of care are meeting the needs of patients and families.

“I’m beginning to identify patterns for improvement on our unit,” says Slicis. “I collaborate with my nursing director and clinical nurse specialist so that process-improvements are implemented as a team. I’m most proud that I can be there for patients and families who require a consistent presence. I strive to bring patients and families into the care-planning process, including preparing for extubation, letting them know why pressure ulcers can occur despite excellent care, and other relevant issues.

“I think it’s important to note that all members of the team are empowered

through inter-disciplinary rounds. Dietitians, social workers, physical therapists, occupational therapists, chaplains, case managers and physician assistants all share a responsibility to do what’s best for the patient, and we all have a voice. The question is always, ‘What can we do for this patient and family today so that they have the best ability to heal?’”

Says Gina Chan, RN, attending nurse on the Bigelow 14 Vascular Surgery Unit, “I’ve had a visible impact on the hospital experience for patients and families. They’re so grateful when I call them at home, even if they don’t have any questions or concerns. Being able to follow the patient daily and share information with the whole team has improved communication and improved care.”

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



Attending nurse, Sarah Keegan, RN, helps patient, Axel Kaufmann, familiarize himself with the *Patient & Family Notebook* on the Ellison 16 Innovation Unit.

The Education Plan

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

As educators, we're taught to, 'know your target audience and their learning needs.' In the case of Innovation Units, that was somewhat of a challenge, since our audience was the entire MGH community. How do you identify and address the learning needs of an entire hospital community? In typical MGH fashion, I reached out to colleagues across the organization. Thankfully, the seeds of relationship-based care had been well nurtured. Collaboration and partnerships blossomed around the common goal of educating staff about the important work taking place on Innovation Units.

With input and support from many, a curriculum was established, reviewed, revised, vetted, and finalized. From the beginning, we employed the process-improvement strategy: Adopt, Adapt, Abandon, in developing the education plan. What started as a three-hour seminar ended up a 90-minute interactive presentation and discussion session. The content was constantly revised and updated as we learned by doing (Adopt, Adapt, Abandon).

The goal of the education plan was to provide just the right amount of information (without overwhelming anyone) so that individuals from different role groups could understand the concepts and be able to participate to the fullest on Innovation Units. At times it was like being the coach of a crew team—getting everyone to row in the same direction at the same time. But our objectives were clear:

- Create a strong base of support for success
- Engender a consistent understanding and application of the 12 interventions designed to strengthen relationships with patients and families.

We knew that employees have different learning styles. We knew the challenges associated with taking time away from patient care to attend educational sessions. Our plan had four components:

- An Innovations 101 seminar
- HealthStream modules focusing on the specific interventions
- Unit-based modules on a variety of topics delivered by educators from the Knight Nursing Center
- Weekly meetings with attending nurses

The Innovations 101 seminar was videotaped, widely distributed, posted on the Knight Nursing Center website, and ultimately became part of the HealthStream module, giving employees several opportunities to receive the same, consistent information.

The Innovations 101 slide deck was made available for use at the unit level, and an abbreviated version was created for various other forums and purposes. HealthStream modules included information on: process-improvement; the 7 Ps; handovers (SBAR); discharge teaching, teach-back/show-back; the *Patient & Family Notebook*, the Discharge Envelope; and the Patient & Family Checklist. By special request, unit-based education was developed to address: SBAR at the local level; what should be included in the *Patient & Family Notebook*; tips on using in-room white boards; tips on using teach-back/show-back; and guidance for using the 7 Ps as a rounding tool.

Of all the strategies employed as part of the Innovation Unit education plan, perhaps none has been more effective than weekly lunch meetings with attending nurses. These meetings are an opportunity for attending nurses to come together, talk about their experiences, support one another, and participate in educational sessions specifically tailored to their needs. Guest instructors have included Mary Cramer, process improvement program director, who discussed process-improvement as a methodology for change; and Barbara Blakeney, innovation specialist, who led discussions on right-brain/left-brain thinking, innovator's DNA, and (along with the Lunder 9 attending nurses) the current CMS Innovation Tool Kit.

Rick Evans, senior director of Service Improvement, spoke about dashboards and the importance of metrics in assessing patient-satisfaction. Other presenters included; Kate Fillo, RN, education nurse, on teach-back/show-back as a patient-family education tool; Lynda Brant, project specialist, on evidence-based practice; and Knight Center staff on developing and presenting PowerPoint presentations. We were fortunate to have Terry Fulmer, RN, dean of Northeastern University's Bouvé College of Health Sciences, speak about the role of the attending nurse.

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Innovation Units

Consultant, Mary Connaughton, RN, led a session on leadership at the bedside. And more recently, attending nurses had access to a five-part, on-line leadership series hosted by the American Nurses Association and Capella University.

We are still guided by the mantra: Adopt, Adapt, Abandon. An evaluation of the education plan is underway, and a revised program is being created to ensure that this culture of innovation and excellence is sustainable.

For more information about the Innovation Unit education plan, call Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development, at 617-643-6530.



Above: professional development specialists, Kathleen Larrivee, RN (center-right) and Carol Ghiloni, RN (right), hold educational huddle with staff of the Lunder 9 Oncology (Innovation) Unit.
Below: Gino Chisari, RN, director, The Norman Knight Nursing Center for Clinical & Professional Development, meets with attending nurses at weekly educational lunch session.



The Communication Plan

—by Georgia Peirce, project manager

Change demands that everyone involved be on the same page. In the case of Innovation Units, that meant timely, accurate, consistent communication geared for specific audiences: nurses; support staff; attending physicians and house staff; therapists and others who visit the units; patients; families; visitors; and the MGH and Partners communities at large.

The goal of the Innovation Unit communication plan was to:

- inform and educate Innovation Unit staff, patients, families, and visitors about the work
- raise awareness within the PCS, MGH, and Partners communities
- facilitate and optimize communication among staff on Innovation Units and all patient care units

The strategy involved a multi-media approach to generate visibility and create a broad-based understanding of what we were trying to achieve. Special branding allowed all communications about Innovation Units to be easily recognized (See logo on oppo-

site page). Our Patient Journey Framework (See page 5) placed the patient and family at the center of the work and offered a visual overview of the components of our work. An Innovation Unit education plan was created (see article on page 10). A dedicated issue of *Caring Headlines* shared a message from senior vice president for Patient Care, Jeanette Ives Erickson, RN, showcasing Innovation Unit interventions and introducing the new attending nurse role and other related articles.

Information about every aspect of the Innovation Unit initiative was accessible via an on-line portal. Articles, graphics, best practices, presentations, and links to relevant resources were easily accessible. And an Innovation Unit Handbook containing streamlined information was provided to staff.

At the unit level, each Innovation Unit was identified by multi-lingual entryway signage featuring the Innovation Unit logo. Tabletop

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Tabletop Displays (in English and Spanish)

Bienvenido a Ellison 16 Medicina General

UNIDAD de INNOVACIÓN

A través de todo el Hospital Mass General, estamos comprometidos a brindar la atención médica más segura y de más alta calidad a todos los pacientes y familiares. Como parte de este compromiso continuo, el hospital ha seleccionado 12 Unidades de Innovación con el fin de incrementar aún más los ya elevados estándares de calidad en atención médica. Queremos asegurarnos que durante su estadía en el Hospital Mass General todo marche sobre ruedas, sepa quienes están a cargo de su atención y cómo contactarlos. También queremos que se sienta preparado para el momento de su retorno a casa. Durante toda su estadía usted siempre tendrá asignado un médico y una enfermera quienes lo atenderán. Además, una Enfermera de Planificación y Coordinación revisará junto a usted el plan de tratamiento a seguir. También recibirá una copia de la "Guía para el Paciente y sus Familiares". En esta guía, usted y sus familiares podrán anotar cualquier pregunta que tengan, y estas serán revisadas con su equipo médico todos los días. Le ayudaremos a planificar con antelación para asegurarnos que usted está preparado en el momento de su regreso a casa. Animamos a que realice preguntas, ofrezca sus comentarios y sea nuestro aliado en el cuidado de su salud. El principal objetivo a alcanzar en nuestra labor diaria es su bienestar y comodidad.



Unit Signage

Ellison 16 INNOVATION UNIT

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

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

INNO ATION UNIT

Innovation Unit Logo

displays in visitor lounges provided an introduction to the Innovation Unit initiative in both English and Spanish. Welcome Packets were created and given to patients and families upon admission. These packets contained information about the Innovation Unit initiative, what to expect while hospitalized, and tools to help prepare for a safe and seamless discharge. Attending-nurse business cards were given to patients and families so they'd have a contact name and telephone number if questions arose after they were discharged.

