

CODE CART

DEPARTMENT OF NURSING ANNUAL REPORT 2019

PUBLISHED BY

Boston Medical Center
Department of Nursing

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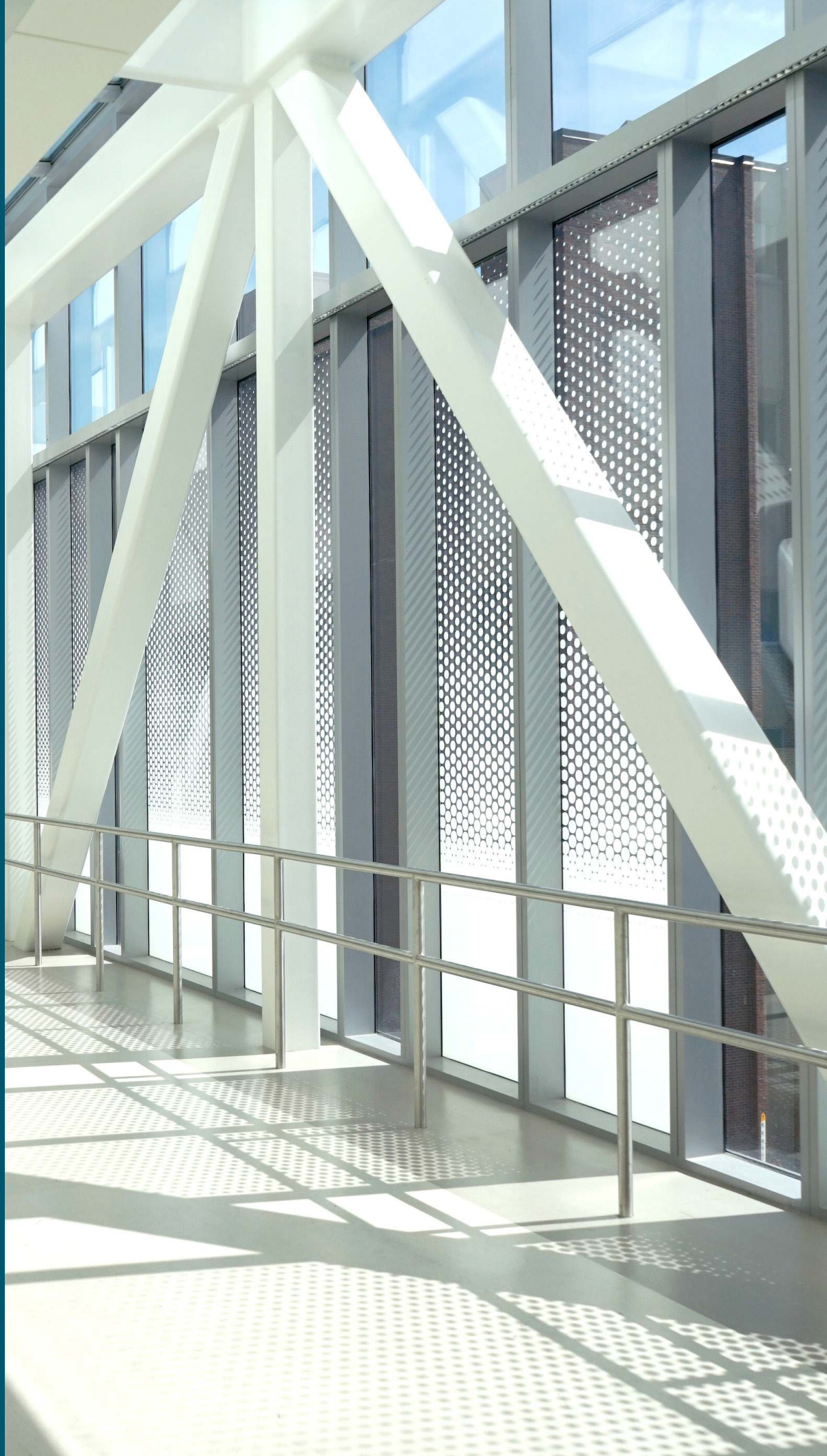
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Dear Colleagues,

I am thrilled to share with you the 2019 Boston Medical Center Nursing Annual Report. Every single day in every corner of BMC our nurses bring to life our mission and core values: Built on Respect, Powered by Empathy; Move Mountains; and Many Faces Create Our Greatness. In this report we highlight but just a few of the amazing accomplishments of our teams.

