

Caring

Headlines

January 22, 2015

collaboration **PVAC** **Physical Therapy** **service excellence** **Orthotics** **evidence-based practice** **PFACS** **HCAHPS** **Chaplaincy** **Caring** **The SAFER Fair** **Patient journey** **relationship-based care**

Quiet hours **LPASS** **hand hygiene** **enterovirus research** **Ebola** **service excellence** **Orthotics** **evidence-based practice** **PFACS** **HCAHPS** **Chaplaincy** **Caring** **The SAFER Fair** **Patient journey** **relationship-based care**

Respiratory Care **warm hand-overs** **standardization** **Quality & Safety** **culture rounds** **LOS** **Nursing** **Caring** **One year later...** **Hourly rounds** **Excellence** **adopt** **Every Day** **adapt** **Attending** **abandon** **nurse role** **values**

LEAF **service excellence awards** **cleanliness** **CAUTI** **standardization** **Quality & Safety** **2014** **staffing ratios** **Social Work** **documentation** **Caring** **Cultural Rounds** **documentation**

ICUs **safety medication** **Interpreter** **welcoming environment** **budget** **NP/SG** **workflows** **CLABSI** **ownership** **eCare** **Volunteers** **MARS** **vision** **Just Data** **culture** **Diversity** **equitable** **patient flow** **care** **equitable** **discharge** **phone calls** **OR** **see something, say something** **Bed Fair** **NP/SG**

smart phones **care** **Occupational** **Fall-prevention** **MDRO** **MARS** **re-design** **safety** **responsiveness** **guardianship** **Caring** **Fall-Prevention** **Collaborate to extubate** **As simple as ABC...DEF** **Caring** **Pat Rowell Extraordinary Achievement Award** **a highlight of Volunteer Recognition Week** **Speech-Language Pathology** **OR** **see something, say something** **Mathews NEEDY Think SPEEDY** **Locate nearby staff for help, then "text it out".**

A look back at 2014

*meeting the challenges before us with
compassion, creativity, and drive*

Relecting back on the events of 2014, I'm struck by the truth and timelessness of Dickens' famous opening lines, "It was the best of times, it was the worst of times..." Has there ever been a year about which that observation *wasn't* true? Life is a series of highs and lows; how we deal with those extremes is what defines us as a people, as a nation, and as an organization.

This past year was no exception. As a nation, we were outraged by senseless acts of terrorism; civil unrest and racial tension escalated amid episodes of violence; airplanes went missing without a trace; the words, 'polar vortex,' became part of our lexicon; hundreds of thousands doused themselves with water as part of the ALS ice-bucket challenge; the first openly gay football player was drafted into the NFL; and 17-year old Pakistani activist, Malala Yousafzai became the youngest recipient of the Nobel Peace Prize.

Closer to home, MGH and Patient Care Services also had an eventful year as this issue of *Caring Headlines* demonstrates. Every discipline participated in the massive effort to prepare for MGH eCare; we worked tirelessly to bring down costs and make care more efficient for patients and families; our work on Innovation Units yielded positive outcomes and boosted patient-satisfaction; the hospital launched a new Diversity Committee; we made incredible strides in preventing CAUTIs, CLABSIs, and falls, and we spent weeks on high alert monitoring the Ebola epidemic. And when you consider all the contributions made by individual disciplines within Patient Care Services, the list is even more impressive.

Speech-Language Pathology established stronger ties with the MGH Home Base program in providing cognitive remediation to veterans. The department created an internship program in the acute-care setting to enhance the clinical education of students interested in

working in medical speech-language pathology. And director, Carmen Vega-Barachowitz, CCC-SLP, accepted a three-year appointment as a member of ASHLA's Health Care Economics Committee.

Physical and Occupational Therapy continued to enhance their clinical practice through inter-disciplinary collaboration and teamwork, advancing a culture of early patient-mobility in critical-care settings and helping patients manage the emotional and physiological effects of lymphedema. Surrounding patients with a multi-disciplinary team that listens and shares knowledge and experience, they are helping to harness the collective strength of MGH for the good of patients.

Respiratory Care worked with Physical Therapy, Pulmonary Medicine, and Nursing to ensure patients with COPD have proper prescriptions for oxygen and aerosol therapy upon discharge. The department worked with Pediatric Nursing to offer daily asthma education to pediatric inpatients affected by the enterovirus. They oversaw an upgrade to state-of-the-art ventilators and other respiratory devices in ICUs and introduced new vibrating mesh nebulizers that enhance patient safety and provide better dose delivery.

The **Chaplaincy** saw the return of the Clinical Pastoral Education (CPE) Residency for the first time since the 1980s, enabling MGH to resume its leadership role as a training site for professional CPE residents. They collaborated with Volunteer Services and the Cancer Center to expand the Environmental Music Program to public areas such as the White and Lunder lobbies. And the Chaplaincy began offering monthly Hindu Spiritual Gatherings and opened a 'harmony space,' a place for meditation, prayer, and reflection at the Charlestown Navy Yard.



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

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Jeanette Ives Erickson (continued)

In 2014, the **Volunteer Department** saw 1,467 individuals contribute 107,250 hours of volunteer service to patients and staff. The Beacon Program grew 28% providing more than 50,000 inpatient and outpatient escorts. The number of palliative-care volunteer hours almost doubled from 173 in 2013, to 344 in 2014. And last year, the Volunteer Department introduced the MGH North Shore Greeter-Wayfinder program, the Center for Perioperative Care volunteer family liaison, and pediatric volunteers on Yawkey 6.

Orthotics began the year with a move of its fabrication workshop from 60 Staniford Street to a more spacious location in Ruth Sleeper Hall. Their on-call and Saturday coverage increased substantially to help facilitate patient discharges. And in collaboration with Shiners Hospital, the department saw an influx of children from abroad who were able to return home with much-needed, customized orthotics to improve their quality of life.

In **Clinical Support Services**, operations associates played a key role in the conversion to MGH eCare for capacity-management and room-turnover processes. For the first time ever, an operations associate (Susan Pierce-Chana from Lunder 9) was the recipient of the Pamela J. Ellis Memorial Secretarial Award. Staffing for unit service associates and operations associates was re-allocated to better meet the needs of patients 24/7. And both role groups were instrumental in supporting improvements such as, quality-assurance and maintenance of supplies at the bedside; a shared-coverage model for overnight shifts; phone conversion; changes in the recording of critical values; and changes to blood-transfusion forms.

Nursing has been busy on numerous fronts. 2014 saw the launch of the Collaborate to Extubate campaign to promote the ABCDEF Bundle (**A**wakening and **B**reathing trial **C**oordination for intubated patients; **D**elirium assessment and management and early **E**xercise; **F**amily involvement) in adult ICUs, the PICU, and RACU. We were fortunate to host a number of visiting scholars, including: Carol Hall Ellenbecker, RN, professor at the College of Nursing and Health Sciences at UMass, Boston (Albert H. Brown visiting scholar); Vicky Vaughn Dickson, RN, nurse practitioner and assistant professor at New York University College of Nursing (Cardiac Nursing Visiting Scholar); and Jan Bellack, RN, president of the MGH Institute of Health Professions (Linda Kelly Visiting Scholar).

Nursing launched the Addictions Consult Team, and in collaboration with others, the Clinical Technologies Oversight Committee, the Product Value Analysis Committee, and the delirium and pain tiger teams. MGH and the MGH Institute of Health Professions continued to partner in the innovative, clinical-education model enhancing inter-professional collaboration and patient outcomes in the Inter-Professional Dedicated Education Unit.

In partnership with other departments, Nursing helped coordinate a number of conferences and activities, including The Cancer Center's annual, Through each other's eyes: sharing what we've learned from living with cancer conference; Comfort Zone Camp, a one-day bereavement program for children who've lost a parent; the NICU Parent Forum; and the Pediatric Psychiatry Conference.

Nursing was instrumental in a number of improvement initiatives including re-designing the Patient Observer Model; introducing an innovative new PICC-line placement process using electrocardiographic guidance; developing the new Estimated Date of Discharge Tool; and contributing to numerous strategies to improve the patient experience.

In the OR setting, nurses have been putting the OR Learning Laboratory Simulation Suite to good use. Vascular OR nurses and interventional radiology physicians meet for skills and team-building simulations focusing on endovascular procedures. Surgical team training brings multi-disciplinary teams together to care for patients in simulated crisis or rarely encountered, high-risk situations.

This year, the Perioperative Service launched ORTV, a digital signage system that delivers essential information and nursing education to staff in a community-oriented way. And they introduced Metavision, electronic documentation for perioperative nurses (the equivalent of eBridge in the inpatient

setting). Metavision allows for a continuous flow of patient information from the first perioperative encounter right through discharge.

To support surgical technologists and OR nurses seeking certification in their fields, review classes were established to help prepare them to sit for exams. As a result of these classes, more than 15 surgical technologists and OR nurses successfully passed their certification exams last year.

You can see why I say we had an eventful year. These are only a few of the outcomes we realized in 2014. I thank you all for your commitment to do right by our patients and families, and for the spirit and enthusiasm you bring to MGH every day. I think inherent in Dickens' observation about the best of times and the worst of times is an understanding that humans naturally rise to meet the challenges before them. And in so doing, we bring out the best in one another and ourselves. That has certainly been the case at MGH. We would not be where we are without your compassion, creativity, and drive. I'm privileged to work with the most exceptional team in health care.

I hope you enjoy this year-end issue of *Caring Headlines* and this look back at the most recent chapter in our incredible journey.

These are only a few of the outcomes we realized in 2014. I thank you all for your commitment to do right by our patients and families, and for the spirit and enthusiasm you bring to MGH every day... We would not be where we are without your compassion, creativity, and drive.

Learning from the past; planning for the future

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

Every fall, the Patient Care Services Executive Committee convenes to review the achievements of the past year and chart the strategic course for the year ahead. Guiding this process is input from collaborative governance and advisory committees, feedback from patients, staff, and leadership, satisfaction surveys, and many other forums throughout the hospital. Close attention is paid to aligning the work of Patient Care Services with the hospital's overall strategic plan, the greater healthcare environment, and local, national, and international factors that impact care-delivery. (See diagram below for outline of PCS strategic planning process).

