2.3 Provide a narrative that describes the CNO’s structural and operational relationships in all areas where nursing is practiced.

Massachusetts General Hospital (MGH) is a complex, tertiary facility with nurses practicing throughout the hospital, within the Department of Nursing and in areas outside the realm of the Department. The Chief Nurse has created an innovative infrastructure that empowers nurses to take the lead in promoting and enhancing high quality patient care. Careful attention has been given to ensure that there are minimal layers between the Staff Nurse and Chief Nurse to streamline decision-making. The newly-formed Institute for Patient Care, in conjunction with a lean organizational chart, provides the structural and operational support for nurses in all areas of the Hospital. The following describes the structures and operational relationships that support the Chief Nurse and her team.

The Institute for Patient Care

The Institute for Patient Care is the new interdisciplinary structure within Patient Care Services (PCS) built on the premise that new connections between individuals and groups and new synergies of concepts, ideas and innovations are essential to enhance practice and achieve improved outcomes in health care. The Institute helps to strengthen the links between members of the clinical disciplines providing care and between the elements common to the practice disciplines – clinical care, education and research.

Its structures provide a platform for fostering, studying and advancing collaboration and for crafting future innovations that will enhance the care environment. With both abstract and practical components, The Institute provides a “think and do tank” for PCS’ work to unite multiple organizational efforts designed to advance high quality, cost-effective, safe care. It is this new vision for interdisciplinary clinical education and research that is centered on meeting patients’ needs; advancing care delivery systems; and fostering, studying, and promoting innovations in the care environment. The Institute’s goals are to:

- Foster an environment of clinical inquiry and experiential learning;
- Promote team learning to optimize safe, effective, culturally-competent patient care; create environments that promote safety for patients, families and staff;
- Participate in the development and evaluation of organizational initiatives;
- Support the development of the current and future diverse workforce;
- Enhance the relevance of research as it relates to public health;
- Support research that advances care that is safe, effective and evidenced-based;
- Provide leadership for innovations in learning for staff, patients and families;
- Develop, implement and evaluate programmatic initiatives that impact staff development and organizational effectiveness; and,
- Make innovations visible through internal and external publications and presentations.

The growth of key systems and programs within PCS over the past decade are the working elements or cornerstones of practice at MGH, which have evolved into The Institute for Patient Care. These systems and programs include:

- **An Articulation of a Professional Practice Model**
  
  As described in Force 1.1, the practice model is grounded in the organization’s vision and values; care that is patient-centered and based on defined standards; infusion of innovation and entrepreneurial teamwork throughout the clinical disciplines; a commitment to collaborative decision-making, professional development, and clinical recognition and advancement; and a commitment to study and build the science of patient care using both research and experiential learning (narrative culture). These elements were first operationalized through staff-driven committees and councils. Today, many have evolved into dedicated programs that are hard-wired into the organizational structure, forming the underpinnings of The Institute for Patient Care. Of note, the 2006 Staff Perceptions of the Professional Practice Environment Survey showed that 92% of staff report being satisfied or highly satisfied with the practice environment.

- **Collaborative Governance**
  
  Collaborative Governance is the core mechanism within the Professional Practice Model used to support nursing practice by bringing decision-making to the bedside. In place since 1997, it is the structure that sets the standard for nursing staff involvement, both formally and informally in both program and unit activities. Its mission is to integrate multidisciplinary clinical staff into the formal decision-making structure of PCS to stimulate, facilitate and generate knowledge that will improve patient care and enhance the environment in which clinicians shape their practice. It is the critical element within the practice model that describes communication and decision-making processes and places the authority, responsibility and accountability for patient care with the practicing clinicians.
Under the direction of the Chief Nurse and the Patient Care Services Executive Committee, nurses from all areas of the hospital, including those not under the supervision of the Department of Nursing, are invited to participate in the governance process; thus giving all nurses a voice and an avenue to actively engage in nursing practice.

The seven standing committees that comprise the Collaborative Governance structure build relationships by bringing together clinicians and support staff from all disciplines to achieve common goals. The committees and their purposes are outlined below.

**Diversity Steering Committee** - Develops strategies that will transform the work setting to become a more inclusive and welcoming environment for staff and patients. The work of the committee includes professional development, student outreach, programs centered on culturally competent care and input into the development of patient education materials specifically designed for use by clinicians who care for diverse patient populations.

**Ethics in Clinical Practice Committee** - Develops and implements activities and programs to further clinicians’ understanding of ethical aspects of patient care. The work of this multidisciplinary committee also involves identifying strategies to integrate ethical judgment into professional practice.

**Nursing Practice Committee** - Reviews, revises, and communicates standards of practice for professional nursing at the Massachusetts General Hospital (MGH). The work includes reviewing and approving new products and new practice recommendations and communicating outcomes and revisions to staff throughout Patient Care Services.

**Nursing Research Committee** - Fosters the spirit of inquiry around clinical practice, supports nurses in the utilization of evidence-based research and communicates the results of institutional research activities.

**Patient Education Committee** - Develops processes for patient and family education, recommends systems and technology to support improved patient education and ensures that all materials and activities reflect the diversity of the populations we serve.