This year, we have real momentum in unit-based reliability with many quality, safety and patient experience initiatives. I am very proud of the unit based work, as well as our broader commitment to staff safety, EPIC improvements for safety and efficiency, and recruitment, onboarding, and retention which create the foundation for exceptional care.

Across the hospital we have seen nurses going back to school and becoming certified. I believe that by the end of next year, we will meet the Institute of Medicine goal of 80% BSN nurses by 2020! Across all departments, clinical nurses are involved in meaningful change with their unit based council work, and their participation in hospital-wide committees and councils.

Thanks to each of you for your commitment to excellence in patient care, and for your support of each other.

With my sincerest appreciation,

NANCY W. GADEN, DNP, RN, NEA-BC

Senior Vice President and Chief Nursing Officer
Boston Medical Center

Boston Medical Center Department of Nursing is Committed to Professional Practice

Mission Statement

EXCEPTIONAL CARE WITHOUT EXCEPTION

Nationally, professional nurses play an important role in our healthcare transformation. At Boston Medical Center (BMC), nurses are leading the improvement of health and health care and strengthening the discipline of nursing through new knowledge, innovations, and improvements. Each day, front-line nurses and nurse leaders in every corner of our system are advancing professional practice, clinical inquiry and the delivery of evidence-based care to the patients, families, and the communities we serve regionally, nationally, and around the world. In partnership with patients and their families, BMC nurses and other caregivers provide a high level, consistent standard of care, delivering compassionate care with the best possible outcomes. Using the patient-centered care model, over 1,600 nurses in our system are driven to deliver 'Exceptional Care Without Exception' on a daily basis.

Nursing Commitment to Professional Practice

The Boston Medical Center (BMC) professional practice model serves as the underlying framework for all we do, unifying BMC nurses around a common belief system. It reflects the care nurses provide to our patients, aligns with the BMC mission, and emphasizes BMC's core values and overarching goals. Even in the face of challenges, BMC nurses provide excellent care with kindness and hope in their hearts. They consider and incorporate those meaningful values into each patient's plan of care, ensuring that patients and families feel respected and well-served. They honor the uniqueness and diversity of all, creating goals and nursing interventions that incorporate the cultural values important to their patients and families. BMC nurses are committed to our care delivery model, patient centered care and shared governance, as both are core components of our professional practice model.

Patient Centered Care

BMC nurses embrace our care delivery model which is Patient Centered Care—"care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions" (Institute of Medicine, 2015). Patient centered care is the practice of caring for patients and their families in ways that are meaningful and valuable to the individual patient. It includes listening to, informing and involving patients in their care. As advocates, BMC nurses provide compassionate care with dignity, respect and sensitivity to patients' cultural values and autonomy.

Shared Governance

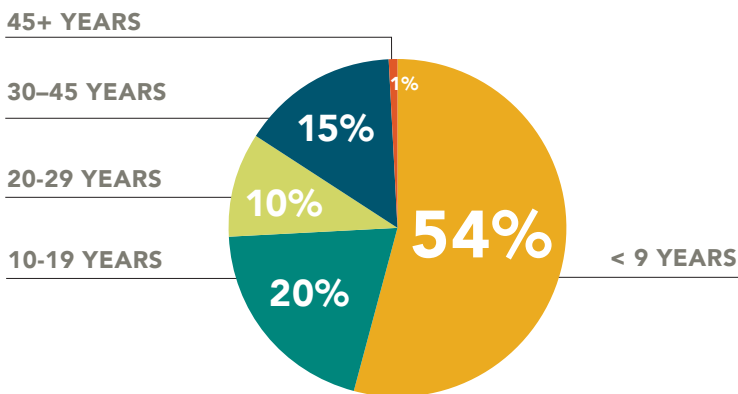
BMC nursing leadership endorses and celebrates shared governance. Shared governance is collaboration among all nurses, whether in scheduling staff, educating new staff, or implementing evidence-based practice. It involves teamwork, problem-solving, and accountability, with the goals of improved staff satisfaction, productivity, and patient outcomes. It is working together to make decisions that affect nursing practice and patient care. We are committed to interprofessional collaboration with patients as the focus of all we do. BMC believes that institutions that utilize shared governance at the organizational, departmental, and unit levels experience decreased turnover rates, increased nursing satisfaction and better patient outcomes.