The 2014 PCS Strategic Plan

- Optimize the patient experience ensuring a coordinated, standardized, and evidence-based model of care-delivery throughout the Patient Journey
 - Outcomes included enhanced and sustained improvements on Phase I, II, and III Innovation Units through effective education, evaluation, and use of resources. The Center for Innovation in Care Delivery and The Yvonne L. Munn Center for Nursing Research collaborated in evaluating the impact of Innovation-Unit interventions on the patient experience and on quality (see Innovation Unit article on page 6)
- Implement and evaluate the consistent use of standardized documentation tools to support processes for optimizing the patient experience and outcomes
 - Patient Care Services joined the MGH community in successfully implementing the administrative and financial aspects of Partners eCare. Work was conducted to implement new processes and technology consistent with Partners eCare and fully participate in the development of content, reports, testing, and device-integration

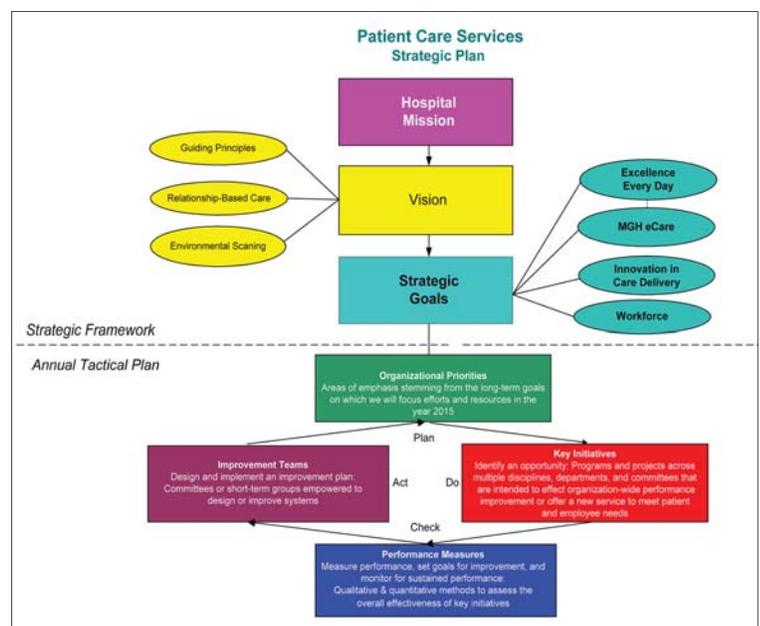
- Create a welcoming, accessible environment that attracts, retains, and develops a culturally competent workforce while embracing the diversity of our patients, their families, our employees, and the communities we serve
- Under the leadership of Deborah Washington, RN, director of PCS Diversity, unit-level culture rounds were launched to enhance staffs' understanding of how culture impacts the patient's plan of care

The 2015 Strategic Plan

Looking forward, several assumptions were articulated to guide the 2015 PCS strategic planning process:

- Partners eCare (the transition to Epic) will require a significant time commitment as well as a dynamic understanding of the end-to-end process, including timing, education, implementation, etc.
- The Joint Commission survey of MGH will occur some time in 2015
- Greater emphasis will be placed on improving quality, safety, and service

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The Strategy (continued)

- Cost-reduction pressures will continue
- Leadership changes may bring a shift in the direction of our work (new governor, attorney general, and Partners leadership)
- Numerous hospital strategies will require our attention
- Capacity challenges will have to be addressed
- High performance is critical to success
- We cannot afford redundancy in our systems
- Developing cultural competencies is critical to our success

After much deliberation, the PCS Executive Committee approved a four-point plan for the coming year. The goals and tactics include:

- Excellence Every Day: optimize the patient experience by providing the highest quality, safest, most efficient care that meets or exceeds the expectations of patients, families, the hospital, or external organizations

Tactics:

- Develop and implement a plan to enhance patient-satisfaction scores (such as quiet, pain-management, and responsiveness)
- Take necessary steps to ensure a successful Joint Commission survey
- Develop and implement a plan to prevent catheter-associated urinary tract infections (CAUTIs) and central-line-associated bloodstream infections (CLABSIs)
- Enhance the culture of safety by implementing strategies to share errors and near misses
- Increase awareness and utilization of the numerous resources available through Interpreter Services to support the delivery of equitable care
- Begin the process of establishing a data warehouse
- Partners eCare: implement and evaluate the use of standardized documentation tools to support the process of optimizing the patient experience and outcomes

Tactics:

- Identify, train, and deploy ‘super-users’
- Estimate, articulate, and plan for the costs associated with implementation and evaluation
- Develop and conduct readiness activities, engaging patients, families, direct-care staff, and unit-level leadership
- Provide training and skill-development opportunities
- Adopt, adapt, or abandon workflow and documentation tools in preparation for Partners eCare
- Innovation in Care-Delivery: enhance the patient experience, ensuring a coordinated, standardized, and evidence-based model of care-delivery throughout the Patient Journey

Tactics:

- Re-examine the 15 Innovation-Unit interventions utilizing input from staff, leadership, and interviews with patients
- Design an implementation and sustainability plan regarding revised Innovation-Unit strategy with a focus on standardization first and customization as appropriate
- Identify and implement interventions to promote throughput and safe hand-overs for patients and families in Phase IV settings
- Workforce: be an employer of choice known for embracing diversity, inclusion, and staff-engagement in order to foster an informed, self-sustaining, creative workforce

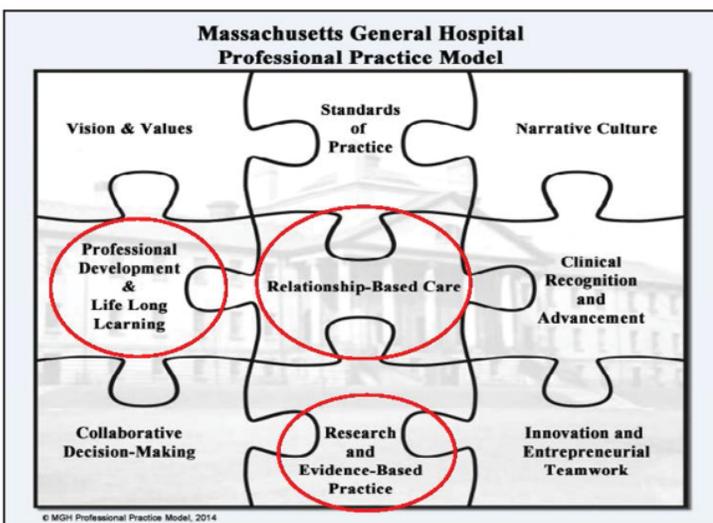
Tactics:

- Develop and enhance communication strategies to leverage input from advisory groups
- Equip managers to support optimal individual performance
- Help hiring managers pursue more leads to enable diverse leadership recruitment
- Increase accommodations for employees with disabilities
- Create a more supportive environment where individuals can raise questions and ask for support

During the 2015 strategic planning process, senior vice president for Patient Care, Jeanette Ives Erickson, RN, proposed three modifications to the Professional Practice Model (see diagram on this page) to ensure it remains relevant and reflective of our current practice environment:

- Professional Development was expanded to include Life-Long Learning
- Patient-Centered Care was changed to Relationship-Based Care
- Research was expanded to include Evidence-Based Practice

These changes were presented at the Innovation Units Retreat held January 15, 2015, during presentation of the 2015 PCS strategic goals. The more than 250 attendees comprised of staff and leadership from all PCS disciplines supported the modifications and the proposed 2015 strategic plan.



Innovation Units

a look back and a look ahead

—by Linda Lacke, senior project manager; and Marianne Ditomassi, RN, executive director for PCS Operations

An Innovation Unit Retreat kicked off the new year. More than 250 participants spent the day reflecting on what's working, talking about what could be done better, and charting a plan for the future... Participants came away with a renewed sense of direction and purpose.

Launched in 2012, MGH Innovation Units were intended to be testing grounds for change—a strategic initiative designed to create an environment for the timely trial of new ideas. The initiative began with 12 inpatient units, and in 2013, more inpatient units were added as part of Phases II and III of the roll-out. To date, 41 inpatient units are designated Innovation Units.

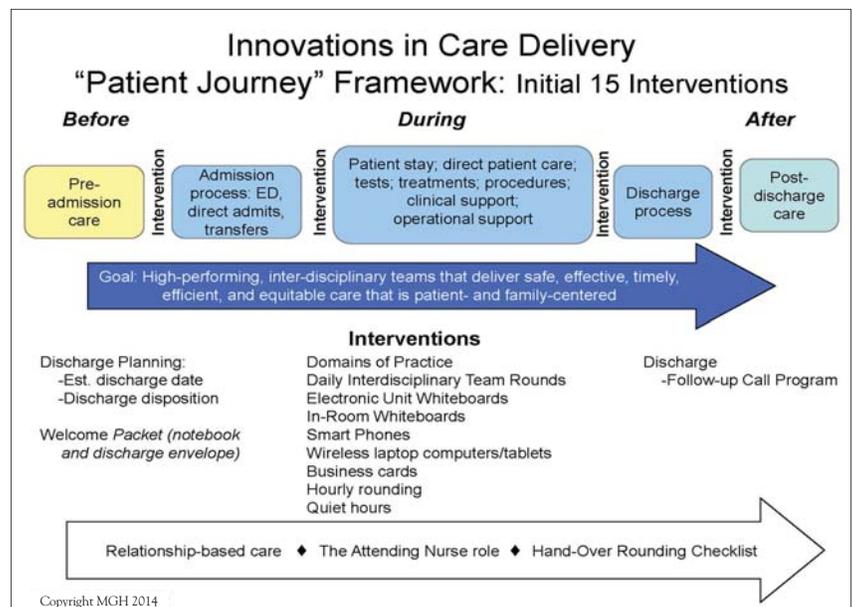
In the inpatient setting, Innovation Units centered around the patient journey. As a backdrop for our work, we created a Patient Journey Framework (see diagram at right)

to depict the process of care before, during, and after hospitalization. At the heart of the Innovation-Unit initiative are 15 interventions that were generated by 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. Continuity is enhanced by standardization wherever possible.

Innovation Unit Evaluation

Innovation Units continued to be evaluated in 2014 with very promising preliminary results. Led by Jeff Adams, RN, and Dorothy Jones, RN, a survey was conducted of staff on Phase I Innovation Units to assess their perceptions of the impact of the interventions. A health services research approach was applied in evaluating the relationship between patient-experience indicators (HCAHPS), quality indicators (NDNQI), Staff Perceptions of the Professional Practice Environment Survey (RPPE), and Leaders Perceived Influence components (LIPPES).

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Findings:

- Respondents to the Intervention Impact Survey perceived that inter-disciplinary team rounds, smart phones, and hourly rounding had the greatest impact on quality and safety; in-room white boards, follow-up phone calls, and the role of the attending nurse had the greatest impact on patient-satisfaction; and inter-disciplinary team rounds, smart phones, and the role of the attending nurse had the greatest impact on staff-satisfaction and cost-efficient care (see chart below right)
- The patient-experience categories: Room Cleanliness, Discharge Information, Nurse Communication, and Quiet at Night showed a statistically significant improvement following implementation of Innovation-Unit interventions on adult units (see chart below)
- Quality indicators such as central line-associated bloodstream infections (CLABSIs), catheter-associated urinary-tract infections (CAUTIs), and fall rates all decreased post Innovation-Unit implementation
- In the presence of professional-practice-environment components, Clinician Control Over Practice and Conflict Management, CLABSI improvement was accelerated with statistical significance
- Pressure Ulcer Stage II improvement shows slight acceleration in the presence of better Clinician-MD Relationships

Evaluation efforts in 2015 will look at the impact of all phases of Innovation Units and any differences that may emerge between them.