Unit-Based e-Bulletins



Inter-disciplinary rounds, team huddles, e-bulletins, and other vehicles supported an easy flow of unit and patient information. Focus groups and 'idea books' provided a mechanism for staff to informally share suggestions on how to improve emerging systems and processes.

The introduction of several new communication tools made sharing information even easier. An Admitting Face Sheet, Attending Nurse Guidelines, the use of SBAR (Situation, Background, Assessment, Recommendations) for all patient hand-offs, in-room white boards, CBEDS white boards at nurses stations, specially programmed phones for staff nurses, and portable laptops for attending nurses all contributed to a culture and ease of information-sharing.

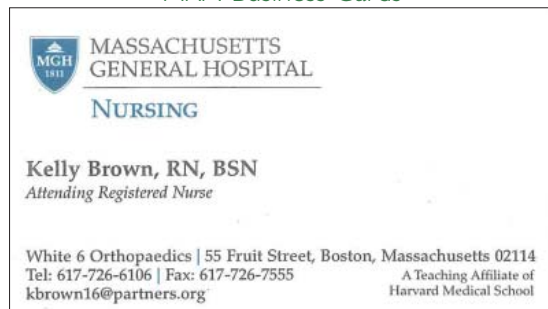
As Innovation Units evolved, news was shared more broadly. An Innovation Units update was distributed to MGH leadership, trustees, Partners leadership, and others. Through her role as a CMS innovation advisor, Barbara Blakeney, RN, innovation specialist in the Center for Innovations in Care Delivery, helped spread news at the national level. In the October, 2012, *Fostering Nurse-Led Care* (by Ives Erickson; Dorothy Jones, RN; and Marianne Ditomassi, RN) our work on Innovation Units was

showcased in their chapter, "Innovations in Care Delivery." The October, 2012, issue of *Nursing Economics* featured the article, "Attending Registered Nurse: an Innovative Role to Manage Between the Spaces," by Ives Erickson, Ditomassi,

and Jeff Adams, RN. And on October 11, 2012, MGH Innovation Units were prominently featured in the world premiere of the movie, *If Florence Could See Us Now*, during the ANCC National Magnet Conference in Los Angeles.

When it comes to enhancing care and improving patient outcomes, if you find something that works, communicate, communicate, communicate. For information about the Innovation Unit communication plan, call Georgia Peirce, project manager, at 617-724-9865.

ARN Business Cards



Inter-disciplinary rounds

—by Gayle Fishman, RN, staff specialist

Of all the strategies implemented recently to increase and improve communication, perhaps the most dynamic has been inter-disciplinary rounds. The collaboration that occurs when all disciplines come together to share information is an example of teamwork at its best. The most effective way to avoid obstacles to care is to know about them at the earliest possible opportunity. Inter-disciplinary rounds gives every member of the care team a chance to share information, contribute to the plan of care, and trouble-shoot potential problems to keep them from impacting care.

Inter-disciplinary rounds are one of the key interventions being introduced on Innovation Units. On the White 6 Orthopaedics Unit, for example, the attending nurse, staff nurses, case managers, physical therapists, occupational therapists, social workers, nurse practitioners, and physicians meet every weekday to have input into the care and discharge plan for each patient. This team approach ensures well-coordinated care and fosters communication among clinicians of all disciplines. The focus is on the plan of care, how best to achieve the patient's short- and long-term goals, and how to prepare him or her for a smooth transition to post-discharge care.

Said one member of the White 6 team, "Inter-disciplinary rounds keeps everyone on the same page. We all hear the same information at the same time, so we can craft our plan of care in a way that's best for the patient. It has had a noticeable impact on communication on our unit."

Bringing clinicians together for inter-disciplinary rounds has another benefit. Relationships are forged that might not otherwise have been, creating a stronger synergy among the team. This aspect of relationship-based care spills over into other venues from pre-admission, to hand-overs within and between care settings, to discharge, and throughout the continuum of care.

The inter-disciplinary team works together to anticipate needs at every stage of hospitalization from pre-admission to post-discharge. Depending on the patient's condition, resources may be needed to help optimize the plan of care to ensure it can be carried out across settings. On each Innovation Unit, a representative from the Office of Patient Advocacy is available to field concerns brought forth by the team, the patient, and/or the family. And since patient advocates participate in inter-disciplinary rounds, they don't have to be brought up to speed on the situation—they already know it.

Increased participation by all disciplines has resulted in better patient and family outcomes, earlier recognition of patients at risk, and improved communication among members of the healthcare team. For more information about inter-disciplinary rounding, call Gino Chisari, RN, director, The Norman Knight Nursing Center, at 617-643-6530.



Members of the Lunder 9 inter-disciplinary team round every weekday morning.

Evaluating change on Innovation Units

—by Jeff Adams, RN, director; The Center for Innovations in Care Delivery, and Dorothy Jones, RN, director; The Yvonne Munn Center for Nursing Research

The goal of evaluating the work on Innovation Units was to gain an understanding of the change experienced as a result of introducing 12 interventions (described on pages 4–5). Quantitative and qualitative questions were developed to guide data-collection and analysis. Administrative data (related to length of stay); survey data (related to responses to change); feedback from focus groups (related to the experience of change); and narratives from staff were all analyzed to evaluate change within this complex and changing situation. Early findings show encouraging trends and insights into the impact of innovation on staff and patient outcomes. Results suggest positive trending around length of stay and patient- and family-satisfaction as well as opportunities for improvement and support for relationship-based care and standardized practices.

For the purposes of evaluation, change was examined as it relates to three categories:

Philosophy and Culture Change

Staff consistently described relationship-based care as, “feeling that the organizational culture was shifting.” “Knowing the patient” supported relationship-based care and inter-disciplinary collaboration. Autonomy and shared decision-making was reflected by disciplines working together to achieve outcomes.

Roles

The attending nurse (ARN) role was embraced by all role groups, described as, “a significant innovation.” The ARN was viewed as a, “positive addition for patients, families, and staff,” and scored higher on all categories of the Staff Perceptions of the Professional Practice Survey compared to the total Patient Care Services population.

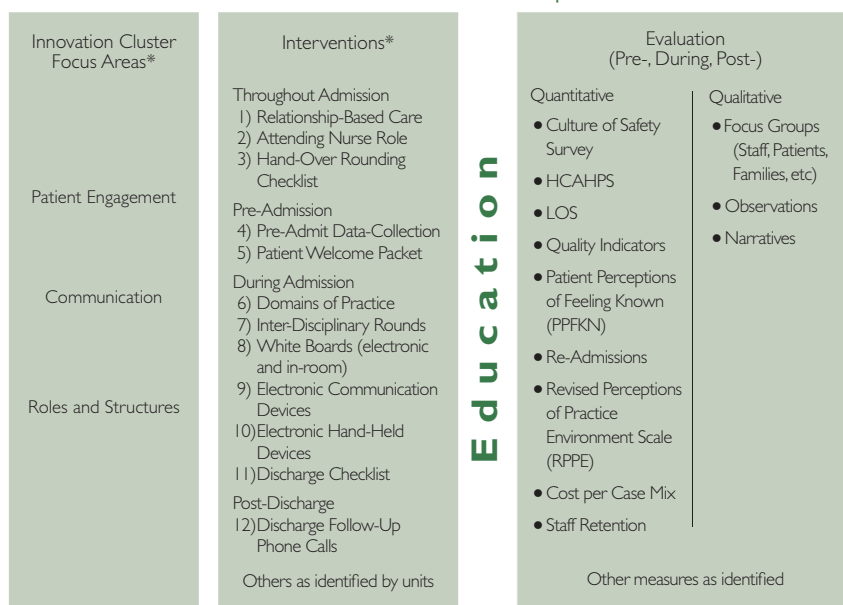
Data pointed to increased inter-disciplinary rounding and improvements in the hand-over process. Inter-disciplinary team members noted that when all disciplines participate in rounds, they’re increasingly useful.

Standardization of Practices and Processes

Twelve interventions were introduced on Innovation Units, including: a discharge checklist; follow-up phone calls; hand-held devices; quiet time, and a welcome packet (to name a few). Implementation of these (and other) interventions occurred differently on different units, often related to the unique culture or service of that particular unit or environment. In general, interventions were described as positive additions to care-delivery. Hand-held devices were especially well received, while other innovations (connectivity of laptops) posed challenges.