BMC Nursing Philosophy: Nurse Theorist Dr. Madeleine Leininger

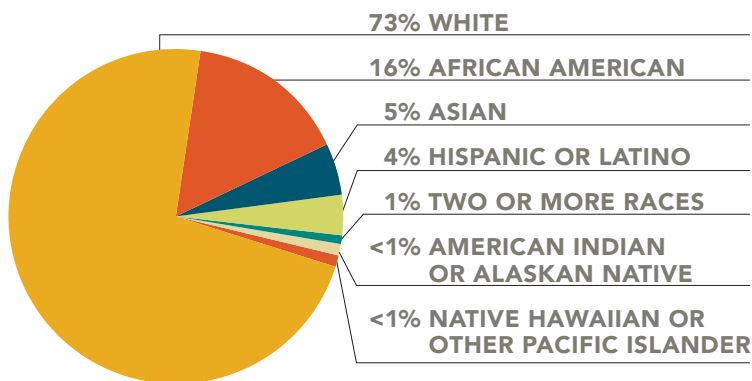
The Cultural Care: Diversity and Universality Theory was developed by Dr. Leininger to guide in the provision of culturally congruent nursing care provided to diverse populations. BMC Professional Nurses embrace their duty to provide supportive care that is tailored to specific individual and groups and consider what is culturally valued and believed by those populations. BMC nurses consider and incorporate those meaningful values into the patients' plan of care so patients and families feel respected. Nurses at BMC create goals and nursing care interventions that incorporate special cultural values important to their patients and families. Our diverse patient population has better outcomes because of the adoption and enumeration of this theoretical framework.



YEARS OF SERVICE



ETHNICITY



77% RNS WITH BSN, MSN, OR PHD

13% RNS WITH SPECIALTY CERTIFICATIONS

1783 REGISTERED NURSES

407 CNAS & LPNS

231 ADVANCED PRACTICE NURSES

90% FEMALE



**BUILT ON RESPECT
POWERED BY
EMPATHY**





Quality of Care

BMC nurses partner with patients and families to influence change in our hospital. Our Professional Practice Model incorporates our philosophy of nursing, theoretical frameworks, and tenets of our professional nursing practice. Our nursing philosophy is based upon patient centered care with an emphasis on creating caring, therapeutic and synergistic relationships with our patients and their families. Establishing relationships is the foundation of our care delivery. Nurses create partnerships with patients and families to establish goals and plans for delivery of patient centered care. To ensure care coordination, our nurses practice collaboratively with the interprofessional team to develop the plan of care. To help create these plans of care, nurses incorporate specialty guidelines and evidence-based practice to assure optimal patient outcomes. These care plans are individualized with the patient and family and reviewed at interprofessional rounds. Patient centered care results in our patients and their families “feeling cared for” and produces exceptional clinical outcomes, patient experience, and professional accountability for practice.

Clinical Outcomes

Interventions Contributes to CAUTI Reduction

According to the Agency for Healthcare Research and Quality (AHRQ), catheter-associated urinary tract infections (CAUTI) are associated with negative patient outcomes such as discomfort, prolonged hospitalization, associated health care cost increases, and mortality. AHRQ reports that up to 25% of hospitalized patients have an indwelling catheter during their hospital stay and the practice of catheter utilization is often not clinically indicated.

Quality nursing care starts with improving the delivery of patient care. Professional nurses take pride in doing the right thing, but quality care is more than will; it is a mindset of inquiry and the capacity to use appropriate tools to improve systems in which we work. To that end, we are committed to chasing zero and the eradication of healthcare-associated infections.

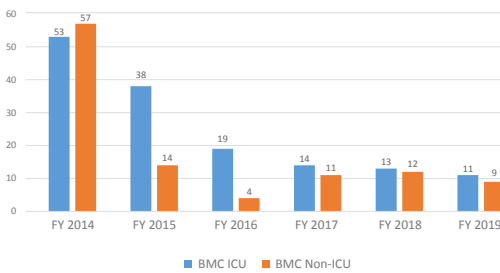
During the past six years, there have been many interventions put into place at BMC to reduce the incidence of catheter-associated urinary tract infection (CAUTI). In 2015, a task force, comprised of nurse managers, staff nurses, nursing leaders, nurse educators and infection preventionists, was formed. This group met monthly to assess current practice and products and provide recommendations for change. The first change was the implementation of a new foley catheter kit. The kit contained a smaller catheter, an improved betadine prep kit and detailed insertion instructions.