We have made clinically significant improvements across the board on adult patient-experience indicators; we have made statistically significant ($p < .05$) improvement in Room Cleanliness, Discharge Information, Nurse Communication, and Quiet at Night; and ($p < .10$) in Overall Rating.

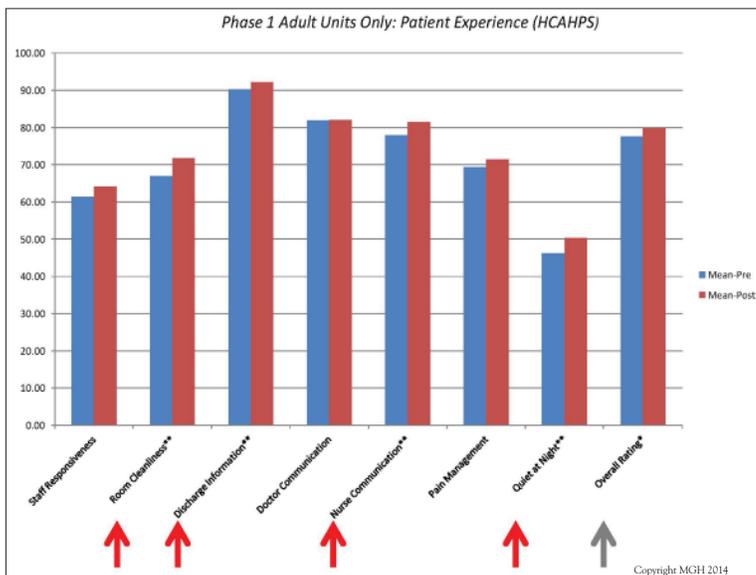
Looking ahead

An Innovation Unit Retreat on January 7th kicked off the new year. More than 250 participants spent the day reflecting on what's working, talking about what could be done better, and charting a plan for the future. Representatives from Phase IV Innovation Units (non-inpatient setting) had an opportunity to learn from the experiences of those who came before and cultivate ideas on how to translate the patient journey framework to their own areas of practice. Participants came away with a renewed sense of direction and purpose.

Some comments shared in the Innovation Unit survey included, "Inter-disciplinary rounding is a great opportunity to make sure all members of the team are on the same page." And, "Implementing strategies to empower our patients to be part of the care team has created a trusting approach to care."

Phase IV Innovation Units

- Anticoagulation Management Service
- Bigelow 10 Dialysis Unit
- Blake 14 Labor and Delivery
- Bulfinch Medical Unit
- Emergency Department
- Outpatient Occupational Therapy
- Outpatient Physical Therapy
- Outpatient Social Work
- Outpatient Speech-Language Pathology
- Perioperative (PACU, OR, CPC, PATA, Endoscopy)
- Radiation Oncology
- Infusion Units (Yawkey 8 and Cox 1)
- White 13 CRC (Research)



Perceived Impact of Intervention (moderately high to high)

Quality/Safety	Patient Satisfaction	Staff Satisfaction	Cost
Interdisciplinary Team Rounding 78%	In-Room White Board 77%	Interdisciplinary Team Rounding 71%	Voalte phones 55%
Voalte phones 74%	Follow-up phone calls 71%	Voalte phones 70%	ARN Role 47%
Hourly Rounding 69%	ARN Role 71%	ARN Role 62%	Interdisciplinary Team Rounding 41%
In-Room White Board 65%	Interdisciplinary Team Rounding 70%	In-Room White Board 62%	
ARN role 65%	Hourly Rounding 67%	Hourly Rounding 59%	
Follow up Phone calls 61%	Voalte phones 64%	Handover communication tool 57%	
Handover communication tool 61%			
Quiet Time 52%	Quiet Time 58%	Quiet Time 50%	
		Follow up phone call 49%	

Improving the patient experience

—by Rick Evans, chief, Service Excellence

2014 brought many challenges. We endured a severe winter and flu season, saw the roll-out of the revenue-cycle portion of Partners eCare, went through a tight budget cycle, and were on high alert for the spread of the Ebola virus. All these issues demanded a high level of focus from staff and leadership throughout Patient Care Services. As a result, though some of our patient-experience metrics improved, many remained relatively constant.

Throughout the hospital, staff continued to hone best practices and advance interventions like, quiet time, hourly safety rounds, discharge phone calls,

and other interventions introduced as part of our Innovation Unit work. Inpatient units worked hard to adopt these interventions and adapt them to their respective practice areas.

In fact, this past year our Nursing Communication scores reached their highest levels ever. The nursing survey domain remains in the top quartile compared to all other hospitals nationwide. Our Communication About Medications domain saw another year of improvement. And our scores for Discharge Information, Overall Rating of the Hospital, and Likelihood to Recommend MGH remain among the highest in the nation. These are achievements we should be proud of in a year that saw so many challenges.

As seen in the chart at left, our commitment to Innovation-Unit interventions has contributed to significant improvement regarding patients' perceptions of their experience at MGH. Despite the challenges, all measures remain substantially higher than they were just a few years ago.

2015 is a new year with new obstacles and new opportunities. Sustaining best practices and ensuring that every patient has a positive experience while in our care remains a top priority. We want to hear more comments like these recorded in our 2014 patient-satisfaction surveys:

"Everyone there [at MGH] was absolutely wonderful. The staff from housekeeping up to the doctors were fabulous. Everyone was very friendly. Everyone was very concerned. The room was amazing."

"Just excellent care. Excellent attention. They considered me as a person, not as a number. Just a delightful experience."

A comparison of our inpatient HCAHPS results from 2011 to 2014.

Survey Measure	Pre-Innovation 2011	2013	2014 YTD	Change (2011 - 2014 YTD)
Nurse Communication Composite	79.4	81.9	82.2	+2.8
Doctor Communication Composite	81.9	82.5	81.7	-.2
Room Clean	69.8	74.5	72.3	+2.5
Quiet at Night	45.2	50.2	49.5	+4.3
Cleanliness/Quiet Composite	57.5	62.4	61.0	+3.5
Staff Responsiveness Composite	63.6	64.7	64.0	+.4
Pain Management Composite	71.5	72.3	71.9	+.4
Communication About Meds Composite	62.7	65.5	66.3	+3.6
Discharge Information Composite	89.8	91.8	91.7	+1.9
Overall Rating	79.1	81.2	80.3	+1.2
Likelihood to Recommend	89.4	90.4	89.9	+.5

Patient-education

a focus on access and quality

—by Brian French, director, The Blum Patient & Family Learning Center

This past year, The Maxwell & Eleanor Blum Patient and Family Learning Center continued to support the MGH community—patients, families, and staff—in numerous ways. Perhaps most notably was the creation of an MGH Patient Education website. A survey of Patient Education Committee champions helped identify certain barriers to effective patient-education, such as difficulty accessing resources and too many options once materials were found. Blum Center staff, in collaboration with the Patient Education and Informatics committees designed an updated intranet site that’s easier to use. The goal was to minimize the

number of steps clinicians had to take to find the site; direct users to preferred sites and standardized materials; and provide easier access to frequently used patient-education materials. MGH-produced materials are highlighted, and links are available to preferred search engines and databases for evidence-based materials in many languages. Staff can access the site through:

- Partners Applications > PCS Clinical Resources > MGH Patient and Family Education Materials & Resources
- Open the yellow folder entitled, “Patient Education,” on the left-hand tool bar in the CAS discharge module

MGH staff can access a wealth of patient-education information via the MGH intranet. Many hand-outs produced by MGH clinicians and national organizations are available. Understandably, choosing the most appropriate materials can be challenging due to the sheer volume of resources. Blum Center staff worked with numerous content experts and groups to review and edit documents so they adhere to recommendations for plain language and to standardize materials as much as possible. Reviewed materials include those for patients with heart failure, coronary artery disease/MI, and pneumonia.

Blum Center staff also worked with content experts to review and update the videos seen on the MGH Patient Education channel. More than 200 educational videos in English and Spanish are now available to patients and families.

This past year, the Blum Center took advantage of its presence on Facebook and Twitter to educate the public and the MGH community about health-related topics and promote the services and programs of the Center. Using social media sites allows Blum Center staff to interact directly with individuals not physically present in the Center and to raise awareness about health and illness, disseminate newsworthy stories, and promote educational programming.

For more information about the services offered by the Blum Patient and Family Learning Center, call 617-724-7352, or ‘like us’ on Facebook (facebook.com/MGHBlumCenter and click “Like.”) or ‘follow us’ on Twitter (twitter.com/MGH_



Cultivating an organizational culture of inclusion

—by Deborah Washington, RN, director, PCS Diversity Program; Robin Lipkis-Orlando, RN, director, Office of Patient Advocacy; and Anabela Nunes, director, Interpreter Services

Leadership, education, and practice are at the forefront of our work as we strive to cultivate a culturally skilled workforce, build effective multicultural teams, and foster an organizational culture that is sensitive to the feelings and circumstances of all.

2014 was a year of influence for the PCS Diversity Program. Several projects aligned our commitment to diversity with internal and external partners. Our work continued to raise awareness about the complexities associated with diversity, making a difference, and the importance of inclusion in all aspects of health care. Leadership, education, and practice are at the forefront of our work as we strive to cultivate a culturally skilled workforce, build effective multicultural teams, and foster an organizational culture that is sensitive to the feelings and circumstances of all.

The Hausman Program

This past year, local schools of nursing convened to explore best practices in campus-based diversity programs. In attendance were out-of-state representatives and spokespersons from The Future of Nursing Campaign. Some of the topics discussed included the importance of culture-based mentoring for ethnic minorities; how diversity programs help level the playing field for students of diverse backgrounds; and that diversity encompasses socioeconomic status, quality of secondary education, and the customs and traditions that govern culturally distinct neighborhoods.

The Hausman Fellowship graduated ten senior minority nurse fellows who are now available to join the nursing workforce. Three Hausman alumnae are presently enrolled in graduate programs.

The Hausman Multicultural Nurses Group, led by nursing director, Kathy Myers, RN, continues its education of students in BSN programs who join the MGH nursing staff after graduation.

The Future of Nursing Campaign

The PCS Diversity Program continues to have a national presence through The Future of Nursing Campaign's Diversity Committee and participation in the Massachusetts State Action Coalition. Together, we are working to increase the number of baccalaureate-prepared nurses and support greater numbers of nurses on organizational boards to make the value of nursing leadership more visible.

Cultural Rounds

Bringing culturally informed education to the workforce remains a priority. The goal is to provide a process through which staff acquire skills to interact with patients, families, and each other in a culturally sensitive way with no bias or preconceived assumptions. Unit-based Cultural Rounds are designed to provide hands-on opportunities to learn while minimizing time away from the unit. Cultural Rounds include case presentations, a review of documentation, or one-on-one observation of culturally informed clinical practice.

External Stakeholders

Community engagement remains a vital component of the PCS Diversity Program. Health literacy, support of minority nurse organizations, and customized training programs are at the forefront of our nationally recognized approach to diversity and inclusion. PCS diversity initiatives are sought by organizations across the country.