**Quality Committee** - Identifies opportunities to improve patient care and clinical knowledge/skills in the use of performance improvement processes. This multidisciplinary committee works closely with the Director of the PCS Office of Quality and Safety, and through the Director, collaborates with the hospital-wide Quality Steering and Patient Care Assessment Committees.

**Staff Nurse Advisory Committee** - Provides a forum for communication between the Chief Nurse and Staff Nurses. Committee members representing all patient care units dialogue with Chief Nurse and members of the nursing executive committee about matters of patient care, professional development and quality of work-life.
The 2006 Collaborative Governance Annual Report (OOD 22) provides a comprehensive overview of the charges, accomplishments and future goals for all the committees under the Collaborative Governance structure.

- **The Norman Knight Nursing Center for Clinical & Professional Development** – Established in 1997, The Norman Knight Nursing Center focuses professional nursing education at MGH on the creation of a “learning organization.” The Center supports a robust array of professional development activities, including orientation and continuing education curricula, liaison functions with area schools of nursing, leadership development programming, and administration of numerous award programs for clinical staff.

- **The Maxwell & Eleanor Blum Patient and Family Learning Center** – In 1999, the hospital established a consumer library and multimedia-learning center for patients and families. The Blum Center’s library contains over 500 books, 150 videos and DVDs, and 250 pamphlet titles, as well as access to computer resources and anatomical models. Staff and volunteers are on hand to help patients and families learn about health, illness and treatment choices. Serving more than 30,000 visitors in 2006, The Blum Center recently began collaborating on an innovative-shared decision-making project to match patients and families with specific video resources, as recommended by primary care providers, to help them in making health care decisions.

- **The Yvonne L. Munn Center for Nursing Research** – In 2003, several research activities under the auspices of a dedicated research center, were named for and endowed by Yvonne L. Munn, RN, Associate General Director and Director of Nursing at the MGH from 1984-1993. The Munn Center supports a growing inventory of research-related programs and activities. Examples include a post-doctoral nursing fellowship program, a research advisory group and a peer support and networking group for doctorally prepared staff. Research activities in the Munn Center will be described in more detail in Force 6 and RD 4.

- **The Center for Innovations in Care Delivery** – Launched early in 2007, the goal for The Center for Innovations is to provide the support and resources needed to encourage and develop innovation in clinical practice. Through the Center, interdisciplinary resources in
education and research can be optimally matched with opportunities to impact patient care. The Center for Innovations provides a way for clinicians to more efficiently chronicle, study and advance the innovations that occur at the bedside in all areas of clinical practice.

As illustrated in this diagram, these four Centers and the program and initiatives within Patient Care Services are combined to form The Institute for Patient Care.

With the formation of The Institute for Patient Care, the Chief Nurse has created a central entity linking disciplines and professions within Patient Care Services in order to foster teamwork, share best practices, and bring an informed, interdisciplinary approach to patient- and family-centered care. The Institute is the overarching structure strategically placed to connect existing centers within PCS and to help support numerous interdisciplinary programs to enhance the ability to provide high-quality care for patients and a vibrant professional practice environment for staff.
Through The Institute, activities within each Center can be linked in new way to facilitate connections across the other Centers and programs that will ensure the work of the organization is integrated and advanced through creative collaborations and partnerships.

**Nursing Organizational Structure**

- **Senior Vice President for Patient Care Services and Chief Nurse**

  As Senior Vice President for Patient Care Services, the scope of responsibility for the Chief Nurse expands beyond nursing to include Physical, Occupational and Respiratory Therapy, Speech-Language Pathology, Social Services, Chaplaincy, Interpreter Services, the Volunteer Office, the International Patient Center and the Professional Resource Departments supporting these clinical areas.

  Under this organizational structure (OOD 2b), the Associate Chief Nurses and Directors for all these areas report directly to the Chief Nurse. This streamlined reporting relationship helps to facilitate operations within the organization and create strong working relationships between nursing and members of the interdisciplinary team. With this structure, the Directors of these departments and the Associate Chief Nurses comprise the Patient Care Services Executive Committee (PCSEC).

  Under the direction of the Chief Nurse, the charges of PCSEC are to:

  - Consider and adopt policies and procedures relating to 1) patient care; 2) education for nursing and health professions; and 3) other matters affecting the optimal operation of Patient Care Services.
  
  - Act in an advisory capacity to the Chief Nurse on all matters affecting the optimal operations of Patient Care Services.
  
  - Serve as a liaison between the Nursing and Health Professions staff and the administration of the hospital.

  As described in Force 1.1, the Chief Nurse and her PCSEC management team uses the strategic planning process to develop the PCS Strategic and Annual Operating Plan that provides a framework to identify and prioritize initiatives to enhance the delivery of nursing care. As a member of the hospital’s senior management team described in Force 2.1, the Chief Nurse uses the strategic planning process to align the goals for PCS with those of the hospital’s strategic plan. The Chief Nurse’s leadership position within the hospital’s organizational structure ensures her involvement in
the strategic planning and policy-making decisions for the hospital and gives nursing a strong voice within the organization.