Both length-of-stay and HCAHPS data demonstrate a statistically significant positive response to changes on Innovation Units. Evaluation of re-admission rates in relation to interventions is pending. Data is still being collected, and other tools are being employed for analysis to provide new insights into the impact of these innovations. For more information, call 617-643-7092.

MGH Innovation Units Conceptual Schema



*Clusters are a lens with which to gain perspective about particular interventions

*May apply to any or all of the cluster focus areas

Education

Dashboards: *tools by which to gauge our success*

—by Amy Giuliano, senior project manager

Innovation Units. The dashboard reflects a baseline measurement for a specified set of KPIs and compares it to data reported by units on a quarterly basis. The Innovation Unit Dashboard includes data related to:

- quality and safety (including Nursing Sensitive Indicators)
- infection control
- ALOS and re-admissions
- patient-satisfaction
- staff-satisfaction
- throughput and efficiency (patient volume and financial metrics)

The usefulness of any dashboard is dependent on the quality of the data. For the Innovation Unit Dashboard, KPIs were selected for comparison with certain criteria and relevant external benchmarks. For consistency with other Partners entities, the dashboard uses a red-green-yellow color scheme, similar to the one used in other Partners-wide reports. The Innovation Unit Dashboard contains a

separate Notes file where detailed information about metrics, benchmarks, and availability of data from original sources is stored.

The baseline Innovation Unit Dashboard reporting period was fiscal year 2011. It is available on the Innovation Unit portal page and the PCS intranet. The first complete intervention reporting period was April–June, 2012, and the Innovation Unit Dashboard for that period showed improvement over baseline performance in a number of categories, including LOS, re-admissions, and progress toward patient-experience targets.

The PCS Office of Quality & Safety plans to expand this dashboard to include all inpatient units in the near future. For more information, call Amy Giuliano, at 617-643-9670.

When implementing change, having the ability to evaluate outcomes and assess the success (or failure) of variables and interventions is essential. Dashboards are a type of reporting tool used primarily in healthcare and business settings to provide a concise view of meaningful metrics. Typically, metrics, or key performance indicators (KPIs), are gathered from a number of units or departments and consolidated into a single report and presented in an easy-to-read format. The use of color and shading helps demonstrate favorable (and unfavorable) performance against benchmark measures, and it's useful for tracking progress toward attaining specific goals.

Recently, a dashboard was developed to help gauge the success of interventions employed on

Innovation Unit Dashboard

[illegible]

HCAHPS Dashboard

—by Richard Evans, director, Service Improvement

MGH regularly surveys patients and families to get a sense of their hospital experience, and we use the results of those surveys to guide our improvement efforts. Feedback indicates that the patient experience is improving significantly, and Innovation Units are leading the way.

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) tool we use to survey patients is administered by phone, and the results are available to the public.

This year, due largely to the interventions implemented on Innovation Units, our efforts to improve the patient experience are taking hold, and our HCAHPS survey results are reflecting that improvement. Throughout the hospital, scores have improved in almost every category. We are seeing notable increases in nursing communication, hospital quietness and cleanliness, the quality of discharge instructions, and the likeliness of patients to recommend MGH to others. These increases represent significant improvement and should be applauded as a substantial achievement.

HCAHPS Dashboard

Measure	2010 (Top Box Result)	2011 (Top Box Result)	2012 YTD (Top Box Result through September 6, 2012)
Nurse Communication Composite	78.8	79.4	80.8
Doctor Communication Composite	80.4	81.9	81.8
Room Clean	71.4	69.8	72.8
Quiet at Night	45.9	45.2	48.4
Cleanliness/Quiet Composite	58.7	57.5	60.6
Staff Responsiveness Composite	63.1	63.6	64.5
Pain Management Composite	70.7	71.5	72.1
Communication About Meds Composite	62.0	62.7	64.1
Discharge Information Composite	89.8	89.8	91.2
Overall Rating	78.4	79.1	80.4
Likelihood to Recommend	89.3	89.4	91.0

KEY

Result declining from 2011

Result improving from 2011

Result flat

2012 Data Complete through 8/31/12

All Results reflect Top-Box %

Date Pull: 10/16/12

Early results from Innovation Units are very promising. With their positive feedback, patients and families are validating the interventions being employed—relationship-based care, communicating more effectively, standardizing systems and processes, and using technology to leverage efficiency. HCAHPS scores on Innovation Units have risen at a rate exceeding the already impressive rate of the overall hospital. Some survey categories have risen more than six points, and Innovation Unit scores in some categories now lead the hospital.

Our marked improvement on HCAHPS scores is an achievement for every MGH employee to celebrate, because every individual in every role group in every department plays a part in our success.

For more information about our HCAHPS scores or service-improvement efforts, call Rick Evans, senior director of Service, at 617-724-2838.

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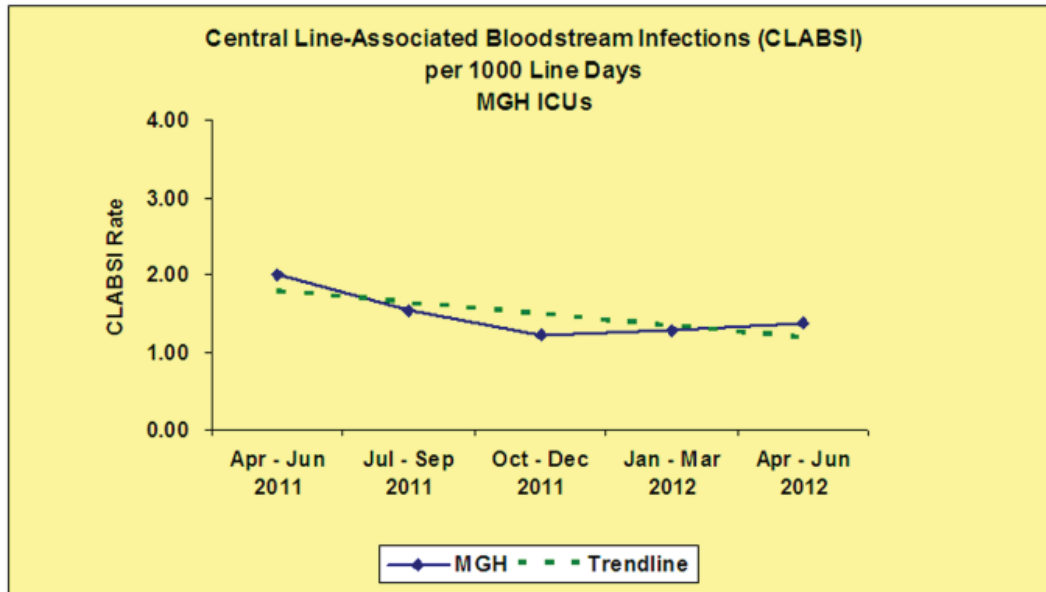
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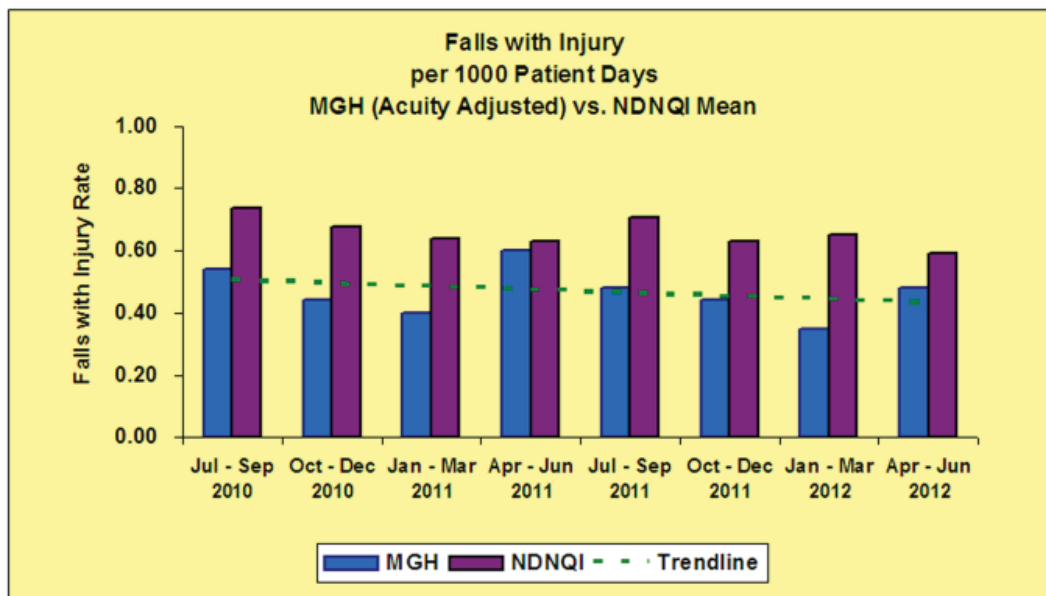
Next Publication
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Tracking improvement