A key factor in decreasing CAUTI in 2019 were these noteworthy best practice changes:

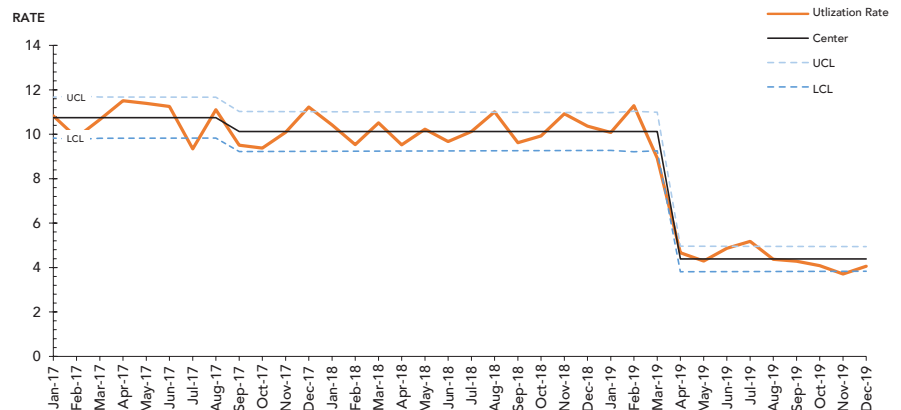
- A bladder protocol for urinary retention
- Indications for insertion and continuation of indwelling urinary catheters
- Perineal care protocol for patients with urinary catheters
- Urinalysis, with reflex to culture protocol on patients with an indwelling urinary catheter
- Use of the PureWick female incontinence device
- Daily rounding on all patients with indwelling foley catheters
- Sending email communications to the foley team to determine if foley removal is possible

All of these interventions have contributed to a significant reduction in CAUTI and utilization of foley catheters. A big thank you to all our patient care providers in helping reduce patient infections.

Incidence of CAUTI 2014–2019



Foley Utilization per 1000 Patient Days





Journey to Reduce CLABSIs

In 2018, the raw number of Central Line-Associated Blood Stream Infections (CLABSIs) in the medical Intensive Care Units (MICUs) was nine. This number was much higher than the national average. With hospital-acquired infections (HAI) such as central line-associated blood stream infections, ideally you want your number to reach “zero”. Zero is an extremely high bar and takes vigilance, cohesive teamwork and a culture of safety. For these reasons, the interdisciplinary team set out to address the problem of CLABSI on their units utilizing improved communication, safer products and enhanced verification processes.

The first improvement intervention utilized was a standardized approach aimed to strengthen the current auditing and rounding processes. The team initiated daily nurse manager auditing of all central lines in the MICUs. This process involved a conversation with each nurse and medical team member taking care of a patient with a central line. The team members were asked specific questions. These questions were primarily aimed at determining if the central line can be removed that day. The questions addressed specific criteria that warranted a central line. If a central line did not meet the criteria, the line was removed.

If criteria to keep the line was verified, the team would proceed to audit the full bundle of care being done for central line care and maintenance every shift (i.e., shift assessments, central line dressing changes per protocol, daily chlorhexidine baths, IV tubing changes, scrubbing the hub etc.) Additionally, charge nurses were empowered as champions. On each shift, charge nurses would round on central lines and verify that central line dressings were dry, intact and labeled. They would speak with each nurse about the plan for the line. This conversation reinforced the nurse-manager conversation.

During the improvement cycles, several evidence-based product changes were also made to further reduce CLABSIs. The team recognized that several of the previous CLABSIs had involved dialysis lines and occlusion of lines due to blood clotting. To improve this issue the dialysis catheters were replaced with a new product offering a larger bore. The chlorhexidine bath process was changed, and the team opted to use disposable wipes with chlorhexidine. Single and dual lumen midlines as options were promoted as an option for a line that could stay in longer than standard peripheral IVs but did not incur the same infection risk.

These diligent efforts by the team in FY 2019 yielded significant results. The addition of improved communication practices, auditing processes and evidence-based products resulted in the number of CLABSIs in the MICUs going from nine in FY 2018 to only one CLABSI in FY 2019!



Number of Patients with Hospital-Acquired Pressure Injuries in 2019

MARCH 3%

JUNE 2%

SEPTEMBER 3%

DECEMBER 2%

* Data from the pressure injury prevalence surveys are submitted to the National Database of Nursing Quality Indicators (NDNQI) and Massachusetts Hospital Association (MHA).