Utilizing this structure, the PCS operating plan addresses short-term tactical issues to establish priorities for the year. The plan aligns nursing priorities with its long-term goals to guide decision-making, communicate goals, and provide a framework for accountability for nursing practice throughout the organization. The four strategic goals for Patient Care Services for 2006-2007 were to:

1. Increase diversity in the workforce.
2. Improve the physical environment of care.
3. Create and improve systems and provide adequate resources that enable staff to do their job.
4. Work with staff to create new patient care delivery models.

Preliminary strategic goals for 2008 are cited in Force 1.1.

Additionally, the Chief Nurse has the authority and responsibility for the hospital-wide development, implementation, and evaluation of the plan for providing nursing care. The three key areas of focus include: quality of care and treatment of all patients; conduct and discipline of all staff members; and the administration of all programs of education, research, and clinical care. As stated in her position description (OOD 10a), she directs the activities of all sections of the institution responsible for direct patient care and assures that competent, compassionate patient care is uniformly provided to patients in ambulatory, inpatient and community settings.

The hospital’s policy and procedure, “Credentialing and Authorization of Nurses in the Expanded Roles and Physician Assistants Who are MGH and MGPO Employees” (OOD 10d) is one example to demonstrate how the structural and operational relationships within the Department of Nursing and Hospital support nursing practice. The Hospital’s General Executive Committee has delegated the accountability for credentialing of these clinicians to the Chief Nurse. The Chief Nurse or her designee is responsible for the guidelines to approve the credentialing and authorization processes. This accountability extends to clinicians practicing in all areas of the hospital and in outpatient practices that are part of the Massachusetts General Physicians Organization and are not under the supervision of the Department of Nursing.

In addition to the Chief Nurse, all nursing roles and responsibilities, defined in position descriptions, help to describe the operational relationships within the organization and how they support nursing practice.
**Associate Chief Nurse**

The Associate Chief Nurse is a key member of the Chief Nurse’s clinical and senior management team responsible for providing oversight and leadership to support direct care, nursing practice and decision-making on designated group of units. As a member of the Nursing Executive Operations Team, the Associate Chief Nurse participates in the efficient and effective management of the department of nursing and the development of its strategic plan. Responsibilities of the position, outlined in the position description (OOD 23a) include:

- Directing the development and implementation of standards, policies, and programs to ensure excellence in nursing practice, and,
- Designing and directing the implementation of programs and processes to support organizational mission and goals.

As nurses are best positioned to understand the needs of their patients and families, the Associate Chief Nurse is in the position to form high-level relationships within the organization and take on leadership roles to support nursing practice and promote quality patient care. As will be described in Force 2.5, the Associate Chief Nurse for Oncology, Surgery, Orthopaedics and Neurosciences has a hospital-wide leadership role in the development of the electronic medication administration record project for the hospital – a project to automate medication administration.

As will be described in Force 13.4, the Associate Chief Nurses for Medicine, Emergency Services and the Heart Center has taken an organizational leadership role in the planning for the new inpatient building for the hospital. Working with architects and building planners, the Associate Chief Nurse is co-chairing a multidisciplinary committee team that will determine the functionality and space programming for this new building.

Additionally, the Associate Chief Nurse is also responsible for assuring the competent, compassionate patient care is uniformly provided to patients in inpatient, ambulatory, and community settings in all areas where nursing is practiced. This is an important distinction, as most nurses in the ambulatory and community settings at MGH do not report through the Department of Nursing infrastructure.

Given this responsibility, the Associate Chief Nurses have been instrumental in establishing service-based nursing practices committees in the hospital. Modeled after the Collaborative Governance Nursing Practice Committee, five specialty-based practice committees have been formed in oncology, medicine, cardiac, obstetrics and pediatric nursing to bring together specialty
care nurses to develop and share consistent practice standards. The following is a description of one of these committees.

At MGH, the Cancer Center includes inpatient and ambulatory care clinical areas. Nurses in the Cancer Center work in areas governed by the Department of Nursing as well as areas outside the department. Established in 2003, the Cancer Center Nursing Practice Committee brought together nursing representatives from all areas of the Cancer Center to make practice decisions about the care of their patients.

The nurses in the Cancer Center, with the support of the Associate Chief Nurse for Oncology, actively address practice issues and make clinical decisions about guidelines for care that are applied across all areas of the Cancer Center. Attachment 2.3.a is the roster of committee members including nurses from the Cancer Center’s ambulatory and inpatient practice sites. The Cancer Center Nursing Practice Committee vision statement:

“Nurses at the Massachusetts General Hospital Cancer Center take pride in the delivery of compassionate care in an evolving health care environment. Patients and their families are the primary focus of our practice. As integral members of a multidisciplinary team, nurses provide the balance between innovative and individualized expert care. We are committed to the highest professional standards through research, certification, and lifelong learning. We foster ongoing development of our colleagues through mentorship and peer support. Oncology nurses at the Massachusetts General Hospital Cancer Center value an environment that respects diversity, enhances quality of life, and preserves human dignity.”