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Diversity (continued)

Special Events

Black History Month and the YWCA's Stand Against Racism event continue to engender organization-wide participation from staff and leadership. These events promote mindfulness of issues that continue to shape our local and national consciousness about diversity and inclusion.

The Hausman eMentoring program began in 2014. These webinars are intended to enable minority nursing students to mentor other minority nursing students with the participation of minority faculty. This program is conducted in partnership with the University of Mississippi Medical Center School of Nursing.

Disabilities Awareness

This past year, the MGH Accessibility Resource Site (MARS) was launched as a part of our commitment to meet the needs of patients with disabilities. The site provides access to all resources and equipment available for patients and families with disabilities. Individuals can search for specialty equipment, such as adaptive call bells, portable lifts, hearing amplifiers, and more. The site offers a 'Learn About' section with suggestions about how to accommodate a variety of disabilities, frequently asked questions, and links to related internal and external sites. MARS is a perfect complement to the 'Excellence Every Day Disabilities portal page which has a wealth of information, including policies, updates, a calendar of events, and news articles. Lunch and learn sessions will be offered in 2015 for staff who want customized training on MARS.

The Disability program continues to lead the way in removing barriers and ensuring accessibility to care and services for all MGH patients and families.

Interpreter Services

Diversity is at the very heart of the work of MGH medical interpreters who, every day, help improve the health and well-being of the diverse communities we serve. Last year, Medical Interpreter Services engaged in nearly 100,000 patient and/or provider encounters.

Interpreter Services reflects the diversity of our patient population with interpreters from Cambodia, Russia, the Sudan, Argentina, Colombia, Morocco, and many other countries. They pride themselves on providing a cultural and linguist bridge enabling patients and families to access the highest quality care.

In many cases, MGH interpreters have been in similar life situations as the patients and families they interpret for. Not only are they able to communicate in a language that patients understand, they can inform the discussion with first-hand knowledge of circumstances and traditions ensuring the exchange is

culturally meaningful and appropriate.

While diversity can sometimes be an obstacle to communication, MGH interpreters help overcome those obstacles, establishing an empathetic and therapeutic relationship between patients and caregivers. MGH medical interpreters are privileged to be part of the health-care team and contribute to the delivery of the highest quality care to our increasingly diverse patient population.



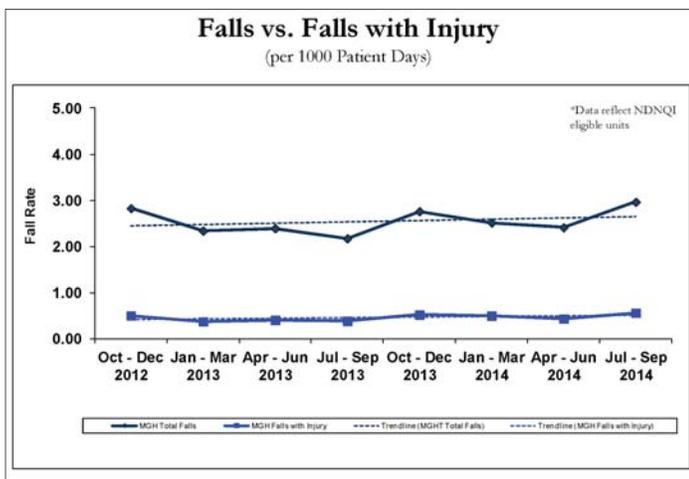
Director of PCS Diversity, Deborah Washington, RN (right) conducts Cultural Rounds with staff nurse, Maybelle Besem Mbiatem, RN, and patient on the White 10 Medical Unit.

Best practices and nurse-sensitive quality indicators

—by Colleen Snyderman, RN, director, PCS Office of Quality & Safety

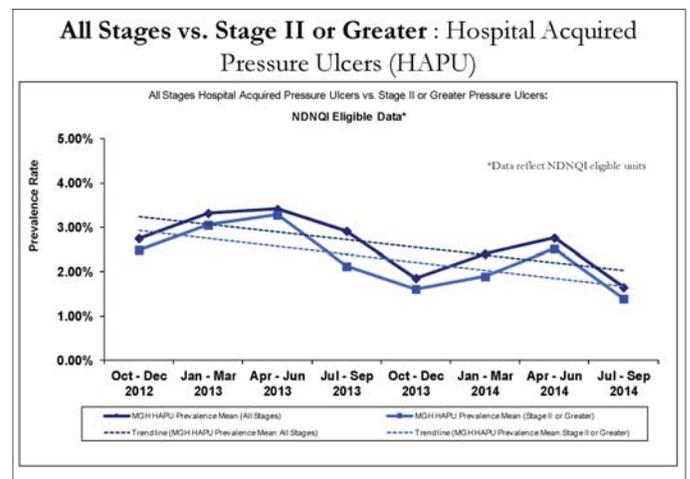
Quality

Clinical-quality, nurse-sensitive indicators help us measure and track aspects of patient care shown to be sensitive to nursing interventions. PCS leadership uses this data to guide decisions about performance-improvement, research, and innovative solutions. Specific tactics are determined by unit leadership to improve unit-level performance. Best practices are reflected in positive trends. The following graphs illustrate our performance for each clinical-quality, nurse-sensitive measure. As indicated below, for more information about each clinical-quality measure, refer to the Excellence Every Day portal page referenced beside or below each graph.



Portal page: http://www.mghpcs.org/eed_portal/EED_fallprevention.asp

- Falls Committee
- Daily fall-risk assessment
- Double-sided, non-skid socks
- Use of bed alarms, low beds, and mats
- Room signage to assist in communicating patient needs to care team
- Unit efforts focused on specific patient-population characteristics (e.g., Neuro)

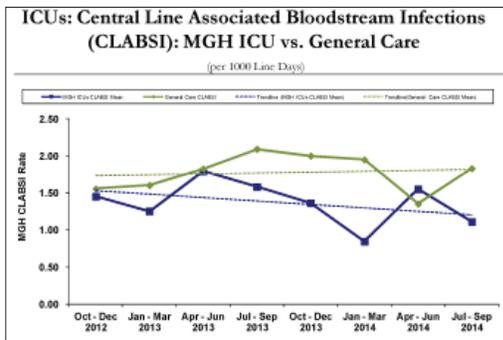


Portal Page: http://www.mghpcs.org/eed_portal/EED_skin.asp

- Skin Committee
- SKIN Bundle
- Attention to assessment of skin on admission
- Expert wound consultation
- Use of specialty beds (e.g., dolphin mats)
- Prevention efforts related to devices such as tracheostomies and drains

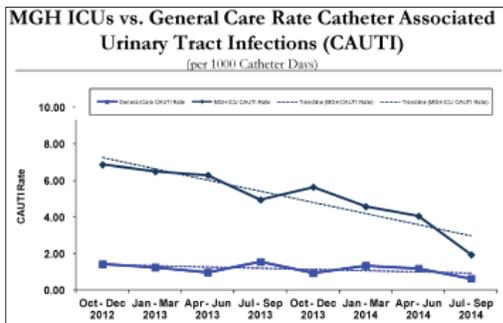
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Quality & Safety (continued)



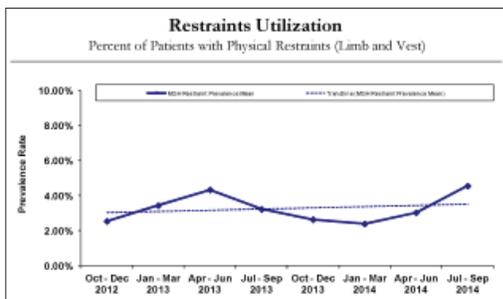
Portal Page: http://www.mghpcs.org/eed_portal/EED_centrallines.asp

- Critical Care Quality & Safety Committee charged with interdisciplinary CLABSI-improvement
- Insertion checklist
- Daily assessment for removal of central lines
- Bio-Patch
- Chlorhexidine bathing for ICU patients
- Scrub the Hub campaign



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

- CAUTI Interdisciplinary Task Force
- Indications for use embedded in POE template
- Daily assessment for removal of urinary catheters demonstrates a decrease in utilization rates
- Avoid-Reduce-Maintain (ARM) Bundle
- Audits focused on catheters being secured shows a 94% compliance rate



Portal Page: http://www.mghpcs.org/eed_portal/EED_restraints.asp

- Restraint Solutions Committee
- New non-restraint equipment available (e.g., sensory mitts and sleeves)
- eBridge restraint note template to improve documentation reflects patient need, provider order, and required elements

Safety

PCS leaders work with staff of the MGH Center for Quality & Safety and the PCS Office of Quality & Safety to conduct root-cause analyses, develop improvement plans, and follow up on serious safety events and significant near misses, such as: falls with injury; medication errors; adverse patient outcomes; and professional conduct events. Improvement plans can result in area-specific or organizational improvements that may require education, system-improvements, and/or changes in policies. Communication about these improvements is based on severity and risk and may occur in many ways including: policy changes; HealthStream classes; one-on-one training; practice alerts; articles in *Caring Headlines*, and/or Tuesday Take-Aways. Some of the topics addressed in 2014 were:

- Medication safety
- Non-tunneled central-line removal
- Blood transfusion documentation

- Critical lab results
- Controlled-substance administration practices
- Fall-prevention interventions
- Application of heat and cold
- Timing of urine cultures and catheter-associated urinary-tract infection (CAUTI)
- Glucometry and wrist-band scanning
- PICC line removal
- Regulatory requirements and controlled substances

PCS is working hard to ensure compliance with controlled substances. We are collaborating with a number of departments including: the PCS Office of Quality & Safety; Nursing; The Knight Center for Clinical & Professional Development; Pharmacy; Compliance; Police & Security; Human Resources; Occupational Health; Employee Assistance; and a number of external resources. Leadership and staff have received extensive training on surveillance and best practices related to controlled substances, and this work will continue in 2015.