Preventing Pressure Injuries at BMC

Hospital Acquired Pressure Injury (HAPI) prevention is a hospital-wide safety initiative that takes a team effort. The skin and wound care program at BMC provides patients and staff an environment of safe care. This care is guided by a comprehensive and competency-based pressure injury prevention program using evidenced-based practice.

Every year, BMC participates and completes quarterly pressure injury prevalence surveys. In 2019, the skin care team evaluated a total of 1,325 patients for pressure injuries.

These prevalence surveys are conducted by “skin care” champions from every unit of the hospital. The skin care team provides a head-to-toe skin assessment on each patient and reviews their chart for inclusion of best practice pressure injury preventive measures such as the Braden score, proper bed support surface, re-positioning, incontinence management and nutritional support.

Once they’ve completed the assessment, they incorporate an interdisciplinary approach and communicate their findings to their peers, nurse managers and clinical educators, building effective teamwork, improving communication and ultimately, improving patient outcomes. The skin care team continues to act as a resource for skin and wound care assessment on their units.

Several members of the skin committee have identified what being a member of the team means to them:

“I like seeing the improvement in patients’ skin health.” – Jill, MICU A

“As staff, the importance of being on the skin committee is bringing information to our units, helping our colleagues get excited about skin and how to document skin issues they find when caring for patients.” – Laura, M6E

“I like the skin care committee because I feel wound care and pressure injury prevention is 100% nurse driven. We are captains of the ship, we do the assessments, planning, interventions and hands-on monitoring and healing” – Lisa, M6W

“The skin team is the first line of defense to help the patient, families and doctors.” – Lisa, M7E

“Participating in the skin committee has improved my bedside practice in preventing pressure injuries using evidence-based practice. As a committee member, I have met many RNs from different units who work together to promote healthy skin and prevent HAPI.” – Bridget, SICU

The skin team provides support and commitment in engaging all staff and is critical to our program’s success.



CONGRATULATIONS TO THE CCU, 7E, 6W, 4E AND PEDI UNITS WHO HAD NO HOSPITAL-ACQUIRED PRESSURE INJURIES FOR THE YEAR!



Improving Treatment of Postpartum Severe Obstetric Hypertension with Nurse Released Nifedipine IR

In the US, hypertensive disorders have a significant association with maternal morbidity and mortality (Hitti, 2018). Severe hypertension (SBP greater than or = 160mmHg and/or DBP greater than or = 110mmHg sustained for 15 minutes) in an obstetric patient constitutes an obstetric hypertension emergency and should be managed within 1 hour (ACOG, 2019).

In 2017, a maternity multidisciplinary team at BMC created a severe range Hypertension (HTN) OB algorithm to optimize timely treatment of HTN.

Subsequent analysis of the algorithm determined that we were not reaching our goal of having all severe range HTN crisis treated within one hour. The mainstay treatment was IV labetalol and this created delays for three reasons: 1) Many of our patients did not have IVs 2) The antihypertensive medications were not ordered consistently 3) BMC requires that IV labetalol include EKG monitoring and this created a need to have the resource nurse present for all IV labetalol administrations. The mother/baby unit did not have telemetry nor are the mother/baby nurses tele-certified. There was often a delay in treatment while waiting for the resource nurse.

Based on the current evidence for treatment efficacy for severe range HTN management, the multidisciplinary team created a nurse released order set for nifedipine IR with a new algorithm to reflect the change including the nurse and provider responsibilities for using the order set.