The charge of the committee is to establish, communicate and evaluate standards that promote safety, comfort and successful outcomes for individuals with an actual or potential diagnosis of cancer using evidence-based practice. Evidence-based nursing practice, as defined by the group, is “the integration of the best evidence available, nursing expertise, and the values and preferences of the individuals, families, and communities served”. (Sigma Theta Tau, 2004)

This year’s accomplishments include the development of standardized assessment guidelines for mucositis, a chemotherapy/radiation teaching tool for patients and review of portacath guidelines that will be incorporated into the hospital policies and procedures once finalized. Attachment 2.3.b are meeting minutes reflecting the work of the committee.

The Ambulatory Nursing Practice Committee described in Force 1.2 and the role of the Associate Chief Nurse in supporting collaborative practice committees, as seen with the Cancer Center’s Nursing Practice Committee, illustrates the importance of this role in developing and nurturing operational relationships with nurses outside the Department of Nursing to support nursing practice and clinical decision-making.
• **Unit-Based Triad**

At the bedside, the unit-based triad leadership structure oversees clinical operations to keep clinical decision-making closest to those caring for the patient. The triad is comprised of the Nursing Director, Clinical Nurse Specialist and the administrative Operations Coordinator. The latter two positions report directly to the Nursing Director. The Nursing Director reports immediately to the Associate Chief Nurse. Under the leadership of the Nursing Director, the triad supports unit-based decision-making providing the greatest level of support to the Staff Nurse.

Within the triad, the Nursing Director is accountable for the delivery of consistent, high quality, cost-effective patient care, promoting the development and satisfaction of nursing and support staff, providing operating efficiencies and insuring compliance with hospital and regulatory policies and standards of practice. This role is an essential leadership position in the hospital organization, responsible for providing an environment for effective patient-focused nursing care.

• **Nursing Director**

The Nursing Director’s responsibilities outlined in the job description (OOD 23b) include:

- Implementing and evaluating approved policies, procedures and standards of care,
- Collaborating with the registered nurse, physician and other health care professionals to plan the delivery of care on the unit and to create joint protocols for patient care, and
- Evaluating the outcomes of patient care; using patient satisfaction information to recommend and integrate appropriate changes.

• **Clinical Nurse Specialist**

The Clinical Nurse Specialist (OOD 23c) is responsible for promoting, competent, compassionate and professional nursing care for patients and families across the continuum. The Clinical Nurse Specialist supports decision-making at the unit level by:

- Responding to change in clinical practice by planning, designing, implementing and evaluating guidelines, protocols and standards in collaboration with the Nursing Director and care team,
- Identifying current trends in health care and their implication for nursing practice, and,
- Applying new technology, nursing theories, research findings and experiential knowledge to improve nursing practice.
• **Staff Nurse**

With the unit-based leadership from the triad and with structure of the Professional Practice Model, the Staff Nurse is able to focus clinical decision-making at the bedside. As articulated in the Staff Nurse position description (OOD 23e), the nurse is responsible for assuring competent, compassionate, individualized, nursing care for specific patients and families. This includes delegating to and supervising non-professional and support staff. Using scientific principles, the use of nursing process and a primary nursing model to support decision-making, the Staff Nurse:

- Identifies, facilitates, and evaluates outcomes of nursing care for an individual patient or group of patients,

- Coordinates involvement of the patient, family and health team members in patient care, including patient/family teaching and discharge planning, and,

- Participates in unit and departmental committees for formulation of nursing and hospital policies and procedures.

**Communication Strategies**

In addition to having streamlined structural and operational relationships, communication is essential to maintaining strong relationships with nurses in this complex environment. The Chief Nurse uses a variety of strategies to stay connected with and to the nurses at all levels of the organization in the decision-making process. These strategies include:

- Off-site retreats with Staff Nurses and nursing leadership to help guide decision-making within the department. Attachment 2.3.c is the agenda from the Magnet Redesignation Kick-Off Retreat in which nurses from all levels of the organization were involved in making decisions about the direction for the launch of the Magnet Redesignation process;

- Routine meetings and retreats with the Patient Care Services Executive Committee (PCSEC) and her senior clinical management team to develop and implement the PCS Strategic and Operating Plan. Attachment 2.3.d and OOD 13f outlines outcomes from the annual PCSEC Strategic Planning Retreat for 2007;

- Regularly scheduled (weekly) meetings with the Associate Chief Nurses and Nursing Directors to discuss issues specific to nursing;
- Monthly Staff Nurse Advisory Committee – as part of the Collaborative Governance Model, the forum allows staff nurses to communicate issues directly to her and her leadership team;

- Bi-monthly articles in Caring Headlines, the PCS newsletter, reaching all nurses and staff within PCS and across the hospital, includes an editorial from the Chief Nurse to staff (attachment 2.3.e);

- Bi-monthly PCS News You Can Use, an electronic e-mail newsletter established in 2006 to share time-sensitive information with all nurses and staff within PCS and across the hospital (attachment 2.3.f);

- Meetings with nursing staff in areas outside the Department of Nursing to keep staff up-to-date on issues related to nursing and nursing practice. For example, in June 2006 the Chief Nurse held a meeting with the nurses in the ambulatory practice setting to discuss topics pertinent to their work life and practice. Agenda items covered in that session included: a progress report on the plans for the new building, an introduction to the Institute for Patient Care, an update on the Massachusetts Patient Safety Act and Staffing Ratio legislation about nursing staffing and information regarding the strategic planning process for Patient Care Services.