National Patient

National Patient Safety Goal	Elements of Performance
Identify Patients Correctly	<ul style="list-style-type: none"> • Use at least two patient identifiers when providing care, treatment, and service • Eliminate transfusion errors related to patient misidentification
Improve Staff Communication	<ul style="list-style-type: none"> • Report critical results on a timely basis
Use Medications Safely	<ul style="list-style-type: none"> • Before a procedure, label medications , containers or solutions • Reduce harm associated with anticoagulants • Maintain and communicate accurate patient medication information
Use Alarms Safely	<ul style="list-style-type: none"> • Every alarm annunciated or signal warrants action • Individualize patient specific parameters to decrease unnecessary alarms • Remove monitoring from patient when no longer needed
Prevent Infections	<ul style="list-style-type: none"> • Use hand hygiene • Use evidence-based guidelines to reduce hospital acquired infections (HAI) such as CLABSI and CAUTI and infections after surgery • Educate patient and their caregivers about how to prevent hospital infections
Identify Patients at Risk	<ul style="list-style-type: none"> • Identify patients most likely to commit suicide
Universal Protocol	<ul style="list-style-type: none"> • Perform universal protocol (UP)(pause) during invasive procedures to ensure correct patient, correct procedure, correct site, and correct equipment

Safety Goals

2014-2015 PCS Initiatives	EXERCISE YOUR EXCELLENCE What you can do to support initiatives
<ul style="list-style-type: none"> • Blood transfusion documentation improvement • Arm band bar coding improvements 	<ul style="list-style-type: none"> • Ensure there are 2 signatures, vital signs, dates and times on all documentation when administering blood products • Use scanning technology when administering medications and performing glucometry
<ul style="list-style-type: none"> • Standardization to RN only model for Critical Lab Result Call backs • iPASS handoff trials in process, full implementation in 2015 	<ul style="list-style-type: none"> • RN reads back critical results from the computer or a written results • Complete iPASS training
<ul style="list-style-type: none"> • Medication reconciliation improvement project • Morphine First Initiative • PRN Pain Medication initiative (coming in 2015) • Anticoagulation Management Service (AMS) 	<ul style="list-style-type: none"> • RN clarifies PAML after provider completes (provider must complete within 24 hours) • RN reviews PAML with discharge medications • Encourage the use of morphine before stronger pain medications such as dilaudid • Review of patient anticoagulation profile using AMS icon upon admission • Provide the Warfarin Guide to patients who will be discharged on Warfarin
<ul style="list-style-type: none"> • Interdisciplinary Clinical Technology Oversight Committee • Ensure MD orders/travel requirements • Individualize patient alarms when appropriate 	<ul style="list-style-type: none"> • Ensure every patient with ECG/pulse oximetry has an order • Review the need for monitoring every day • Obtain MD order for discontinuing ECG/pulse oximetry • Individualize alarms when appropriate
<ul style="list-style-type: none"> • Hand Hygiene monitoring • CLABSI – Critical Care Quality & Safety Committee; Hopkins Peer to Peer Initiative • CAUTI Interdisciplinary Taskforce 	<ul style="list-style-type: none"> • Use hand hygiene before and after patient contact • Education for patients/families should include but is not limited to hand hygiene and other relevant infection prevention • Review daily the need for central lines and urinary catheters • Remove lines and catheters as soon as indicated • Secure urinary catheters
<ul style="list-style-type: none"> • Initial Nursing Assessment (INA) Suicide Assessment 	<ul style="list-style-type: none"> • Complete suicide assessment within 24 hours of admission • If patient at risk for suicide alert provider and implement suicide precautions
<ul style="list-style-type: none"> • RNs facilitate UP during procedures at the bedside, procedural areas, and operating rooms • New MGH Universal Protocol initiative includes PCS participation 	<ul style="list-style-type: none"> • Facilitate a “PAUSE” with the team to ensure correct patient, correct procedure, correct site, and correct equipment for all invasive procedures • Complete documentation of the UP

National Patient Safety Goals

—by Colleen Snyderman, RN, director, PCS Office of Quality & Safety

The goals are intended to help organizations implement changes to prevent these events from occurring in the future. Adherence to practices articulated in the NPSGs is critical to preventing patient harm and is a major focus of every Joint Commission survey.

Each year, in an attempt to raise awareness, the Joint Commission directs attention to National Patient Safety Goals (NPSGs) based on an analysis of reported safety events that have resulted in patient harm. The goals are intended to help organizations implement changes to prevent these events from occurring in the future. Adherence to practices articulated in the NPSGs is critical to preventing patient harm and is a major focus of every Joint Commission survey.

Our commitment to Excellence Every Day emphasizes our desire to deliver high-quality care, keep patients safe, and maintain a culture of regulatory readiness. In advance of our upcoming Joint Commission survey, Patient Care Services has been working with collaborative governance committees, the MGH Center for Quality & Safety, and compliance groups to enhance our understanding of, and compliance with, current National Patient Safety Goals.

- All PCS staff have been issued National Patient Safety Goal badges
- Inter-disciplinary tracers are conducted weekly in all areas. Tracers provide an opportunity for staff to engage in mock survey situations and identify issues that might need improvement
- Weekly focused audits are conducted to ensure that blood transfusion, PAMLs, restraint documentation, and other critical tasks are being performed and completed

The RN-only model for accepting critical lab results is an improvement that was implemented based on feedback from the Staff Nurse Advisory Committee.

- Each month, information about a National Patient Safety Goal is presented at the Staff Nurse Advisory Committee meeting, PCS Combined Leadership Meeting, and other forums as needed. The RN-only model for accepting critical lab results is an example of an improvement that was implemented based on feedback from the Staff Nurse Advisory Committee
 - Performance-improvement initiatives are formulated at the unit level to address any trends identified by quarterly, nurse-sensitive-indicator data
 - Important information about our efforts is communicated in various ways through HealthStream classes, *Caring Headlines*, Tuesday Take-Aways, practice alerts, and *PCS News You Can Use*
- Sustaining a state of perpetual readiness requires constant vigilance and the participation of the entire workforce. We're fortunate that PCS Advisory

Committee members are serving as quality champions to help ensure adherence to quality and safety standards and National Patient Safety Goals. Additional

communication and educational strategies are planned for 2015.

The table on the preceding page provides a more detailed look at the 2014–2015 National Patient Safety Goals and the initiatives we're using to address them in the spirit of Excellence Every Day.

For more information, call the PCS Office of Quality & Safety at 3-0140.

Partners eCare

gearing up for the transition to a fully integrated clinical information system

—by Annabaker Garber, RN, director, PCS Clinical Informatics

In early 2014, more than 500 clinicians and staff from MGH participated in sessions to help design, build, and test components of Partners eCare...The sacrifice, effort, and expertise contributed by staff was (and continues to be) a monumental asset in the creation of 'one record' for our patients.

2014 was an active year for Patient Care Services as we participated in the development of Partners eCare (the fully integrated, clinical information system that will go live at MGH in 2016). MGH staff were actively involved in the design and build of the product; we implemented the revenue-cycle portion of the system, and we adopted an electronic notes writing tool in preparation for the transition.

In early 2014, more than 500 clinicians and staff from MGH participated in sessions to help design, build, and test components of Partners eCare. These sessions were often multi-day commitments for long periods of time. The sacrifice, effort, and expertise contributed by staff was (and continues to be) a monumental asset in the creation of 'one record' for our patients.

In July, 2014, the revenue-cycle component of eCare was implemented, including activation of the master patient file (the personal information of more than 5 million patients), registration, admission, transfer, bed-placement and cleaning, scheduling, and billing. More than 8,500 MGH employees from 934 departments were trained; 392,000 appointments were converted from the old scheduling systems to the new one.

Departments within Patient Care Services that schedule outpatients (such as Physical Therapy, Occupational Therapy, Speech-Language Pathology) are now using the revenue-cycle component of eCare, as are other ambulatory practices throughout

MGH. Registration and bed-placement are now managed with the new system, which affects all inpatient-care units. Bed turnover (indicating when dirty beds are cleaned and ready) is managed with the new system, affecting unit service associates on all units. And of course, implementation of the billing component affects every patient who receives care at MGH.

In preparation for the full transition to Partners eCare, we implemented eBridge, an electronic notes tool used by Nursing, Case Management, Respiratory Care, Chaplaincy, physicians, nurse practitioners, and physician assistants. The addition of eBridge means that nearly all patient notes are now electronic and accessible in CAS. This is a great intermediary step as it gives staff the opportunity to practice charting and finding notes electronically, skills they'll need when we convert fully to Partners eCare. It also helps us develop skill at writing 'the good note' electronically. Notes currently in the electronic system will be accessible for viewing through a viewer embedded in Partners eCare, preserving continuity in the patients' historical records.

MGH will be implementing the clinical component of the fully integrated medical record in the inpatient setting, March 26, 2016, and in the ambulatory setting, shortly before and after the inpatient implementation.

Optimizing patient flow

reducing length of stay while maintaining optimal quality, safety, and service

—by Amy Giuliano, senior project manager

MGH functions at high capacity every day. Bottlenecks in the system can restrict patient placement and limit the hospital's ability to accommodate incoming patients. The Optimizing Patient Flow initiative is intended to improve access and patient progression, and enable a sustained reduction in length of stay while maintaining optimal quality, safety, and service.

Background

Optimizing care-delivery so that patients can be discharged as soon as they're clinically ready is good for patients and good for hospitals. Senior vice president for Patient Care, Jeanette Ives Erickson, RN, and medical director of the Vascular Center, Michael R. Jaff, DO, are leading the Optimizing Patient Flow initiative. This hospital-wide effort is intended to improve access and patient progression, and enable a sustained reduction in length of stay (LOS) while maintaining optimal quality, safety, and service. MGH functions at high capacity every day. Bottlenecks in the system can restrict patient placement, impede progression, delay discharges, and limit the hospital's ability to accommodate incoming patients.

Key objectives of the Optimizing Patient Flow initiative are:

- reduce the time patients spend in the hospital due to non-medical-related issues (e.g., poor coordination around discharge and timing of tests, avoidable delays, etc.)
- eliminate bottlenecks that restrict patient placement, impede progression, delay discharges, and limit our ability to admit patients

A number of key initiatives have been identified to help engage leaders, improve processes, and measure outcomes through the work of the Patient Progression Improvement effort led by Jaff, Ives Erickson, and chief medical officer and senior vice president for the Department of Medicine, Brit Nicholson, MD. Four services were selected based on their potential to reduce excess inpatient days and overall hospital-wide length of stay. Those services are Medicine, Surgery, Neurology, and Neurosurgery.

Guardianship Pilot

A pilot program was conducted in the Neuroscience Service to tackle the issues of delays in discharge and the burdensome paperwork associated with the guardianship process. Key to the success of the pilot was the introduction of a dedicated advanced practice nurse to work with social workers and the medical team to expedite the identification of guardianship cases and complete the required paperwork as efficiently as possible.

A key outcome of the pilot was that 100% of guardianship patients identified in the pilot were able to move to the next level of care when medically ready to do so. Data showed a reduction in the overall length of time to process guardianship cases internally, a decrease in the number of days from filing the paperwork to discharge, and a 40% decrease in average length of stay over baseline.

Estimated Date of Discharge Tool

A new on-line tool was developed to ensure appropriate documentation is completed and the estimated discharge date is communicated among patients, families, and clinicians. The Estimated Date of Discharge (EDD) tool is for use by all members of the inter-disciplinary team. The tool provides real-time access to updates about the estimated date of discharge, the expected discharge disposition, barriers to discharges, and the status of tasks related to impending discharges.

The EDD was rolled out in early December. During the first few days of use, teams accessed the tool for more than half of all inpatients. Initial data is promising. With continued focus on communication and awareness among members of the

continued on next page

Length of Stay (continued)

care team, patients, and families, the tool will help foster efficiency, patient-satisfaction, and a shorter overall length of stay.

Levels of Care Education

An education plan was developed to help care teams and families understand and communicate about the most appropriate level of care for patients following discharge from MGH. The goal is to maximize patients' recovery and independence by identifying placements best suited to meet the needs of patients and families.