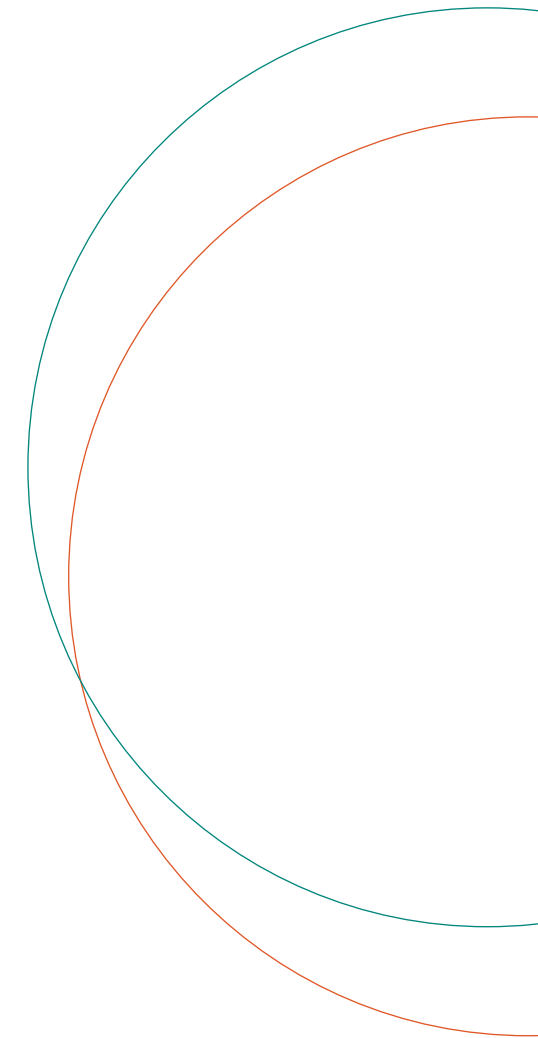
The team added this nurse released order set into every patient's admission and later added this to all patients who were readmitted.

The original goal for 1/31/19 was that at least 80% of our patients with severe range HTN would be treated with antihypertensive within 1 hour of first severe range BP.

Since 2019, we exceeded that goal with 88% of all patients receiving antihypertensive within 1 hour of first severe BP range and 100% of patients who needed antihypertensive received them.

We greatly reduced our need to access the resource RN with the use of nifedipine and have increased our timely approach to treatment within 1 hour of the severe range BP.

Our anecdotal review earlier in the year found that close to 100% of patients now get the needed nurse released nifedipine within an hour of the severe range blood pressure.





Mother-Baby Early Bloomers Program

Late preterm infants (born at 34-36.6 weeks gestation) are at increased risk of hypothermia, hypoglycemia, respiratory complications, feeding difficulties, neurodevelopmental delays, hyperbilirubinemia, infection, extended length of stay and higher infant mortality. They comprise 70% of all preterm births in the United States.

Late preterm infants need a focused nurse assessment that closely monitors for stress associated with hypothermia, infection, weight loss and require interventions to prevent complications that lead to mother infant separation and breastfeeding failure. Late pre-term infants have lower rates of breastfeeding compared to term infants (over 37 weeks' gestation), and the disparity is even greater for African American infants.

Boston Medical Center (BMC) is a Baby Friendly designated hospital and supports breastfeeding best practices. Clinical nurses recognized these interventions were not sufficient to help late pre-term infants successfully breastfeed. Due to feeding challenges which result in dehydration and hyperbilirubinemia, the readmission rates for this patient population were 33.3% in September 2018.

After clinical nurses from the mother baby unit reviewed the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) evidence-based guidelines on late pre-term infant breastfeeding, the clinical nurses along with support from a professional development specialist, and nurse managers, implemented AWHONN's evidence-based enhanced breastfeeding support interventions targeting late pre-term infants and their mothers. Their goal was to decrease the rate of late pre-term infant readmissions within the first year of life related to breastfeeding issues on the Mother-Baby unit.

The program was named "Early Bloomers" and the protocol designed by the staff consisted of:

- Increased vital sign monitoring to assess for and prevent hypothermia
- Increase infant feedings to every 2-3 hours
- Automatic consult with a lactation consultant placed at the time of delivery
- Automatic eligibility for donor breast milk
- "Early Bloomers" kit provided to the mother to assist with breastfeeding and hand expression to increase milk production
- "Early Bloomers" kit provided to the

mother to assist with early initiation of breastfeeding and hand expression to increase milk production

- A special demarcation "Early Bloomer" on the nurse/patient assignment which indicates the increased care demands of this patient population

In April 2019, the Early Bloomer Nursing Pathway was fully implemented, providing guidance for the assessment and care related to breastfeeding of late pre-term infants on the Mother Baby Postpartum Unit.

As a result of their work, the readmission rate of late preterm infants related to breastfeeding issues within the first year of life went from 33% to 0%. This clinical nurse-led evidence-based change guided nursing practice and made a positive impact on late per-term infant outcomes.

top left photo by Ed Collier



Newborn and Pediatric Bereavement Conference

When families bring new life into the world or are able to watch their children grow into adulthood, it is a time of happiness, hope and joy. As medical professionals at BMC, we understand and recognize there are times when tragic events occur that may not allow families to follow their intended path.