In summary, using the PCS Strategic and Annual Operating Plan and Collaborative Governance Model as framework, the Chief Nurse has organized her management team structure in a way to create streamlined operational relationships throughout the organization. This operational structure, along with the defined roles of nurses at all levels of the organization clearly support unit-based decision-making and giving nursing a strong voice in the decision-making process throughout the organization.
Cancer Center Nursing Practice Committee
Membership List

Coaches:
- Susan Finn, RN, Clinical Nurse Specialist, Cancer Center Adult Infusion Unit
- Barbara Cashavelly, RN, Nursing Director, Cancer Center Ambulatory Practices

Chairs:
- Alicia Rounds, RN, Staff Nurse, Thoracic Surgery/Ellison 19
- Pat Ostler RN Research Nurse, Thoracic Disease Center, Yawkey 7

Members:
- Mimi Bartholomay, RN, Clinical Nurse Specialist, Cancer Center Adult Infusion Unit & Radiation Oncology
- Cindy Knauss, RN, Staff Nurse, Outpatient Bone Marrow Transplant/Cox 1 & Inpatient Oncology/Ellison 14
- Andrea Hansen, RN, Staff Nurse, Cancer Center Adult Infusion Unit/Yawkey 8
- Gail Umphlett, RN, Staff Nurse, Radiation Oncology/Yawkey 8
- Jeanne Griffin, RN, NP, Nurse Practitioner, Thoracic Oncology Team
- Esther O'Dette, RN, Staff Nurse, GI Oncology Practice Nurse
- Rachel Bolton, RN, Staff Nurse, Proton Center (Pediatrics)
- Corrina Lee, RN, Staff Nurse, Inpatient GYN Oncology/Bigelow 7
- Loren Winters, NP, Nurse Practitioner -Breast Oncology/Yawkey 9
- Emily Kramer Olson NP, Nurse Practitioner GI Oncology/Yawkey 7
- Diane Smith, RN Staff Nurse & Practice Nurse, Hematology/Lymphoma Disease Center
- Judianne Henderson, NP, Nurse Practitioner, Sarcoma Center/Yawkey 7
- Leah Gordon- Rowe, RN, Staff Nurse, Cancer Center Adult Infusion Unit/Yawkey 8

Note: Yawkey locations are all ambulatory-based practices.
**Cancer Nursing Practice Committee**

**Date:** September 6, 2006  
**Location:** Yawkey 7970  
**Coaches:** Barbara Cashavelly RN, Susan Finn RN  
**Co-Chairs:** Alicia Rounds RN, Pat Ostler RN  
**Present:** Diane Smith RN, Rachel Bolton RN, Gail Umphlett RN, Pat Ostler RN, Emily Olson RN, Sue Finn RN, Barbara Cashavelly RN, Mimi Bartholomay RN

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| Retreat     | **Date:** October 18<sup>th</sup>, 2006  4:30PM-6:45PM  
Need to present overview of mucositis and port-a-cath groups work. We will also present the purpose of the Practice committee is to try to recruit new members and also ask for suggestions of future work.                                                                                               | Pat will present mucositis overview. Barbara and Sue will discuss who will do PAC presentation |
| Mucositis Group | • Discussed which scales to use for assessing degree of mucositis should be one recommended for consistency  
• Update on PowerPoint for Nursing Grand Rounds 9/13/06  
• Nursing Pocket Guide;  
Discussed way to make pictures of mucositis with scale readily available to staff nurses if unable to get pocket guide funded. Thought if policy put on line maybe we could link it to pictures. Afraid if we did get cards, how many would use and how quickly would we be out of them.  
• Policy should be imbedded in the new cancer center nurses course and will be should be included in the online MGH Policy and Procedure Manual. | • Group felt it should be CTC so all would easily understand it.  
• Mimi and Alecia/ Rachel et al completed power-point presentation  
• Concerned too many clicks would be overwhelming to busy nurse who needs information. Mimi will continue to pursue funding options by asking Tom Lynch for money. SUCCESSFUL  
• Sue to work on |
| Portacath Group | • Review of central Catheter booklet  
Alecia/ Rachel et al discussed differences in flushing/ dressing change techniques etc. and need to change MGH policy that is different from overall medical community before we can put recommendations in booklet. Need evidence of CDC guidelines etc, have literature, just need to gather together. Need to rewrite policy to back up what we put in booklet. | • Will put booklets on hold and rewrite policy first.  
• Next Meeting of Port a cath group 9/19/06 |
## Magnet Champion Retreat Agenda
- **December 4, 2006**