The education plan has been presented to the General Executive Committee, Patient Care Services leadership, and several physician groups. The next step is to enhance the communication plan and ensure staff have the tools and language necessary to talk with patients about the next level of care.

The Bottleneck Team and more...

A bottleneck team is being mobilized under the leadership of senior vice president for Administration, Jean Elrick, MD, to identify and reduce barriers to timely discharge.

Other areas where opportunities have been identified, and planning is underway, include: improving weekend flow and discharges, transition to post-acute care, managing long length-of-stay populations, and enhancing communication strategies.

Measurement

A key step in evaluating opportunities for improvement was looking at length of stay by service and diagnosis to identify factors that hinder timely discharge. This review helped identify bottlenecks that inhibit discharge prior to the 10:00am target.

Meaningful, achievable, length-of-stay targets were established in a phased approach that encompasses three levels of reduction:

- Phase I, reduce by 0.5 day off FY15 budget target (current targets)
- Phase II, reduce by 0.75 day
- Phase III, reduce by 1.0 day

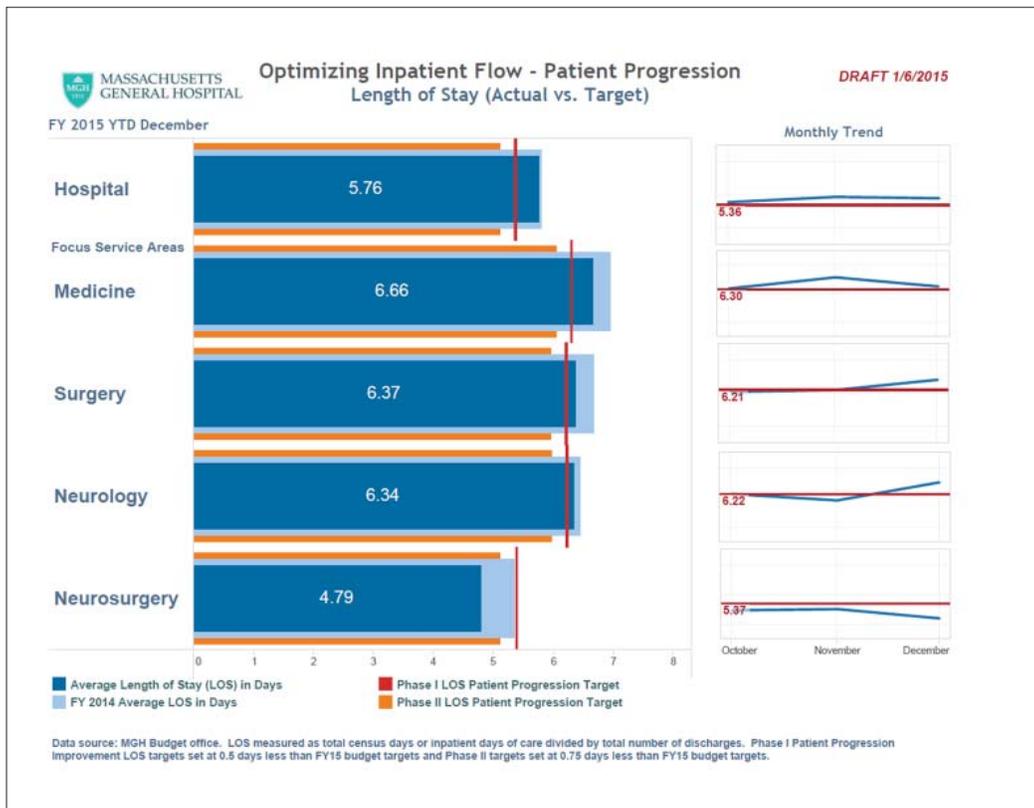
Measurement is a key component of the Patient Progression Improvement work. A weekly dashboard was created to monitor length of stay, pre-10:00am discharges, volume statistics, and, since a significant number of patients are admitted

through the Emergency Department (ED), delays in ED patients being placed in beds. Potentially avoidable days are determined by comparing the number of days spent at MGH to the number of days spent at other national academic medical centers by patients of similar diagnostic and demographic characteristics.

Everyone in the MGH community plays a part in optimizing patient flow so that patients can receive the right care, in the right place, at the right time.

For more information about efforts to optimize patient flow, visit the web portal on the MGH intranet <http://intranet.massgeneral.org/LOS/>. If you have questions, comments, or suggestions, please direct your e-mails to: MGHLOS@partners.org.

The graph below: Fiscal year 2015 year-to-date average length of stay shows favorable performance compared to fiscal year 2014 in the focus services of Medicine, Surgery, Neurology, and Neurosurgery. Statistics through December highlight opportunities for length-of-stay reductions (relative to targets) in Medicine, Surgery, and Neurology; average length of stay in Neurosurgery is favorable compared to targets. Hospital-wide average length of stay is 5.76 days.



Collaborative governance

2014 Annual Report

—by Mary Ellin Smith, RN, professional development manager

Collaborative governance was implemented in 1997 as a key element of Patient Care Services' Professional Practice Model... Almost 18 years later, collaborative governance remains a driving force in our professional practice with more than 300 clinicians serving on eleven committees or sub-committees.

In 1997, collaborative governance was implemented as a key element of Patient Care Services' Professional Practice Model. Collaborative Governance is a communication and decision-making body that places the authority, responsibility, and accountability for patient care with practicing clinicians. Almost 18 years later, collaborative governance remains a driving force in our professional practice with more than 300 clinicians serving on eleven committees or sub-committees.

The work of collaborative governance champions and committee leaders influences the care we provide and the knowledge we share throughout PCS. Following is a brief summary of what collaborative governance committees accomplished in 2014.

The Diversity Committee continued to educate champions and the MGH community around the importance of cultivating a culturally skilled workforce and fostering an organizational culture that embraces diversity. Champions shared case studies of patients from different cultures and traditions, espoused the power of partnering with patients and families in making decisions about their care, and stressed the importance of approaching every situation from a place of openness and inclusion.

The Ethics in Clinical Practice Committee continued to work to ensure patients' wishes are known and understood through advance directives. They hosted an educational booth in the Main Corridor for National Healthcare Decision Day. Conducting ethics rounds as part of their meetings has led many clinicians to request consultations on

setting up their own unit-based ethics rounds. In response to those requests, the committee hosted an educational program for more than 40 clinicians.

The Fall Prevention Committee continued its work to raise awareness about the importance of identifying patients at risk for falling and strategies to keep all patients safe. The committee sponsored a contest asking staff to come up with creative ideas to prevent falls. The winner, White 11, developed an approach to help prevent falls that occur when patients need to use the bathroom. Fall Committee champions continued to monitor data from the PCS Office of Quality & Safety and served as consults to areas with high fall rates.

With the roll-out of eBridge, the **Informatics Committee** continued to give voice to the concerns and suggestions of clinicians who'll use the new systems and provide input on content and functionality. Champions helped vet ideas for the new eBridge Transfer to OR/ Procedure template.

The Pain Management Committee continued to provide leadership in ensuring clinicians have the knowledge and skill they need to assess and manage pain as part of a multidisciplinary team. Champions reviewed and provided feedback on pain-related procedures and the criteria for PRN pain-medication ordering. The committee hosted a Pain Awareness booth in September as part of Pain Awareness Month.

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Collaborative Governance (continued)

The Patient Education Committee continued its work to ensure patients are able to obtain, read, understand, and use healthcare information to make appropriate decisions and comply with treatment instructions. Champions published articles in *Caring Headlines* and hosted a health literacy booth and the annual Blum Visiting Scholar Program as part of Health Literacy Month.

The Policies, Products, and Procedures Committee brought their clinical knowledge and expertise to bear as they reviewed more than 60 procedures in 2014. The committees' feedback, ranging from medication administration and delivery methods, to narcotic wasting procedures, to the removal of central lines and dressings, ensured that the voices of practicing clinicians were heard. Champions worked closely with Materials Management to review new products to ensure they were not only cost-effective but met the needs of staff who would be using them.



The Research and Evidence-based Practice Committee continued to lead efforts to ensure care-delivery is evidence-based through a review of research articles, Journal Club presentations, and 'Did You Know' posters. Journal Club presentations included such topics as family presence during resuscitation and NICU-nurse activism in ethical dilemmas. Two 'Did You Know' posters focused on Temporal Artery Thermometers and Pressure Ulcers.

The Restraint Solutions in Clinical Practice Committee recognized the need for restraint-free products, devices that allow patients to remove the restraint and move safely in their bed or chair, but also prevent patients from harming themselves or others. Champions worked with Materials Management to trial several devices and worked with the Product Value Added Committee to bring these products into the hospital. Champions continued to share case studies at their monthly meetings.

The Skin Care Committee reviewed and provided feedback on the wound-care formulary and pressure-ulcer survey. They continued to provide consultation on challenging skin-care issues as part of the case-study discussion at their meetings. Champions recognized that one cause of skin breakdown could be attributed to not using ceiling lifts when appropriate. To raise awareness, champions created a music video to drive home the point that ceiling lifts protect skin and prevent injury.

The Staff Nurse Advisory Committee provided input and guidance on a variety of clinical and administrative issues. Champions dialogued with leaders across the organization on such issues as National Patient Safety Goals, changes in practice regarding IV therapy, opportunities to continue to improve HCAHPS scores, ideas to reduce length of stay, and strategies to deliver cost-effective care that is safe high-quality and efficient.

Committee champions showcase their work at the annual SAFER Fair on September 17, 2014, under the Bulfinch tent.

The learning organization

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

Senge describes the learning organization as a dynamic system in a state of continuous adaptation and improvement. In order to perpetually provide the highest quality of care to patients and families, we must always be in a state of growth, change, and improvement.

The teachings of Peter Senge provide the foundational pillars of our professional-development philosophy. In his book, *The Fifth Discipline*, Senge discusses what he calls, the learning organization. He describes the learning organization as a dynamic system in a state of continuous adaptation and improvement. Sound familiar? MGH, Patient Care Services, and The Norman Knight Nursing Center for Clinical & Professional Development certainly fall into that category. In order to perpetually provide the highest quality of care to patients and families, we must always be in a state of growth, change, and improvement.

2014 was a productive year for the Knight Nursing Center. Among our many activities, we were delighted to introduce Cvent for course registration. This on-line event-registration system has received a lot of positive feedback. It's among several new tools designed to enhance staff's ability to find educational offerings and register with a simple click of the mouse. As program dates approach, Cvent automatically sends registrants their course materials. On the day of the course, sign-in is as easy as another click of the mouse. Course evaluations can be sent via Cvent, and once received, continuing education certificates are sent by return e-mail. And Cvent allows us to automate many of the record-keeping requirements that were previously handled manually. Look for enhancements to Cvent that will further improve staff-satisfaction with registering and taking courses through the Knight Nursing Center.