Bereavement care is one of the realities of being a nurse. Research indicates that dealing with death and dying is a leading factor in nurse turnover and job dissatisfaction related to a lack of bereavement skills and preparedness.

In March 2019, BMC held its 1st Newborn and Pediatric Bereavement Conference. Thirty-eight nurses in maternal child health, surgical services, and pediatric units were invited to attend an eight-hour bereavement training which granted nursing contact hours. Skill stations were reviewed including cuddle cot, memory making rituals and simulations emphasizing the nurse to family empathic communication. Guest speakers included Decedent Affairs, New England Donor Services, photographers, Chaplaincy Services and a bereaved parent speaker panel. The conference concluded with strategies for self-care provided by an integrative nurse, an employee social worker and lots of love from BMC's therapy dogs.

The conference had a great turnout and was well received by nurses who verbalized the conference helped staff develop skills and increase confidence in caring for patients and families who have experienced a loss at BMC.



Healthy Organization and Practice Environment (HOPE) Committee

The HOPE committee, comprised of staff nurses, was established in early 2019 and its purpose was to advance a practice environment which promotes civility and respect among all team members. The committee was co-chaired by professional development staff Maureen Plunkett, RN, MS and Eduarda Fonseca, RN, MS. Sponsors for the committee included Beth Milaszewski, LICSW and Carol Conley, RN, DNP.

The committee set out to introduce best practice ideas to promote positivity by generating ideas that will foster a healthy practice work environment, identify strategies and tactics to address incivility and bullying and create a community of support for nursing staff.

The monthly meetings provided a highly interactive setting in which nurses representing units across all specialties could share challenges and successes in dealing with difficult behaviors and share strategies for encouraging positive behaviors. Topics covered in learning sessions included understanding implicit bias; how to differentiate bullying from incivility and the process for dealing with each; and understanding generational differences.

Each month, the team works on a message of the month which is distributed through handouts and posted on the HOPE team link on the nursing webpage.

An ongoing project for the HOPE team was to collaborate with unit-based council colleagues and leadership to articulate a set of unit-based staff commitments. To achieve this, members used several strategies including creating posters and flyers to solicit staff suggestions around specific themes:

- How we count on each other
- How we promote teamwork
- How we support each other

The impact of this initiative will be measured through data obtained in the NDNQI survey.

Members have also collaborated with their colleagues at the unit level to create programs to recognize kindness and positive behaviors. One example of this is the “Daily Daisy” in the CCU in which staff acknowledge positive actions of their peers.

At the conclusion of each meeting, members are asked to provide post-it feedback. This feedback guides the direction and agenda for future meetings. The response of the registered nurses who participate on the committee has been overwhelmingly positive. One of the perioperative representatives, Christine Gagliano, BSN, RN expressed it best:

“The HOPE committee is dedicated to encouraging a healthy practice environment. It’s a supportive group that reinforces collaboration and teamwork, plus provides skills at handling confrontations. As a nurse and HOPE committee member, I can encourage and advocate for a healthy practice environment, that is essential to effective patient care and best patient outcomes.”



Bedside Rounding

In May 2019, the 5 West Intermediate Care Unit's Unit-based Council engaged a diverse team of nurses from the bedside, the local nurse manager and physician groups in an exciting patient safety-focused quality improvement project. The initiative focused on improving the quality and efficiency of MD-RN communication and patient safety. It is well known in hospital settings that poor communication across teams can lead to serious medical errors. This team had reviewed adverse events experienced on the unit that ultimately led to the prioritization of this project by stakeholders. The team utilized the multidisciplinary evidence-based model for bedside rounding already employed in the ICU settings at Boston Medical Center.

The primary process goal of this quality improvement project was to include the nurses in the physician rounding at the patient's bedside. Physician colleagues were asked to stop by the nurse's station prior to rounding and announce the start of bedside rounds to the nurses. Nurses would pause what they were doing if possible and join the team for rounds. This method used for testing of a new workflow was "Plan, Do, Study, Act". This allowed for rapid changes of the new process to continuously improve the methods used.

At the beginning of the project, signs were posted around the unit to remind the teams of the new process. The unit coordinator was asked to audit the process daily and served as "gatekeeper", reminding teams as they entered the unit space. There were barriers to this change in physician workflow. Physician "buy-in" took time to build. The value of nurse participation and the benefits this provided to patient safety were the main driving forces, while resistance to change and fears that the new process would add additional time to rounds were the main barriers identified by the teams.