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<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter/Facilitator</th>
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<tbody>
<tr>
<td>8:00 am to 8:30 am</td>
<td>Continental Breakfast</td>
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| 8:30 am to 9:30 am  | Welcome/Presentation  
                      Nursing at MGH: The Three Things  
                      that Make You Most Proud                                     | Jeanette Ives Erickson, RN                                  |
| 9:30 am to 9:45 am  | Break                                                                  |                                                            |
| 9:45 am to 10:15 am | Magnet Re-Designation:  
                      An Overview                                                      | Marianne Ditomassi, RN  
                      Keith Perleberg, RN  
                      Sheila Golden-Baker, RN  
                      David Reisman                                                   |
| 10:15 am to 10:30 am| The Denver Magnet Conference  
                      Experience                                                      | Kate Boyle, RN  
                      Heather Fealtman, RN  
                      Joanne Parhiala, RN                                             |
| 10:30 – 10:45 am    | Break                                                                  |                                                            |
| 10:45 am to 11:15 am| DISCOVER-  
                      3 Outstanding Examples of Practice on your unit                  | Suzanne Algeri, RN  
                      Joanne Parhiala, RN  
                      Gayle Peterson, RN                                              |
| 11:15 am to 12:00 pm| COMMUNICATE- Strategies for Getting Out the Message                    | Magnet Ambassadors  
                      Adele Keeley, RN                                                  |
| 12:00 pm to 1:00 pm | Working Lunch: Champions,  
                      Ambassadors, Nurse Managers,  
                      Clinical Nurse Specialists and  
                      Associate Chief Nurses                                           | Angelleen Peters-Lewis, RN                                      |
| 1:00 pm to 1:45 pm  | MOTIVATE: Maintaining MAGNET MOMENTUM before,  
                      during and after the Site Visit                                   | Sheila Golden-Baker, RN  
                      David Reisman                                                     |
| 1:45 pm to 2:30 pm  | Putting Your Plan on Paper                                             | Sheila Golden-Baker, RN  
                      David Reisman                                                     |
| 2:30 pm to 3:00 pm  | Closing Remarks & Presentation of Tool Kit                             | Keith Perleberg, RN  
                      Sheila Golden-Baker, RN  
                      David Reisman                                                     |
Day 1:

I. Levers of Control

- J. Ives Erickson provided an overview of the key concepts of Levers of Control.
  - There is a balance of tensions between top down direction versus bottom up creativity; unlimited opportunity versus limited attention; and self-interest versus the desire to contribute.
  - This balance of tensions involves moving toward a philosophy of customer/market driven strategy, customization, continuous innovation, meeting customer needs and empowerment.
  - An example of this balance of tensions is patient/family needs versus organizational survival (financial).
  - The four “levers” include: 1) belief systems, 2) boundary systems, 3) diagnostic control systems and 4) interactive control systems. People can thrive if leaders use all four of these levers.
  - **Belief systems** are core values and provide inspiration and direction. The Patient Care Services vision, values and guiding principles were referenced as an example. J. Ives Erickson asked the group if the workforce is aware that we’ve articulated this. Many felt that their staff model these beliefs but that they may have never seen this documented.
  - **Boundary systems** identify risks to be avoided and define limits of freedom. They are used to set limits on opportunity seeking behavior that can potentially derail the larger agenda. Modifying the charges for the Collaborative Governance Committees to make boundaries clear was stated as an example.
  - **Diagnostic control systems** are critical performance variables that communicate business strategy, set & support clear targets and conserve top management attention. The nursing dashboard was cited as an example. This dashboard needs to be user friendly, meaningful, include all disciplines and be readily available to staff. A potential need for a PCS Collective Dashboard that captures metrics for all disciplines in order to facilitate a unified [PCS], multidisciplinary approach to achieving goals was discussed. Information in the dashboard should be supplemented with interpretation of the data from leadership personnel. A member of the group commented further by stating that we are currently giving mixed signals to the staff – we want them to advance but we don’t involve them in the every day work (e.g. not everyone has email access). There is a desire within the workforce for a stronger link and regular access to PCSEC members.
  - **Interactive control systems** identify strategic uncertainties and trigger organizational learning.
II. Current Reality Discussions
J. Ives Erickson reviewed key information from each of the mini retreats – Quality & Safety, Diversity, Magnet and Collaborative Governance. Results from the communication survey were also shared with the group, as well as other important issues including capacity expansion & management, Building “3C”, Cbeds, The Institute for Patient Care, The Center for Global Health & Disaster Response, The Island Hospitals and Employer of Choice. Finally, a framework for becoming a learning organization was shared as well.

III. Annual Goals
- Each member of the group shared his/her goals for 2007 in the categories of Clinical Recognition & Collaborative Governance participation, cost management, diversity, quality & safety and team and how each incorporated aspects of the Levers of Control.

IV. Brainstorming/ Discussion
- The group worked to identify the five things we are going to do differently. The key themes that emerged:
  - People
  - Communication
  - Respect
  - Service
  - Access – standards, control, learning
  - Engage staff in decision making
  - Using technology as an enabler
  - The group agreed that these themes were focused on the workforce and identified several tactics.
  - Each member of the group was asked to review this list of tactics and to select his/her top five.
  - This was the focus of discussion on Day 2.

