“All human development, no matter what form it takes, must be outside the rules; otherwise we would never have anything new.”

— Charles Kettering, American inventor, engineer, and businessman
Innovation units are designated inpatient care units that will be used as testing grounds for change, allowing us to create new care-delivery models and quickly determine whether new ideas should be adopted, adapted, or abandoned.

The need for improvement has driven progress since the beginning of time. Hence the adage: “Necessity is the mother of invention.” At MGH, we have led the healthcare industry in forward-thinking since our beginning in 1811, constantly searching for better ways to deliver care. Today, we’re on the cusp of yet another groundbreaking advancement, driven by the need to make care more effective, efficient, and affordable for patients and families.

Many of you have heard me talk about the work we’re currently doing under the umbrella of the Partners Patient Affordability Direct Care initiative, specifically, the inception of innovation units. Innovation units are designated inpatient care units that will be used as testing grounds for change, allowing us to create new care-delivery models and quickly determine whether new ideas should be adopted, adapted, or abandoned.

Twelve units have been selected to participate in this grand experiment: 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 goal for each innovation unit is to:

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

This work will be 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

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The graphic below illustrates the process of care before, during, and after hospitalization. Continuity will be enhanced by standardization wherever possible, such as the use of rounding check sheets, hand-over guidelines; and standardized systems for the transfer of information upon admission and discharge.

Success will depend on our ability to improve quality and safety, create healing environments, integrate research and evidence-based practice into care delivery, and ensure opportunities for professional growth and education.

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"Nothing is so embarrassing as watching someone do something that you said could not be done."
— Sam Ewing, reporter, humorist

At the heart of the innovation-unit roll-out is a series of interventions generated by exhaustive discussions at retreats, in break-out sessions, and in informal conversations with staff and leadership throughout Patient Care Services (and the hospital at large). These interventions represent what we consider ‘top-priority’ actions in order to achieve the highest levels of consistency, continuity, and efficiency as we move forward with this work. The interventions we’ll be focusing on include:

- Building relationship-based care into educational curriculum
- Implementing the new attending nurse role
- Enhancing hand-over communication including the use of SBAR tool (Situation; Background; Assessment; Recommendations)
- Enhancing pre-admission data-collection including a revised Admitting Face Sheet
- Creating a Welcome Packet for patients
- Re-visiting and updating domains of practice to ensure across-the-board understanding of each discipline’s scope of practice
- Implementing inter-disciplinary team rounds to ensure effective communication between all members of the care team
- Making use of supporting technology, including electronic whiteboards, Voalté phones, in-room whiteboards, and portable electronic devices (Toughbooks)
- Being proactive in discharge planning and readiness including implementation of a new discharge Checklist tool
- Implementing new Discharge Follow-up Phone-Call Program

Because these interventions are central to our work, I’d like to briefly address each one of them.

**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 three important 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- 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

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“When all think alike, no one is thinking very much.”
—Walter Lippmann, writer; Pulitzer Prize winner

- 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. (For more information about the attending nurse role, see page 10.)

**Enhancing hand-over communication**
This intervention 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 the patient’s home. It relies heavily on the SBAR (Situation, Background, Assessment, and Recommendations) communication tool that ‘prompts’ caregivers to provide complete information during hand-overs. This intervention should be thought of, not as the introduction of a new tool, but as implementation of a new standard of practice.

**Enhancing pre-admission data-collection**
One goal of innovation units is to better know the patients we care for. To ensure continuity and accurate information-gathering for all patient populations, an inter-disciplinary Tiger Team is creating a new Admitting Face Sheet, including anticipated discharge date and projected discharge disposition, to better inform inter-disciplinary care-planning.

**Welcome packets**
We’re in the process of developing a Welcome Packet for patients (and families) to provide them with basic, relevant information, invite feedback for improvement, and help set discharge expectations and preparation.

**Domains of practice**
With implementation of inter-disciplinary rounds, having a greater understanding of the domains of practice of our colleagues in other disciplines is key. Toward that end, I’ve asked each discipline (Nursing, PT, OT, Respiratory Care, Social Work, Speech-Language Pathology, Chaplaincy, etc.) to review and update their domains of practice so we can share this information in various forums, including the Excellence Every Day web portal.

**Inter-disciplinary team rounds**
Currently, there’s no formal mechanism for daily communication between all members of the care team. Inter-disciplinary rounds will 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. Having the right tools makes communication faster and easier. Staff on innovation units will be equipped with specially programmed iPhones (Voalté phones) and portable, wireless laptops to make access to, and dissemination of, information more efficient. And in-room whiteboards and electronic whiteboards at nurses’ stations will enhance our ability to know our patients and coordinate their care.

**Discharge planning and readiness**
We are in the process of developing a discharge Checklist tool... stay tuned, more to come.

**Discharge Follow-up Phone Call Program**
In an effort to reduce hospital re-admissions and ensure patients understand discharge instructions, we will be implementing a Discharge Follow-up Phone Call Program. All patients will be invited to participate. We’re in the process of developing a questionnaire, guidelines, and a training curriculum.

The success of innovation units will be measured by pre-determined metrics related to length of stay, patient-satisfaction, staff-satisfaction, quality and safety, and certain nursing-sensitive indicators.

This is an ambitious undertaking, and we’re highly motivated to succeed. It’s not an exaggeration to say we’re on the cusp of a whole new way of delivering care. If we do this right, we can look forward to increased patient and staff satisfaction, better clinical outcomes, better quality and safety outcomes, and better financial outcomes for patients, families, and the hospital.

I look forward to working with all of you on this ground-breaking initiative. For more information, or if you have questions, thoughts, or ideas, please e-mail me or call 6-3100.
“Discovery consists of seeing what everybody has seen and thinking what nobody has thought.”
—Albert von Szent-Gyorgyi, biochemist, recipient of the Nobel-Prize

Innovation unit inter

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- Create a Welcome Packet for patients
- Re-visit and update domains of practice to ensure across-the-board understanding of each discipline’s scope of practice
“There ain’t no rules around here. We’re trying to accomplish something.”
—Thomas Edison, inventor

ventions at a glance

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• Implement new Discharge Follow-up Phone Call Program