Central-Line-Associated Bloodstream Infection Strategies:

- A standard central-line insertion kit and checklist were created to assist staff in maintaining a sterile process and environment
- The use of chlorhexidine for skin preparation for all central line insertions was implemented based on evidence that this product minimizes risk of infection
- Biopatch dressings were introduced to reduce the risk of infection for PICC lines (peripherally inserted central lines)
- The 'Scrub-the-hub for 20 seconds' campaign (cleaning IV ports prior to flushing) provided nurses with another evidenced-based practice to decrease the risk of infection
- Best practices and clinical narratives have been posted to the Excellence Every Day portal for quick reference

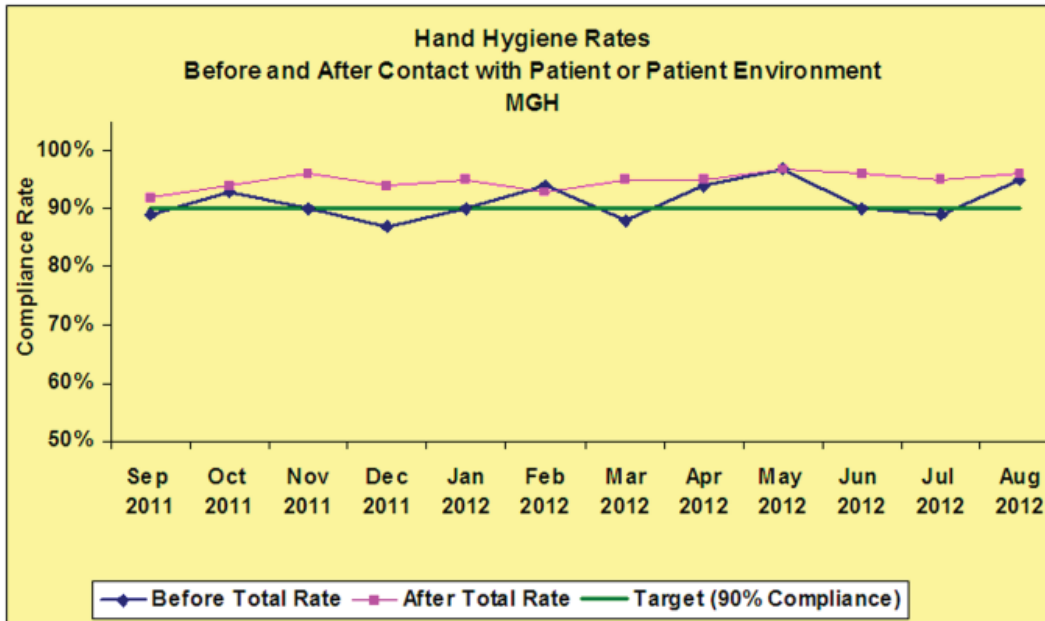


Falls with Injury Strategies:

- A Falls Committee was created to focus on patients at risk for falls
- Implementation of LEAF (Let's Eliminate All Falls) provided evidence-based strategies to minimize risk for falls
- Best-practice strategies and clinical narratives have been posted to the Excellence Every Day portal for quick reference
- Fall-prevention equipment and alarms have been purchased to alert staff to potential falls before they happen

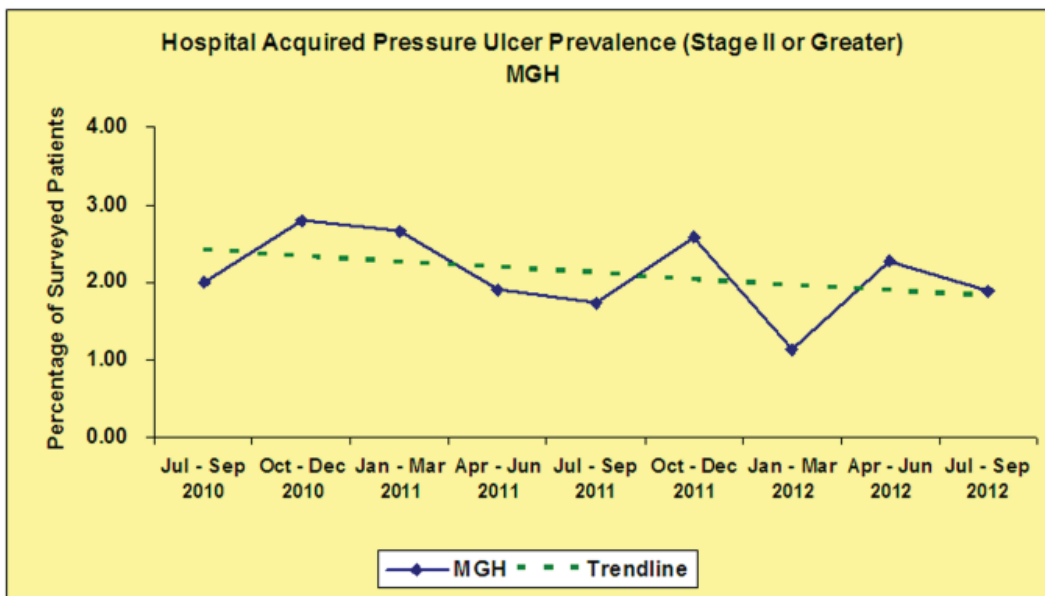
Outcomes

Quality-improvement efforts are only as effective as our ability to measure the results of those efforts. Empirical data is the foundation of evidenced-based practice. The graphs below illustrate our performance in four key areas and highlight some of the strategies employed to achieve these results. These metrics represent just a small subset of our on-going quality-improvement and quality-measurement and efforts.



Hand Hygiene Strategies:

- Regular audits of hand hygiene practice are conducted by infection control specialists to monitor compliance
- Unit and department results are shared with staff
- Hand-hygiene practices are assessed during tracer activities, and feedback is given to the leadership team
- Patient- and staff-education highlight importance of hand hygiene as the single most important step to prevent infection



Hospital-Acquired Pressure Ulcers Strategies:

- Implemented SOS (Save Our Skin) program to standardize skin care and raise awareness about the potential for patient harm related to hospital-acquired pressure ulcers
- Clinical nurse specialists available on units to provide consultation
- Best-practice strategies and clinical narratives have been posted to the Excellence Every Day portal for quick reference
- Information about the SOS program and the importance of maintaining optimal skin integrity is available through HealthStream
- Quarterly pressure-ulcer prevalence (snapshot in time) studies monitor number of hospital-acquired pressure ulcers and help identify opportunities for improvement

(Metrics on this page provided by the PCS Office of Quality & Safety))

“If we all did the things we are really capable of doing,
we would literally astound ourselves....”

—Thomas Edison



Our innovative strategies extend beyond the work being done on Innovation Units. The following pages describe *some* of the efforts underway throughout the hospital to improve care, reduce costs, and make systems more efficient. From safety to diversity, from new technology to standardization, on inpatient units and in outpatient settings, staff are taking initiative and thinking outside the box. We're happy to share some of the strategies and best practices that are emerging to improve care for patients and families.

Creating a culture of safety

—by Patricia Shanteler, RN, staff specialist

Staff closest to patients, at the ‘sharp end’ of care, have a unique perspective on the environment of care and are critical partners in ensuring its safety. Front-line staff have valuable insight into what makes a safe work environment for themselves, their colleagues, their patients, and families. Providing opportunities and easily accessible mechanisms to voice concerns and ideas is one of the most effective ways to make our facility safe for all. Staff advisory councils, leadership rounds, staff meetings, the Culture of Safety Survey, and our on-line safety reporting system are just some of the ways staff can take an active role in promoting safety.

We’re fortunate to have a robust narrative culture where staff have opportunities to share best practices. Sharing stories in various venues promotes a culture of transparency and safety. “Excellence Every Day represents our commitment to providing the safest, highest quality care that meets or exceeds all standards set by the hospital and external organizations.” That statement appears on our Excellence Every Day portal page along with links to a number of related quality and safety sites. If you haven’t yet visited this portal page, you really should—it’s a great source of evidence-based information, formulas for success, quality and safety resources, and so much more. Consider it a ‘one-stop shopping’ site for information-sharing.