This year in celebration of Certified Nurses Day (March 19, 2014), the Knight Nursing Center distributed certification achievement ribbons. Certification is one of the ultimate goals on the professional-development journey and one every clinician should include in his/her educational plan. Earning certification is testament that clinicians are committed to excellence in practice and serves as a promise to patients that we strive to be the best we can be. Some strategies developed by the Certified Nurses Advisory Group led by the Knight Nursing Center include highlighting certification exams each month, providing resource materials to staff, streamlining the reimbursement process, and developing more ways to help nurses at all levels prepare for certification exams.

Inter-professional education became a reality last year with the introduction of a new course. Partnerships: Transforming the Team debuted in July and received positive feedback from the inaugural class. The concept of team dynamics, including effective communication, understanding differences, and learning to work together are the mainstays of the new course, which was suggested via the 2012 Learning Needs Assessment. Based on feedback, the course has undergone some revisions and will appear again on the 2015 calendar.

Being in "a state of continuous adaptation and improvement" motivates us as educators to think futuristically about the learning needs of staff. We look forward to developing new ways to acquire information and new opportunities to engage staff in the learning environment.

For more information, call the Knight Nursing Center at 6-3111.

Patient and family advisory councils

—by Georgia Peirce, project manager

PFACs continue to be an invaluable asset to MGH and the larger healthcare arena. They bring a perspective to the discussion that no one else can, and they do it to help improve care for others.

The MGH mission is grounded in the understanding that all we do as individuals and as a community is guided by the needs of our patients and families. For the past 14 years, patient and family advisory councils (PFACs) have provided a vital mechanism for mining patient and family perceptions and incorporating them into our day-to-day operations and planning.

In 1999, MGH launched its first PFAC with the MassGeneral Hospital for Children Family Advisory Council. Following their lead, other specialty areas launched service-specific PFACs, such as the MGH Cancer Center in 2001, the MGH Heart Center in 2007 (now the the Institute for Heart, Vascular, and Stroke Care), followed by a hospital-wide General PFAC in 2011. Soon after its formation, the Ambulatory Practice of the Future formed the Care Alliance comprised of patients and staff.

Patients, families, and the hospital have found it beneficial to convene these focused PFACs, each bringing voice to a different patient or family experience, environment of care, or specialty area. PFACs are ideally positioned to impact the delivery of care for their respective patient populations and collectively to influence hospital-wide initiatives. PFAC members bring first-hand, highly relevant perspectives to the table and, ultimately, to the hospital's governing body, the Board of Trustees.

Throughout 2014, PFAC members continued to help shape the patient experience by participating in key activities—the Quality and Safety Committee; the Patient-Centered Outcomes Research Institute; CRICO; reviewing patient and family educational materials; participating in care re-design and Innovations-Unit initiatives;

taste-testing potential new food items proposed by Nutrition & Food Services; participating in a full-day retreat sponsored by the MGH Clinical Research Program to promote patient engagement in the research process; reviewing blueprints and plans for new patient facilities; and much more.

In 2014, MGH hosted its 6th annual PFAC dinner, giving members an opportunity to network, share ideas and experiences, and learn about plans for the hospital from senior leadership. The Ladies Visiting Committee funded a position to help manage initiatives across all PFACs, including brochure-development for recruitment purposes; publications to promote PFACs; engagement with community health centers to increase outreach for diverse membership; identifying opportunities for internal and external presentations; and developing a joint PFAC orientation program.

PFACs collaborated with the Kenneth B. Schwartz Center for Compassionate Care and chief nurse to present a joint event focused on creating a more compassionate healthcare system. The event was an opportunity for patients and families to influence the national agenda. The Cancer Center launched a new PFAC focused on Pediatric Oncology. Members presented at the state PFAC conference on the development and strengthening of PFACs throughout the Commonwealth.

PFACs continue to be an invaluable asset to MGH and the larger healthcare arena. They bring a perspective to the discussion that no one else can, and they do it to help improve care for others.

For more information about patient and family advisory councils, call the Office of Patient Advocacy at 6-3370.

The Yvonne L. Munn Center for Nursing Research

—by Dottie Jones, RN, director, The Yvonne L. Munn Center for Nursing Research

This past year was a productive one. We were kept busy with activities like grant-development; implementing and evaluating research projects; participating in the evaluation of Innovation Units; promoting a culture of inquiry throughout Nursing and Patient Care Services; and engaging staff in research activities and committee work.

This past year was a productive one for the Yvonne L. Munn Center for Nursing Research. We were kept busy with activities like grant-development; implementing and evaluating research projects; participating in the evaluation of Innovation Units; promoting a culture of inquiry throughout Nursing and Patient Care Services; and engaging staff in research activities and committee work. Significant progress was made in developing and refining measurement instruments (such as the disruptive behavior scale; the PCA WES scale; and the Staff Perception of the Professional Practice Environment Survey).

Staff throughout Patient Care Services continued to disseminate research findings at national and international conferences and via impact journals. Staff of the Munn Center worked with the Center for Innovation to evaluate satisfaction with, and the impact of, Phase I, II, and III Innovation-Unit interventions on care outcomes. Improvements were made to the Munn Center website, and we created and/or refined policies around grant-preparation, mentoring, developing research proposals, and conducting research in a practice environment.

Doctoral Forum

2014 saw a renewed effort to engage not only doctorally prepared nurses in monthly Forum activities, but to reach out to Center-appointed external faculty nurse scientists from notable university schools of Nursing to actively participate in the Forum.

There is a growing interest in faculty bringing their research to MGH and working with staff to complete their work. Stewart Bond, RN, (managing care of oncology patients) from Boston College, and Ann Marie Barron, RN, (complementary healing interventions) from Simmons College, are examples of expanding faculty partnerships with MGH staff. The Forum continues to be a valuable space where nurse researchers can address issues around methodology, discuss approaches related to research-design, and promote dialogue around clinical inquiry. In January of 2015, Gaurdia Banister, RN, executive director of The Institute for Patient Care, will discuss, "Aligning your Research Agenda with Hospital and Departmental Strategic Goals."

MGH Research Enterprise/ECOR

The Yvonne L. Munn Center for Nursing Research is now a recognized member of the MGH research enterprise and one of 30 research departments at MGH. The Executive Committee on Research (ECOR) is the branch of the MGH research enterprise that evaluates and provides guidance on research policies, education, and development. Banister is a member of the ECOR and shares nursing's perspective on research and other initiatives at MGH. Dottie Jones, RN, director of the Munn Center, presented, "Advancing a Nursing Research Agenda at MGH," to the ECOR this past July, and the presentation was very well received. The Munn Center continues to work closely with members of the Clinical Research Program and ECOR to create partnerships and enhance the visibility of nursing research at MGH.

continued on next page

Research (continued)

Munn Nursing Research Grand Rounds

In November 2013, Munn Nursing Research Grand Rounds were introduced to provide a forum for recipients of the Munn Nursing Research Award and the Munn Fellowship in Nursing Research to present their research findings. Nurse researchers from within the MGH community are also invited to present. Nursing Research Grand Rounds occur quarterly and are open to all members of the MGH community. This past year, several research studies were presented and all were well-attended by interdisciplinary members of the MGH community. The next Munn Nursing Research Grand Rounds will occur on Thursday February 6, 2015, at 1:30pm in O’Keeffe Auditorium. Julie Cronin, RN, clinical nurse specialist, will present findings from her study, “Family Members’ Perceptions of Most Helpful Interventions during End-of-Life Care of a Loved One,” along with Kim Francis RN, who will present her research, “Does Handling Influence Pre-Term Infants’ Pain Experience.” Both presenters are past Munn Research Award recipients.

Connell Nursing Research Scholars

As of June 2014, eight PhD-prepared nurses at MGH had been awarded Connell Nursing Research Scholars Post-Doctoral research awards. Through these awards, provided by the Connell Foundation, nurses had the opportunity to spend time each week conducting research activities, such as developing and submitting grants, developing presentations, and one-on-one mentoring with national nurse leaders in their areas of inquiry. Each scholar worked with Munn Center mentors as well as external

mentors to advance their research efforts and support external funding and publication. Each mentor came to MGH and met with other staff and scholars to discuss research and the impact of discovery on clinical practice. They presented papers, which are available to anyone online. Some of the topics investigated included effective pain-management, infection control, complementary healing modalities, symptom-management, and workplace environment. Grant applications have been submitted, significant publications disseminated, and scholars continue to grow and develop. For those completing their Connell post-doctoral work, a group has been formed to further champion research and promote new opportunities for research studies at MGH.

Research Day 2014

Nursing research activities culminated with more than 40 posters, numerous presentations, and the naming of the 2014 Munn staff research award recipients. A presentation by Elizabeth Manhart Barrett, RN, on, “Power as Knowing Participation in Change,” was a highlight of Nurse Research Day. Manhart Barrett met with staff and external community leaders to promote knowledge-driven practice and discuss nursing’s influence on patient care in the practice environment. The discussion resonated with the MGH community as our professional practice model incorporates Manhart Barrett’s thinking as a key component of professional practice and the work environment that surrounds relationship-based care.

2015 abstract submissions are due January 12, 2015.

Members of the Patient Care Services Executive Team

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

Shelley Amira, associate director, Administration, MGH Center for Global Health and Disaster Response

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

Debra Burke, RN, associate chief nurse

Leila Carbanari, RN, director, International Programs, International Patient Center

Deborah Colton, senior vice president, Strategic Communication, MGPO/PCS

Mary Cramer, senior director, Process Improvement, Ambulatory Management & Performance

Marianne Ditomassi, RN, executive director, PCS Operations and Magnet Recognition

Rick Evans, chief, Service Excellence

Theresa Gallivan, RN, associate chief nurse

Annabaker Garber, RN, director, Clinical Informatics

Marie Elena Gioiella, LICSW, director, Social Services

Antigone Grasso, director, PCS Management Systems and Financial Performance

Bob Kacmarek, RRT, director, Respiratory Care

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

Labrini Nelligan, executive director, Lunder-Dineen Health Education Alliance

Wayne Newell, director, Volunteer Services

Anabela Nunes, director, Medical Interpreters

Reverend John Polk, director, Chaplaincy

George Reardon, director, Clinical Support Services, Orthotics & Prosthetics

Susan Sabia, editor, *Caring Headlines*

Colleen Snyderman, RN, director, PCS Office of Quality & Safety

Michael Sullivan, PT, director, Physical and Occupational Therapy

Nancy Sullivan, director, Case Management

Steve Taranto, director, Human Resources

Dawn Tenney, RN, associate chief nurse

Carmen Vega-Barachowitz, CCC-SLP, director, Speech, Language & Swallowing Disorders and Reading Disabilities

Deborah Washington, RN, director, PCS Diversity

Kevin Whitney RN, associate chief nurse

For more information about any of the activities or programs offered by The Yvonne L. Munn Center for Nursing Research, call 3-0431.