Day 2:
V. Group Exercise
- The top 5 tactics identified to support the PCS workforce:
  1. Increase diversity in the workforce
  2. Improve the physical environment of care
  3. Create and improve systems and provide adequate resources that enable staff to do their job
  4. Work with staff to create new patient care delivery models
  5. Eliminate staff physical injuries

- The large group was split into 4 groups and assigned one of the tactics. Each group was asked to identify a strategy statement, tactics, data needs, workforce boundaries, connection to PCS vision, values & guiding principles and organizational learning/communication strategy.
- Each group was then asked to identify what could be accomplished in the next 6 months and resource/funding requirements.
VI. Initial Next Steps
- Refine group proposals – November 14th PCSEC Meeting.
- Meet with Peter Slavin to review proposals.
- George Reardon will work with HR and the Knight Center to arrange Lean Training.
- Communication Council will develop a communication strategy incorporating feedback from the survey and communicating outcomes from the retreat(s).
- Implement the items identified in each group’s proposal over the next 6 months.
- Reconvene at a retreat in April to review progress.

VII. Additional Next Steps
- Pat Rowell will explore feasibility of expanding employee services, e.g. chair massages
- Need to get concrete regarding how to create a learning organization.
- J. Fitzmaurice & E. Flaherty will critically review datasets to determine what data is required for us to accomplish our work.
- Revisit agendas for PCSEC:
  - Should agendas be more open to promote dialogue and problem solving?
  - Should PCSEC meetings be held on Wednesdays (following GEC & Chiefs Meetings) to enhance communication flow?
  - Should quality be a topic on each PCSEC agenda?
- Consider inviting additional leadership from the therapy and social services departments to joint NM/PCSEC meetings.
- Hold a retreat with advanced clinicians, clinical scholars and Barbara Blakeney, Innovations Specialist, to identify opportunities for innovations in practice, education and research.
- Address recommendations and pending decisions from mini retreats.
Jeanette Ives Erickson

Bottom line: it’s all about the patient

In a major, world-class, academic medical center like MGH, we are perpetually evolving. Systems change. Buildings change. Protocols change. But one thing remains steadfastly constant, and that’s our unwavering commitment to provide the highest quality care to our patients.

As we start this new year, we renews our commitment to provide exemplary care, to bring needed services to the community, and to share our knowledge and passion with the next generation of caregivers.

Our commitment to do right by our patients manifests itself in many ways. Ensuring that care is delivered in a safe, clean, and uncluttered environment is one of our highest priorities. Patient- and staff-safety are at the core of every decision we make. So important is our quality and safety agenda, the hospital recently created a new position: senior vice president for Quality & Patient Safety. After an extensive national search, our own Gregg Meyer, MD, was selected to take on this important role.

Patient Care Services created its own Office of Quality & Safety which is located in the Professional Office Building on Cambridge Street. Employees should avail themselves of these resources (and/or unit-based safety resources) in addressing any quality or safety issue that arises, no matter how small.

I think it’s important to remember why we chose careers in health care in the first place. We were called to the caring professions we hold. We were drawn by a desire to help others. We aspire to excellent patient care, not because it’s required by regulatory agencies but because it’s the right thing to do for our patients.

It’s easy to get side-tracked in the fast-paced, rapidly changing world of health care. But as I reflect on the important work we do, it really seems very simple. We just need to remain true to our basic values. We need to focus on what’s best for our patients. And we need to help each other as we go about our daily work.

Caring for patients is by its very nature, collaborative. Teamwork, within and among disciplines, makes us stronger. Sharing knowledge, information, and decision-making makes us a better, more cohesive team.

Every observation and intervention should be documented to ensure continuity of care and a seamless transition of services. And all documentation should adhere to the rules of acceptable abbreviations.

From smooth, well-communicated hand-offs, to medication reconciliation, to involving patients in discharge planning, every action is driven by a solemn commitment to our patients’ safety and well-being—a commitment we take very seriously.

When the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) visited our campus a few weeks ago, I was proud of the clinicians and support staff throughout Patient Care Services who represented us so well, making our work and our care documented on next page...
Unacceptable abbreviations

<table>
<thead>
<tr>
<th>Unacceptable abbreviations</th>
<th>Intended meaning</th>
<th>Correct entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.O.</td>
<td>Latin abbreviation for once daily and every other day</td>
<td>Write “daily” and “every other day”</td>
</tr>
<tr>
<td>Q.O.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M.S.</td>
<td>morphine</td>
<td>Write “morphine sulfate” or “magnesium sulfate”</td>
</tr>
<tr>
<td>MgSO4</td>
<td>magnesium sulfate</td>
<td></td>
</tr>
<tr>
<td>H.S.</td>
<td>half strength or hour of sleep (at bedtime)</td>
<td>Write “half-strength” or “at bedtime”</td>
</tr>
<tr>
<td>“0” after a decimal point</td>
<td>1 mg</td>
<td>Do not use a zero after a decimal when expressing whole numbers</td>
</tr>
<tr>
<td>(1.0 mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No “0” before a decimal</td>
<td>0.5 mg</td>
<td>Always use a “0” before a decimal when the dose is less than a whole unit</td>
</tr>
<tr>
<td>(5 mg)</td>
<td></td>
<td>Write “sliding scale”</td>
</tr>
<tr>
<td>µg</td>
<td>microgram</td>
<td>Write “µg” or “mg”</td>
</tr>
<tr>
<td>U or u</td>
<td>unit</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU</td>
<td>international unit</td>
<td></td>
</tr>
<tr>
<td>Apothecary symbols</td>
<td>Dram</td>
<td>Use metric system</td>
</tr>
<tr>
<td>Per os</td>
<td>Minim</td>
<td>Write “PO,” “by mouth,” or “orally”</td>
</tr>
<tr>
<td>qn</td>
<td>nightly or at bedtime</td>
<td>Write “nightly”</td>
</tr>
<tr>
<td>BT</td>
<td>bedtime</td>
<td>Write “bedtime”</td>
</tr>
</tbody>
</table>