Staff of the Patient Care Services Office of Quality & Safety disseminate patient-outcome data, patient-satisfaction data, and staff-satisfaction data to help leaders and direct care providers see the fruits of their work. Several patient-outcome measures, including patient falls, hospital-acquired pressure ulcers, physical restraints, and hospital-acquired infections speak directly to our efforts to minimize harm and create a safe environment.

Reducing medical errors is a key factor in sustaining a culture of safety. The Institute of Medicine’s 1999 report, *To Err Is Human*, was a call to action for

healthcare providers. Understanding that most errors are system failures that create the potential for human error has changed the way healthcare organizations view and respond to medical errors.

At MGH, we have created a culture of safety where staff consider themselves signal detectors and key figures in preventing harm. Employees routinely use the on-line safety reporting system to report potential or near-miss events as well as those that result in actual harm (to patients or staff) so steps can be taken to eliminate the threat of future adverse events. A key factor in creating a culture of safety is ensuring that staff feel *safe* reporting errors. Our concept of a ‘just culture,’ ensures that staff feel empowered to report safety events whether or not they result in harm to patients or staff.

In situations where significant harm has resulted from an error, or in the likelihood that a recurrence of the error poses significant risk, the MGH Center for Quality & Safety takes the lead in investigating and following up with staff. The investigation process at MGH is rooted in the just-culture model developed by David Marx, JD, which utilizes lessons learned from other highly safety-conscious industries such as aviation.

A just-culture, or ‘learning culture,’ provides support to staff involved with safety events. The goal is to assess the situation from a systems perspective and ensure staff understand that the process isn’t punitive unless warranted by unacceptable behavior.

We are committed to continuous improvement and vigilance when it comes to patient and staff safety. And every employee is part of the process. For more information on creating a culture of safety, call interim director of the PCS Office of Quality & Safety, Kevin Whitney, RN, at 617-724-6317.

A key factor in creating a culture of safety is ensuring that staff feel *safe* reporting errors. Our concept of a ‘just culture,’ ensures that staff feel empowered to report safety events whether or not they result in harm to patients or staff.

Cultural rounds

—by Deborah Washington, RN, director, PCS Diversity

Change is in the air. Maybe you've noticed. It's inspiring innovative solutions, transformations in inter-professional relationships, and a deepening of our desire to provide patient-centered care. Our conversations about diversity remain an integral part of this changing practice model—as integral as our commitment to provide excellent care to patients every moment of every day. We are no longer freshmen in our education about the importance of diversity. We have moved beyond awareness to care that improves and relieves situations for the vulnerable and underserved.

Culturally competent care is a pillar of our commitment to equity in care-delivery. We have created our own definition of health disparities so we can engage in meaningful self-examination. We have examined our practice for evidence of cultural knowledge and sensitivity in care-delivery. Resources have been provided to support cultural competence as a cornerstone of life-long learning. Not surprisingly, as change springs up around us, cultural competence is also adopting a new form.

Cultural rounds have been offered at MGH since 2008. Mindful of the time constraints inherent in

working at the #1 hospital in the nation, cultural rounds have served as a kind of mobile classroom, bringing learning opportunities directly to patient-care units. Flexibility and a focus on topics relevant to daily practice are the mainstays of today's cultural rounds. Just as the demographic makeup of our patient population remains dynamic, so does the need for our mastery of the skills and knowledge necessary to care for these patient populations.

Cultural rounds is being re-shaped to capture the skills we employ in caring for the multi-ethnic, multi-cultural, multi-lingual communities we serve. Through case presentations, job-shadowing, and documentation of interventions, our new focus is on identifying the attributes and qualities that take culturally competent care from proficient to expert. Entry-level clinicians, clinical scholars, and everyone in between has something to offer. Our goal is to tap into the skills, mindset, and insights of those whose cultural competence exceeds our own and explore how those characteristic could enhance our practice.

We have come far in our journey to become a more diverse, culturally minded, culturally sensitive organization. But there is still much to be mined in our search for excellence. We have come to a fork in the road. Will we be content to sit on our laurels, or will we continue to reach for a higher standard of cultural competence? Yogi Berra once famously said, "When you come to a fork in the road, take it."

For more information about cultural rounds, contact Deborah Washington, RN, director of PCS Diversity, at 617-724-7469.



Director of PCS Diversity, Deborah Washington, RN (center-right), facilitates discussion with staff during cultural rounds on White 9

Opening new avenues of communication

—by Richard Evans, director, Service Improvement

In our efforts to make care more patient- and family-centered, we strive to promote relationships and engage patients and families as active members of the care team. Many of the innovations we've implemented this past year have succeeded in involving patients by enhancing our avenues of communication.

Some examples include:

- Creating the role of attending nurse on Innovation Units. The role is already showing great promise in enhancing relationships and communication with patients and families
- Installing white boards in patients' rooms to help them know the team and share their goals for each day
- Using Face Sheets with pictures of unit caregivers and a description of their roles to help patients and families know staff, understand their roles, and gain an appreciation for how everyone works together

- Providing welcome packets on Innovation Units including the *Patient-Family Notebook* that invites patients to participate more actively in their care, shares descriptions of the many healthcare disciplines, provides prompts for patients who may have questions, and includes space for notes
- Providing a discharge envelope for patients to keep important information and the educational materials they're given throughout their stay. The envelope includes a Going Home Checklist to help patients and families prepare for discharge
- Making follow-up phone calls to patients within 48 hours after being discharged. These calls ensure that patients are safe, that they understand their discharge instructions, and that they're aware of any follow-up appointments or instructions they may have

These and many other innovations are making our care more patient- and family-centered. Results from patient surveys and focus groups show increased levels of satisfaction, communication, and a feeling of being known by caregivers.

Patient-family advisory councils are extremely instrumental in helping develop and test new ideas. Currently, we have the benefit of patient-family advisory councils in Pediatrics, Oncology, and the new Institute for Heart, Vascular & Stroke Care.

Patient-family advisory councils are comprised of 'active' patient and family members interested in supporting efforts to improve care and services. Patients, family members, and staff work together to identify opportunities to improve care. Over the years, patient-family advisory councils have provided input into the design of new buildings, program-development, and patient-education materials. They participated in the process to select the electronic, data-management system, Partners eCare, which will soon be implemented as the unified, electronic medical record for all Partners entities.

All the good intentions in the world to improve care are meaningless if patients and families don't think care is being improved. Hearing their thoughts and ideas, having their input and feedback, is vital for any meaningful discussion of change. That's why opening avenues of communication and engaging patients and families in decisions that affect their care is so important.

For more information about any of the programs or activities mentioned on this page, call Rick Evans, senior director of Service, at 617-724-2838.



Staff nurse, Renata De Carvalho, RN, of the Blake 13 Newborn (Innovation) Unit, calls to check on recently discharged patient, part of the new Follow-Up Phone Call program.

Leveraging technology

— by Jennifer Lassonde, senior project specialist
Clinical Support Services

Effective communication is essential to the delivery of high-quality care. Technological advances are making it easier for staff to communicate in the fast-paced, clinical setting of inpatient care units. Two recent advances that have had a positive impact on communication among staff are the Voalté wireless phones and CBEDS (the Coordinated Bed Efficiency Dashboard System).

Voalté was selected as the mobile technology of choice by inpatient staff last spring and has now been implemented on 14 inpatient units. It's also being used to great benefit by physical therapists, occupational therapists, respiratory therapists, and case managers. Voalté combines a customized software application with the user-friendly interface of an iPhone, providing staff with a communication system that's quick, effective, quiet, and easy to use.

With Voalté phones, staff can send instant messages (text messages) to individual members of the team or several recipients at once, and they can voice-call using the hospital's secure wireless network. All Voalté transmissions are private and secure. A key feature offered by this technology that wasn't possible with pagers is the ability to respond to messages using the same device. When a unit secretary sends a text message to a nurse about a patient, the nurse can quickly respond so the secretary knows the issue is being dealt with. If the nurse responds that he or she is busy, the secretary can alert another staff member.

Plans are in place to provide all PCS inpatient staff with Voalté phones as soon as enhancements to the information network infrastructure are completed. The hope is to have all inpatient areas fully operational by the summer of 2013.

A new product in the CBEDS software is now being used by 16 inpatient units to aide communication about patient census. Electronic Census Boards use information already entered into CBEDS (patient admissions, discharges, and transfers) to provide a real-time display of patient throughput. New fields were added to allow the names of nurses, patient care associates, and other variables to be assigned to patients, eliminating the need for dry-erase boards that used to serve this function.