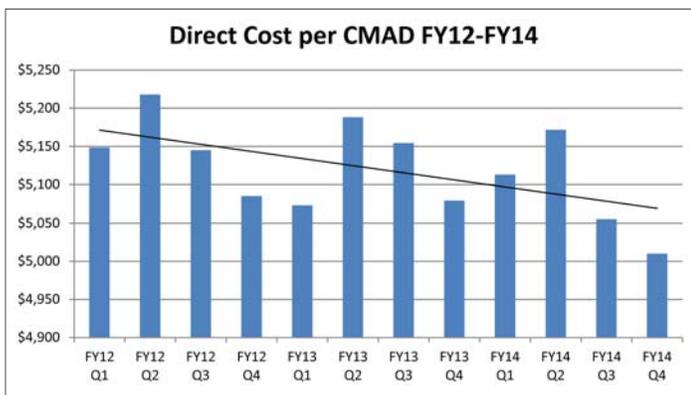
Data tells a story

meeting today's healthcare challenges with a highly skilled, experienced workforce

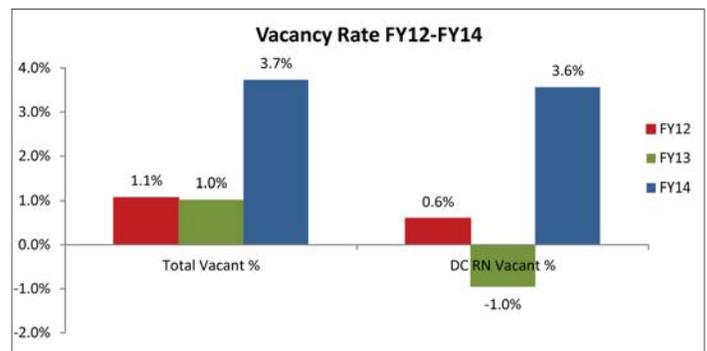
—by Antigone Grasso, director, PCS Management Systems & Financial Performance

It's no surprise to anyone that the fiscal environment in health care has become increasingly challenging. One of the pillars of our strategic plan is affordability—making care more affordable for patients and families. We are engaged in Herculean efforts to improve processes, reduce costs, and explore all viable cost-management ideas. While placing tremendous focus on managing expenses, we have not lost sight of our top priority: providing the best possible care to patients and families. A key factor in our ability to do that is attracting and retaining a highly qualified workforce.

The following graphs show the work we're doing to contain costs and information related to Patient Care Services' exceptional workforce.

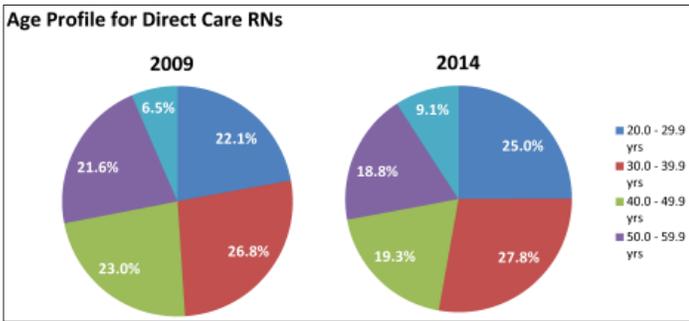


The Direct Cost per Case-Mix-Adjusted Discharge (CMAD) applies costs from direct sources (excludes overhead/indirect sources) to hospital discharges, which are adjusted for patient complexity. The downward trend between FY 2012 and FY 2014 reflects improved expense-management.

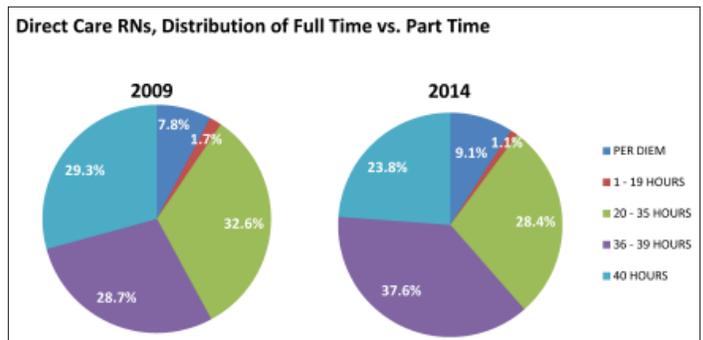


Vacancy rates for Patient Care Services overall and direct-care nurses remain low. The -1.0% vacancy rate in FY13 was the result of opening Ellison 12 and being over-hired against FY13 budget; those positions were funded in the FY14 budget. The vacancy rates across PCS increased to more than 3.5% in FY 2014 due to a position-review process.

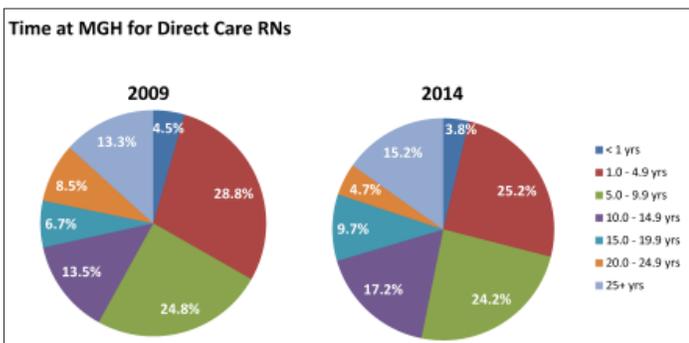
The Data (continued)



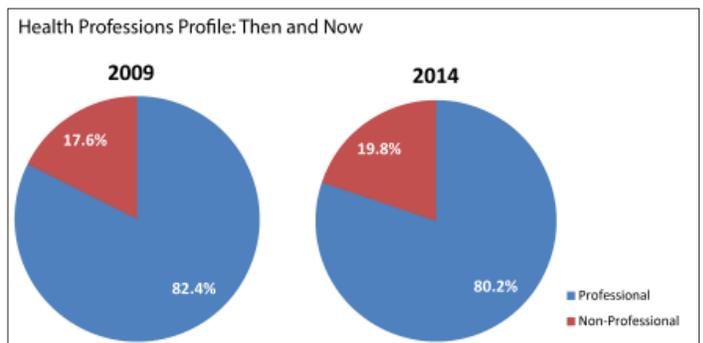
The average age remains unchanged at 41. However, the percentage of nurses under the age of 40 increased to 52.8% from 49%, and the percentage of nurses over the age of 60 increased from 6.5% to 9.1%.



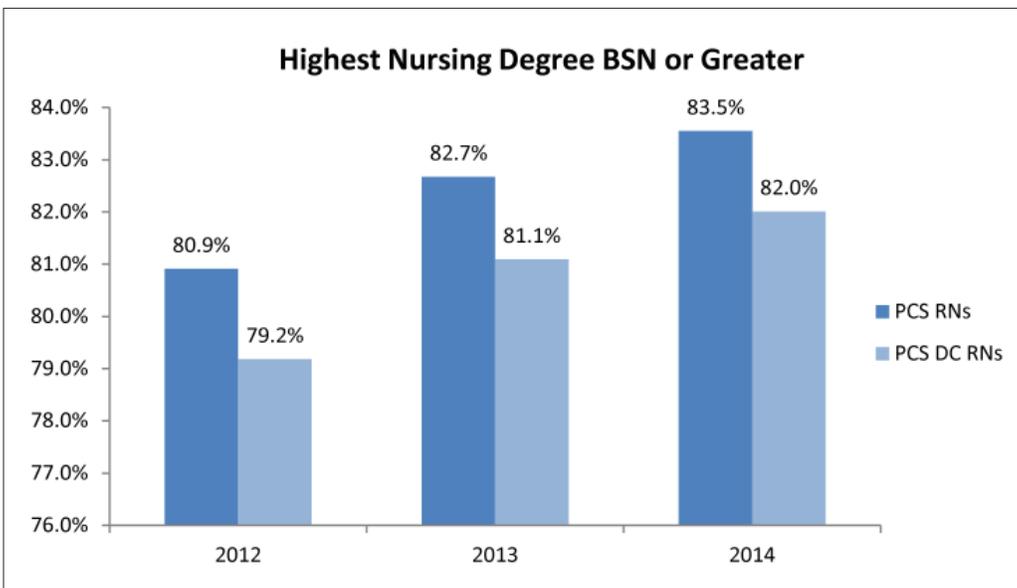
The percentage of nurses working 40 hours a week has decreased to 23.8% from 29.3%.



The percentage of nurses who have worked at MGH for more than 25 years increased from 13.3% to 15.2%.



The increase in percentage of non-professional staff is largely due to organizational-structure changes in response to increased administrative responsibilities.



The percentage of nurses educated at the baccalaureate level or higher continues to increase each year. This increase points to the impact of the decision made in 2006 to require new-graduate nurses hired by Patient Care Services to be BSN-prepared. This metric reflects our alignment with recommendations from the Institute of Medicine and The Future of Nursing report advocating a minimum of 80% of nurses be educated at the baccalaureate level or higher by 2020. It also brings MGH into compliance with the Magnet requirement for 80% of nurses to be educated at the baccalaureate level or higher by 2016.

2014 awards and recognition

—by Julie Goldman, RN professional development manager

Partnering with patients and families, Patient Care Services has created a robust award and recognition program that celebrates the achievements of clinical and support staff. In 2014, those recognized included:

Awards

Anthony Kirvilaitis Jr., Partnership in Caring Award:

- Carla Polonsky, medical interpreter
- Taophee Saheed, unit service associate

Norman Knight Award for Excellence in Clinical Support:

- Jacqueline Dos Santos, patient care associate

Brian M. McEachern Extraordinary Care Award:

- Colleen Kenneally, RN

Jean M. Nardini, RN, Nurse of Distinction Award:

- Maureen Beaulieu, RN

Norman Knight Preceptor of Distinction Award:

- Brenda Pignone, RN

Marie C. Petrilli Oncology Nursing Award:

- Maria Lavadinho-Lemos, RN
- Rebecca Loh, RN

Stephanie M. Macaluso, RN, Excellence in Clinical Practice Award:

- Katharine Kirsh, PT
- Caitlin Laidlaw, LICSW
- Michelle Pollard, SLP
- Theresa Vachon, RN

Ben Corrao Clanon Award:

- Jean Gardner-Amore, RN

Orren Carrere Fox Award:

- Kathleen Figurido, RRT

Scholarships

The Norman Knight Nursing Scholarship Program for Nurses in Doctoral Studies:

- Lorraine Drapek, RN
- Karleen Habin, RN
- Elizabeth Henderson, RN

The Norman Knight Nursing Scholarship:

- Arrick Bator, patient care associate
- Brie Trefrey, RN

Gil Minor Nursing and Health Professions Scholarship to Advance Workforce Diversity in Patient Care:

- Michele Alvarez, patient care associate
- Renatta DeCarvalho
- Kenia Giron, anesthesia technician
- Thiago Godoi, RN
- Carly Jean-Francois, RN
- Harsh Patel, research assistant
- Decima Prescott, RN
- Ying Qi Zhang, research assistant

Cathy Gouzoule Memorial Scholarship:

- Carrissa Gouzoule

Mary Forshay Scholarship:

- Ellen Godena, LCSW



January 22, 2015

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