Medical Interpreters

Every patient has the right to a medical interpreter at no charge. Medical interpreters help protect patient confidentiality, informed consent, the accuracy and integrity of the patient-caregiver interaction, and the delivery of culturally competent care. Medical interpreters are available Monday-Friday: 7:00am-midnight Saturday and Sunday: 8:00am-10:00pm Off hours and holidays: Spanish interpreter: Call: 4-5700, pager #4-0001 Other languages: Call: 4-5700, pager #3-0008 Request a medical interpreter when you have a patient who is non-English speaking, deaf, or hard of hearing.

Advance Directives

An advance directive is a document signed by an adult patient providing instructions on how to make healthcare decisions in the event he/she becomes unable to make decisions on his/her own. One type of advance directive is a Massachusetts Health Care Proxy, which names a person to make decisions for the patient. Other types of advance directives describe the kinds of treatment the patient would like to receive or refuse, and are often referred to as living wills. Federal law requires health-care institutions to put a mechanism in place to ask patients if they have an advance directive. Massachusetts has selected the Health Care Proxy as the preferred form of advance directive.

The MGH Tobacco Treatment Service

Under the current standard, all patients should be asked if they’ve used tobacco products in the past 12 months. If they have, the Tobacco Treatment Service should be notified. A consult (5-7445) should be made. In the smoke-free environment of the hospital, The Tobacco Treatment Service can help patients avoid symptoms of nicotine withdrawal. Every patient who has smoked in the past 12 months should be given a copy of the Guide for Hospital Patients Who Smoke (Standard Register form #64772). A copy of the guide is placed at every patient’s bedside when the room is cleaned. Helping patients to quit smoking is part of the excellent care all clinicians provide at MGH.

Make your practice visible

Document your work

For more information, or to request a quit-smoking consult, call 5-7443.
PCS NEWS
you can use

Information for the staff of MGH Patient Care Services

THURSDAY, NOVEMBER 30, 2006

HAVEN gifts
HAVEN gift-giving — December 14
Each year the PCS community comes together to brighten the holiday season for many of the patients and families who are victims of domestic violence and receive services through the MGH HAVEN Program — Hospitals Helping Abuse and Violence End Now. There are still a dozen or more HAVEN families who have not yet been “adopted” for the holidays. If you would like to participate, e-mail Lulu Sanchez in Interpreter Services, lsanchez@partners.org

HAVEN gift drop-off (December 14):
6:30am-7:30am Dietary Conference Room, Blake basement
10:00am-2:00pm East Garden Room, White basement
(next to the stairway connecting the Blum Center and the cafeteria)

Holiday Fair
Annual PCS Multicultural Holiday Fair — December 14
The Annual PCS Multicultural Holiday Fair will be held December 14 from 10:00am – 2:00pm, in the Main Corridor, featuring seasonal music and information about holiday observances throughout the world. All are welcome to join the festivities, which are sponsored by the PCS Diversity Committee.

Sports Medicine Center opens
MGH Sports Medicine Center up and running
Patients with exercise, sports or athletic-related injuries can now benefit from the best in medical and rehabilitative care under one roof. MGH recently opened its new state-of-the-art MGH Sports Medicine Center, located at 175 Cambridge Street. The center is comprised of nationally known physicians, physical therapists and nurses, exclusively dedicated to the care of athletes. For more information or to schedule a referral, call (617) 643-9999.

PCSNEWS you can use archives can be found at: www.massgeneral.org/pcs/news/news_index.asp
A CBeds progress report

Nursing — in collaboration with Admitting Services and Information Systems — is approaching the halfway point in the Coordinated Bed Efficiency Dashboard System (CBeds) implementation. Currently 18 patient care units, the Post-Anesthesia Care Unit, the Same Day Surgical Unit, and Admitting are live on the new system. Thanks to staff in all these areas for their invaluable support. The remainder of the patient care units and the Emergency Department will go “live” by mid-January.

CBeds is a key initiative designed to improve capacity management by using technology to enhance patient placement and communication, and support room turn-over. For more information contact your operations coordinator or nurse manager.

Durant Fellowship call for applications open through February 1

The Thomas S. Durant, MD, Fellowship in Refugee Medicine supports healthcare professionals in delivering care, services and hope to people ravaged by war, disease, drought, poverty or political unrest. The duration of the fellowship, breadth of experience, and follow-up activities are defined largely by the desire of the fellows and current available assignments and needs. Links to active blogs posted by the 2007 Durant fellows can be found at www.durantfellowships.org.

For more information, please contact the office of Laurence J. Ronan, MD, director of the Thomas S. Durant, MD Fellowship in Refugee Medicine.

PCSNEWS you can use archives can be found at: www.massgeneral.org/pcs/news/news_index.asp