This electronic, patient-census tool is especially helpful on larger units where users can enter information in CBEDS from any computer on the unit and have it displayed on all Electronic Census Board monitors. This eliminates the need for staff to physically travel from place to place to update information. The Electronic Census Board also highlights pending discharge information, so when pending discharges are entered or updated, that information is automatically refreshed on monitors for all staff to

see. The goal is to engage staff in an ongoing conversation about the patient's expected discharge by having the census board display this key information. Note: Electronic Census Boards face away from public areas to ensure patient privacy.

For more information about Voalté phones, CBEDS, or electronic white boards, call Jen Lassonde, senior project specialist, at 617-724-1749.



Above left: staff nurse, Jennifer Solis, RN, uses Voalté phone to contact colleague on the Bigelow 14 Vascular (Innovation) Unit. At right: patient care associate, Lisa Maben, consults electronic white board on Lunder 9.

Innovation through standardization

—by Pratik Rachh, Joan Strauss, and Mary Cramer,
Process Improvement Consulting Team

Standardization may seem antithetical to our long-standing commitment to individualized, patient-centered care. After all, each patient is unique, so how can we ‘standardize’ care-delivery? In fact, standardization is the basis for clinical innovation, optimizing the patient and family experience, and ensuring patient safety.

By standardizing products and processes, we help set expectations for what will be done, who will be doing it, and how long it will take. Whenever possible, those parameters are informed by evidence. When expectations are clearly established, problems with the process become easily discernible and can be investigated before deviations from the norm result in adverse events. When there’s unnecessary variation in how work is performed, it’s impossible to identify problems in the process because no standard way of doing things exists. Each variation contributes to the overall inefficiency of the process.

With high levels of variation in work processes, it’s inevitable that waste, re-work, and work-arounds will emerge. When clinicians have a clear idea of what’s supposed to happen, they can focus on solutions when problems arise, improve the work flow, and move on. Every small improvement adds up to big gains. We get better at diagnosing and solving problems; we get better at developing processes that can be easily tested and ultimately lead to more innovative models of care.

When workflow is standardized across units (or departments), the need for training is reduced, and staff can more effectively function in multiple settings. Staff can spend more time doing what they do best—caring for patients and families. The power of good ideas is amplified as best practices discovered in one area are applied in other areas with relative ease. That’s exactly what’s happening on our Innovation Units. Structured, daily, inter-disciplinary rounds, relationship-based care, and the new attending nurse role are excellent examples.

It’s important to note that standardization seeks to minimize *unplanned* variation. In health care, there’s always a place for purposeful variation intended to meet the individual needs of individual patients. For example, clinical protocols are developed to allow for patient-specific variations, the outcomes of which often result in improved protocols. Interactions between patients and caregivers can be standardized, as well, through the use of checklists or ‘scripting.’ This ensures that all necessary information is consistently and accurately gathered and conveyed with individualized attention to patients’ needs. A consistent flow of information helps build confidence and trust. When patients receive inconsistent information, they lose confidence in their caregivers. By keeping variations to a minimum, we help set realistic expectations and optimize our chances of attaining our care goals.

The literature is full of examples of medical errors that occurred while clinicians, practicing with the best intentions, didn’t follow established, standard, work processes, or the processes weren’t robust enough to safeguard against human error. Standardizing processes helps prevent human error and is a critical strategy in reducing adverse events.

Standardization leads to improved clinical practice and more effective models of care, which ultimately translates to higher-quality care for patients and families, and safer, more efficient processes for the organization as a whole.

For more information about standardization and innovation, call Mary Cramer, director, Process Improvement, at 617-724-7503.

“It is impossible to improve any process until it is standardized. If the process is shifting from here to there, then any improvement will just be one more variation that is occasionally used and mostly ignored. One must standardize the process before improvements can be made.”

—Masaaki Imai, Lean guru

The Always Responsive Project

—by Gaurdia Banister, RN, executive director, The Institute for Patient Care

An inter-disciplinary team comprised of representatives from Nursing, Medicine, the MGH Center for Quality & Safety, the PCS Office of Quality & Safety, Social Services, MGH Practice Improvement, and Newton-Wellesley

Hospital Operations Management recently completed the year-long Always Responsive Project to explore ways to improve the patient and family experience, decrease patient falls, and reduce the number of hospital-acquired pressure ulcers.

The project was based on a guiding principle of The Picker Institute, an independent, non-profit organization dedicated to advancing patient-centered care. The Picker Institute has identified certain aspects of interactions between healthcare professionals and patients and families that should always occur—‘always events.’ The goal of the Always Responsive Project was to ensure patients’ and families’ needs were met by *always* being responsive.

The Phillips 20 and White 8 medical units tested seven interventions; four focused on the patient and family experience, three focused on the efficiency of unit systems. Interventions included hourly safety rounds, the use of white boards in patient rooms, care-team face sheets, and a newly developed welcome video. Care-team face sheets were given to patients upon admission—they included pictures of staff, role descriptions, and what to expect from each member of the team. The six-minute welcome video was available in English and Spanish on hospital television with captioning for Deaf and hearing-impaired patients.

Support-service report cards were used to improve efficiency and communication between disciplines and departments. Communication boards were used to display important quality information for staff. And learning coaches led discussions with staff and leadership and guided group decision-making.

Patients and families were interviewed about their experiences. Some of their responses were:

“Whenever I pressed the call button, people came immediately.”

“The attentiveness of nurses was excellent.”

“Nurses were right there when I was having a bad day. They sat with me and helped me get through the tough times.”

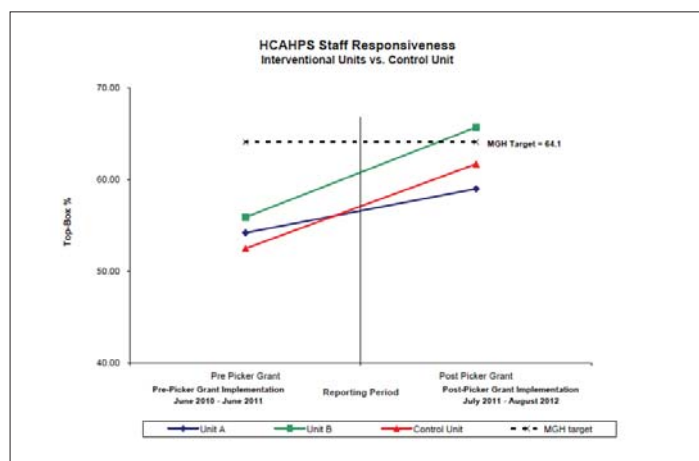
“Caregivers were all on the same page.”

“The white board was great. Keep it updated.”

Hourly safety rounds and white boards are being implemented throughout the hospital. Care-team face sheets are now included in the Patient & Family Notebooks being tested on the 12 Innovation Units. Because feedback has been so positive, a version of the notebook will soon be rolled out hospital-wide.

During the study, patient-satisfaction scores on the pilot units increased, and comments were overwhelmingly positive. The level to which falls and pressure ulcers decreased varied, and those efforts will continue throughout the hospital.

Thank-you to the Picker Institute for supporting this project. For more information, contact Gaurdia Banister, RN, at 4-1266.



There was significant improvement in HCAHPS responsiveness scores for both pilot units. White 8 achieved a 4.8 point increase; Phillips 20 achieved a 9.8 point increase compared to baseline scores (obtained July, 2010–June, 2011) placing them in the top quartile compared to other units and exceeding the score for the entire hospital. These scores are above the 90th percentile for rate of improvement compared to like hospitals across the country.

Volunteers

a 'beacon' of guidance for patients and families

—by Wayne Newell, director, Volunteer Services

For many years, MGH volunteers have provided an invaluable service in the discharge of patients from inpatient units. Until recently, staff on units would call the Discharge Desk in the Main Lobby, and a volunteer would write down the information, then proceed to the unit and transport the patient to the Wang Lobby for discharge.

Beginning in 2007, the role of volunteers expanded to include requests to meet patients arriving at MGH and escort them to outpatient practices and diagnostic areas. In 2008, the name of that role was officially changed from discharge volunteer to patient escort volunteer.

Following that change, the number of requests for outpatient transports increased significantly. And while we had plenty of volunteers to meet the need, we had outgrown the single phone line at the Discharge Desk. We needed a better system.

Our vision was to have a de-centralized team of volunteers available to go from lobby to lobby re-

sponding to requests for both inpatient and outpatient escort services via an on-line request system. Working with the software engineer who developed Interpreter Services' on-line request system, we created our own program, called Beacon. Soon we had an on-line transport-request system that could be accessed on computers in the White, Yawkey, Wang, and Gray lobbies.

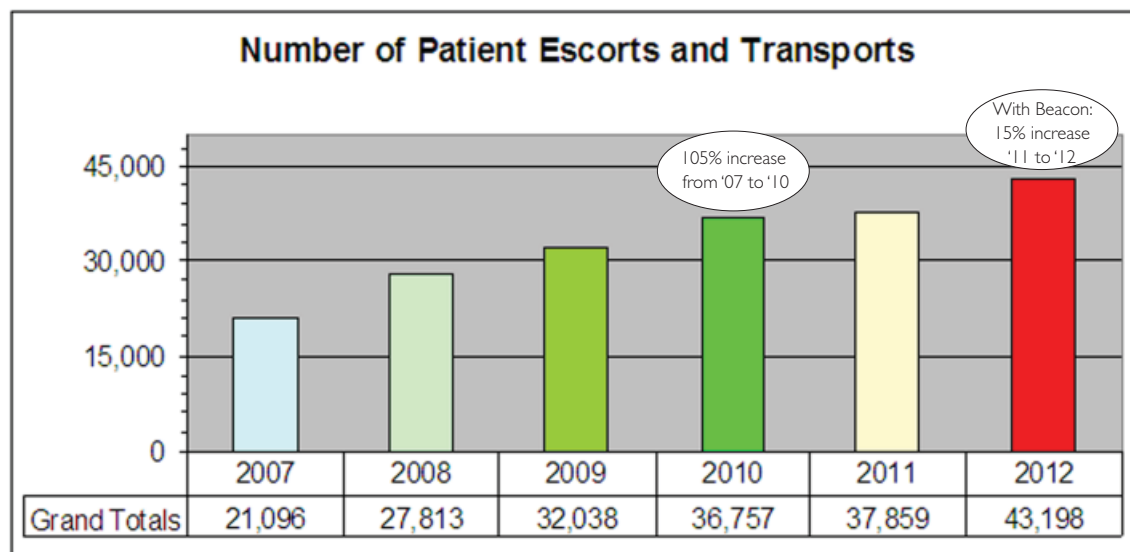
The new system allowed volunteers to travel continuously between lobbies accessing escort requests without having to wait for the phone to ring. And staff requesting patient escorts never got a busy signal or an unattended phone.

After successfully piloting Beacon on a few units, training was conducted throughout the hospital, including an on-line tutorial. The new system was up and running hospital-wide by August, 2011.

Beacon allowed the Volunteer Department to increase the number of volunteers allotted to meet increasing patient-transport demand, and it allowed volunteers to constantly patrol the ground floor, moving from lobby to lobby retrieving their next transport request. Over and above formal on-line requests for transport, volunteers signed a pledge to constantly be on the lookout for patients and families who appear lost or confused and assist them whenever needed.

Through innovative thinking and teamwork, the Volunteer Department developed a system to improve the process of assisting patients and families to find their way. Volunteers are truly a 'beacon' of guidance for patients and families as they journey from home to the hospital and back again.

For more information about Beacon, call Wayne Newell, director of the Volunteer Department, at 617-724-1753.



Graph illustrates the increase in patient-escort requests from 2007 to 2012. By 2010, demand necessitated implementation of the MGH Beacon Innovation.

Under the direction of its new leader, Reverend John Polk, DMin, the MGH Chaplaincy is poised for an innovative new year. After three months of listening and learning, Polk has launched an ambitious, four-point strategic plan. The plan reflects the strategic goals and values of Patient Care Services and complements many of the interventions being implemented on Innovation Units.

- **Goal #1:** to develop efficient and effective patient-centered best practices. Chaplains will strive to discover and standardize best practices related to documentation, conducting spiritual assessments, and developing plans of care.
- **Goal #2:** to strengthen the department's educational programs. Providing equitable care throughout the hospital is a priority. An important means of accomplishing that is a strong educational foundation. The Chaplaincy plans to expand its Clinical Pastoral Education program, the Harvard's Field Education program, the Roman Catholic Diocesan Deacon-in-Training program, and the Pastoral Visitor program to increase the visibility and accessibility of chaplains throughout the hospital.
- **Goal #3:** to lay the groundwork for, and actively engage in, evidence-based practice focusing on research, history, and best practices in spiritual care. How does quality spiritual care help shorten length of stay and thereby contribute to lower costs? What spiritual-care best practices help prepare patients spiritually and emotionally for the hospital experience thereby paving the way for a stronger and shorter recovery time? How can chaplains bring their expertise to bear on dying patients, thereby contributing to death with dignity and peace?
- **Goal #4:** to nurture, strengthen, and provide infrastructure for the Chaplaincy team. Every morning Chaplaincy staff begin their day with a morning huddle. During morning huddle, they receive

Spiritual care

—by Reverend John Polk, DMin, director, Chaplaincy

overnight report from the on-call chaplain, make 'warm' referrals, and engage in reflective prayer for the MGH community including particular patients, loved ones, and staff who may need special attention.

The model of care being introduced on Innovation Units puts patients at the center of their care with active involvement in conversations and decisions made with the inter-disciplinary team. Chaplaincy staff will soon pilot another component of the model: a spiritual care plan designed by each patient and their chaplain. Anecdotal evidence suggests that when caregivers are interested in the spiritual life and religious practices of their patients, it contributes to a more trusting relationship and better outcomes. As integral members of the healthcare team, chaplains want to participate fully in strengthening the relationship between patients and caregivers.

For more information about spiritual care at MGH, call Reverend John Polk, at 617-724-3226.



Staff chaplain, Daphne Noyes (second from left) prays with patient, Melva Wright, and her family on the Ellison 9 Cardiac ICU (Innovation) Unit.

Medical interpreters

—by Anabela Nunes, director, Interpreter Services

Medical Interpreter Services provides interpretation (verbal) and translation (written) services for patients and providers throughout MGH. Interpreters are available in person, via video hook-up, or by telephone and can interpret in ten different languages, including American Sign Language. In addition to staff interpreters, the department has access to a pool of approximately 50 freelance interpreters, which adds another 30 languages to the slate. Through the help of an outside telephone service, in-house interpreter services are augmented by round-the-clock access to Interpreter Phone on a Pole (IPOP) and Video Phone on a Pole (VPOP) available in more than 200 languages.

Patients with limited English proficiency comprise about 20% of the patient population at MGH. Our goal is to meet the needs of all patients (and family members) who are Deaf, Hard of Hearing, or have limited English proficiency. Interpreter Services is a critical component of the safe, high-quality care we provide to the diverse communities we serve.

For more than ten years, the department has engaged in strategic and innovative planning to ensure patients have timely access to effective interpreter services in inpatient and outpatient settings. We piloted a video interpreting program in the Avon Breast Center and the Urology Clinic where a video device was used to contact Spanish interpreters. Staff simply dialed a number and one of our staff interpreters conducted the interpretation via video hook-up.

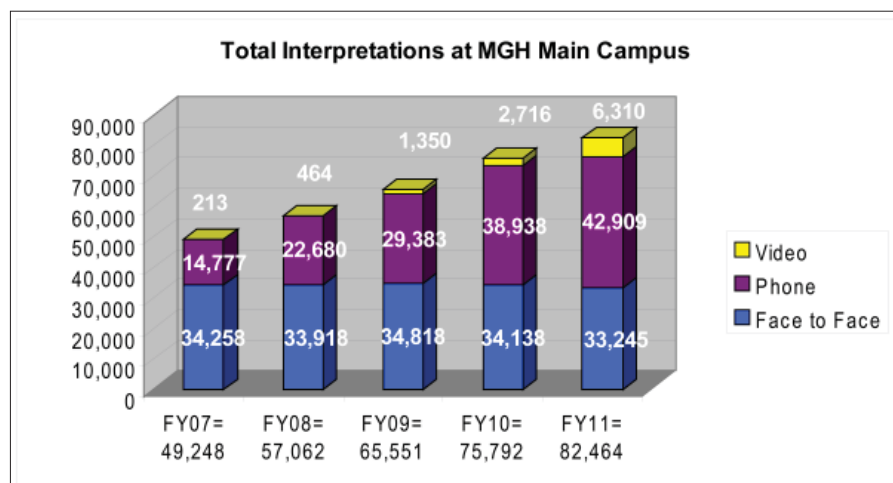
The pilot was a great success, so in 2008, video medical interpreting was implemented in six outpatient clinics. Patients and providers had immediate access to Spanish and Portuguese interpreters using VPOP. With the push of a button an MGH interpreter (or contracted vendor) could be accessed by video on demand.

Today, video medical interpreting is the cornerstone of interpretation services provided by our department to enhance patient-provider relationships. Having video access to Spanish and Portuguese interpreters in 30 inpatient units, perioperative areas, and 18 outpatient clinics, has reduced the wait time for patients, providers, and interpreters, contributing to greater efficiency and improved patient-satisfaction. Since the inception of video medical interpreting four years ago, Interpreter Services has maximized its resources and increased productivity each year. On average, it takes just 17 seconds to contact an interpreter by video.

Eliminating long wait times means more interpreters are available to assist with more interactions. Patients who are Deaf, Hard of Hearing, or have limited English proficiency have greater access to safe and high-quality care.

Recent studies show that patients with limited English proficiency who used a professional medical interpreter (by video, phone or face-to-face) had lower re-admission rates and overall better outcomes than those who didn't have access to, or didn't use, professional medical interpreters. MGH interpreters are proud to play a part in delivering the safest, highest quality care to patients with limited English proficiency.

For more information about Medical Interpreter Services, call Anabela Nunes, director, at 617-726-3298.



There has been a 67% growth in demand for medical interpreter services in just 5 years.

The voice of the patient

—by Robin Lipkis-Orlando, RN, director, Office of Patient Advocacy

The MGH Office of Patient Advocacy helps guide services and programs for patients, families, visitors, and staff to ensure the healthcare experience is a positive one. Central to its mission is respect for the patient's right to control his or her own healthcare decisions. Patients should have equal access to, and receive, equal care; dignity should never be compromised; caring and compassion are as important as technology; and education and information are vital to informed decision-making. Staff of the Office of Patient Advocacy listen and respond to patient and family concerns; they serve as liaisons between patients and the treatment team to resolve conflict and facilitate positive change; they provide information and resources related to patients' rights and responsibilities; they help remove barriers to care for patients with mobility or language issues and other disabilities; and they strive to ensure that care is patient- and family-centered.

In March, the Office of Patient Advocacy became involved with the launch of the 12 Innovation Units. On these units, patient advocates have been participating in inter-disciplinary rounds and meeting with attending nurses to explore how they can best contribute to this work. Having knowledge of patients prior to entering into a relationship with them allows

for more timely and efficient interactions. Staff might refer a patient or family member to an advocate if there's disagreement over the treatment plan; if assistance is needed communicating with members of the care team; if there are discharge concerns; for an explanations of patient's rights and responsibilities; or if there are concerns over delays in tests or procedures.

The role of the advocate varies according to each situation. Advocates might facilitate communication by coordinating a meeting with the members of the team to ensure the voice of the patient is being heard. Advocates might attend meetings with case managers, patients, and families to clarify discharge plans and address concerns. They might assist in educating staff on patient and family needs and expectations. Staff can consult advocates when having difficult conversations with patients or families. Advocates are valuable resources for information about services and accessibility issues.

Supporting staff on Innovation Units has been a rewarding experience for

patient advocates. Their presence fosters continuity and an ability to follow up on issues with ease. Evaluating patients' responses to interventions and incorporating their suggestions into the new culture is truly reflective of patient- and family-centered care. The Office of Patient Advocacy looks forward to collaborating with patients, families, and staff to expand services as we continue to think creatively about how to improve the patient experience.

For more information about services offered by the Office of Patient Advocacy, call 617-726-3370.



Patient advocate, Linda Kane (right), speaks with Lunder 9 (Innovation Unit) attending nurse, Kristen Patrick, RN, following inter-disciplinary rounds.

Emergency Department

—by Maryfran Hughes, RN, nursing director, Emergency Department

Over the past several years, staff and leadership of the Emergency Department have put great effort into enhancing the patient experience, increasing efficiency, and reducing costs. These were the goals that guided

our planning for the successful expansion into the Lunder Building last year. And these are the goals shared by the Partners Direct Care Team, co-chaired by Jeanette Ives Erickson, RN, senior vice president for Patient Care, and Michael Gustafson, MD, chief operating officer at Faulkner Hospital, and the Partners ED Affordability Team, co-chaired by Maryfran Hughes, RN, nursing director of the ED; Everett Lyn, MD, chair of Emergency Medicine at the North Shore Medical Center; and Julia Sinclair, vice president of Clinical Services at BWH.

The Partners ED Affordability Team was given a cost-reduction target to be achieved across all Partners emergency departments over the next three years. Stakeholders agreed that the best way to achieve that goal was to increase throughput, decrease length of stay, decrease ED expense per patient (adjusted for intensity of care), and decrease the amount of time patients spent in the ED waiting for inpatient beds.

Some of the strategies employed include:

- Changes to the triage nursing documentation to promote patient safety, eliminate redundancy, and increase patient throughput. ED staff nurses, clinical nurse specialists, nursing director, physicians, administrative staff, and staff from Partners Information Systems had input into this change, which has enabled triage nurses to realize a 7–10% increase in patient volume with no additional resources and without increasing triage waiting times for patients
- Reducing the number of treatment areas in the ED to minimize the number of hand-offs and the need for re-work. With new construction and renovations taking place, as sections of the ED moved

into the Lunder Building, nurses and frontline staff from all disciplines participated in the development and re-design of new patient-flow processes that resulted in fewer transfers from one treatment area to another. This resulted in fewer hand-offs, safer care, and more ease in moving patients within the ED

- Expanding the screening process in the ED to promote earlier assessment of patients by a physician and earlier initiation of work-ups. With stretcher space limited and many patients not requiring a stretcher to begin their work-ups, a larger screening area was created to allow immediate initiation of care, including labs and imaging studies. In many cases, patients have a shorter length of stay without ever needing a stretcher
- Coordinating the care and community support of repeat patients to prevent ED visits. ED providers, primary care providers, and community agencies are in the process of establishing care plans for frequent users of ED services. Individualized care plans developed with primary providers will be available electronically to staff in all Partners emergency departments to ensure continuity and consistency of care for these frequent ED patients

Stakeholders agreed that the best way to meet cost-reduction targets was to increase throughput, decrease length of stay, decrease ED expense per patient (adjusted for intensity of care), and decrease the amount of time patients spent in the ED waiting for inpatient beds.

Many challenges still lie ahead as we strive to achieve our cost-saving goals. The volume of patients into the ED continues to increase, the expansion of the Observation/Short Stay Program is rolling out, and construction of the physical space continues. Our focus remains finding the best way to support our patients and families as they seek emergency care.

For more information about this important work, call Maryfran Hughes, RN, at 617-724-4127.

Perioperative Services

—by Dawn Tenney, RN, associate chief nurse

Like the Emergency Department, Perioperative Services has been given a cost-reduction goal to be achieved over the next three years (see article on previous page). Jeanette Ives Erickson, RN, senior vice president for Patient Care, and Michael Gustafson, MD, chief operating officer at Faulkner Hospital, co-chairs of the Partners Direct Care Team, assigned three co-chairs to lead this project: Dawn Tenney, RN, associate chief nurse; Fred Millham, MD, chief of Surgery at Newton Wellesley Hospital; and Sanjay Pathak, vice president of Surgical Services at BWH. These co-chairs brought together an inter-disciplinary team to brainstorm, identify, and prioritize the top ten ideas to achieve cost savings. Ideas were presented to the Partners Operating Heads Group, and two ideas were approved for implementation.

The first idea was to standardize high-cost, high-volume products via a Partners-wide Perioperative Technology and Supply Committee. To date, an inter-disciplinary team has been established along with seven sub-committees, called Value Analysis Teams.

These Value Analysis Teams were charged with looking at specific supplies and identifying opportunities to cut costs. As of September of this year, we have identified approximately \$9.5 million in savings. Even as we implement these new ideas, we continue to look for cost savings in other areas.

The second idea was to optimize the use of the perioperative workforce by always ensuring that, “The right person is doing the right job at the right time.” State-of-the-art operating rooms require a workforce with certain technical skills, knowledge of information systems, engineering, and a well-trained support staff to enhance the work of professional staff. Work-flow and tasks need to be studied and re-mapped so that everyone is making the best use of their time and skills; technical and support staff are involved to the full extent of their ability, and all new work is assigned to the appropriate person. There is also a recommendation that we consider creating the role of ‘OR worker of the future.’ Three sub-committees have been convened with focuses on education, staffing models, and role responsibilities. The work of these groups is on-going with recommendations expected by December and implementation by spring of 2013.

For more information about care-re-design strategies in the perioperative setting, call Dawn Tenny, RN, at 617-724-3855.

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