A few weeks into the project the unit council members realized that the signs weren't enough incentive to drive this big change. They began a new Plan, Do, Study, Act cycle and utilized a standardized rounding board. The rounding board listed all the teams that cared for the patients on the pilot unit. When the teams remembered to follow the new process at the nurses' station, they received a magnet, when they did not stop, they received an "x" for the day. Teams who stopped five days in a row would be given a reward. This created some competition amongst teams and seemed to work better than the signs.

While this project is still an active work in progress, it has fostered improved teamwork, interdisciplinary collaboration, patient safety and communication. As a result, the 5W unit council continues to work on this project and has recently initiated testing of a 30-day initiative focusing on solely the General Internal Medicine (GIM) teams who have a high impact on many patients cared for on the unit.



Long Stay Rounds in the MICU

In 2019, the Medical Intensive Care Unit (MICU) observed a concerning trend in their length of stay (LOS) inpatient admissions data. It was noted in some cases patients may be staying longer due to missed opportunities for advance care planning (ACP) discussions with patients, their families and the care team. This included missed conversations on the option for end-of-life care with our General Inpatient Hospice (GIP) program. Hospice care improves the costs of care and length of hospital level stay at the end-of-life and offers relief for many of the symptoms at end-of-life such as pain and respiratory distress. Boston Medical Center (BMC) contracts with Seasons Hospice to provide hospice care to our patients when they qualify at end-of-life.

The team came together to address the problem of increased LOS and possible decreased quality at end-of-life for their patients. Nurse managers, case managers and social workers in the MICU all had noticed how many of the patients had extended stays of at least three weeks long. The team wondered how to address some of the barriers that were preventing timely discharge from the MICU. They looked

to the literature to identify evidence-based strategies that may work in this type of clinical setting to improve the discharge process from the MICU.

The team engaged physicians in discussion about the trends. They proposed a quality improvement initiative coined “MICU Long Stay Monday Rounds”. This new process would include testing dedicated rounds every Monday in the afternoon. The team invited all three Attending Physicians from the MICU teams, palliative care, a nurse representative from Seasons Hospice, a MICU nurse manager, case manager and social worker to the rounds. Buy-in to attend rounds started slow at first but the new process convinced team members of its potential impact and attendance improved.

Since the initiation of MICU Long Stay Monday Rounds, referrals to GIP hospice have steadily increased while length of stay in these patients decreased. This dedicated weekly rounding also helps to ensure that there are earlier ACP discussions and family meetings to improve communication. The MICU team was able to identify barriers to ACP discussions earlier and if indicated,

engage teams such as patient advocacy or ethics. Ethic consults and involvement from Patient Advocacy is often beneficial to the family or team with a particularly complex case.

Through this work the team additionally identified the need to reach out to Shattuck Hospital. Many MICU patients are also discharged there. There have been barriers to transfers and the team hopes to better understand their processes, capacity, criteria and workflows for accepting and admitting patients. This testing will target another group of longer stay patients seen in the MICU.

The whole team acknowledges that each time a patient goes out even a little bit earlier, a bed is created for a patient waiting in the ED. Every time a patient goes on GIP hospice, the family receives 13 months of bereavement support, music therapy and additional supports while they are in the hospital and their inpatient hospital LOS is decreased. This important work on discharges from the MICU provides benefits that extend beyond the original desired outcomes of increased ACP discussions and decreased LOS.



Diabetes Monthly Meeting for Patients

Approaching diabetes education in a new and exciting way can be challenging. In the Endocrinology, Diabetes, Nutrition, and Weight Management department, we have a multidisciplinary team of Certified Diabetes Educators (CDEs) comprised of Nurses, Nurse Practitioners, Registered Dietitians and Pharmacists. These CDEs have collaborated with our diabetes providers and Olivia Weinstein, Culinary Nutrition Manager in BMC's Demo Kitchen, to combine diabetes education with a cooking class focusing on nutritious meals for people who live with diabetes.

Diabetes self-management education has been shown to reduce A1Cs by a mean of 0.74%. Despite this, only 5% of the Medicare-eligible population access their education benefit. Medicare patients with diabetes accessing their benefit for the first time, are allowed nine hours of education the first year. Our combined class allows

patients to prepare and cook these meals with recipes that they can take home. In addition, patients can discuss management of glucose highs and lows, medications, nutrition as well as issues that they might be having that are sometimes unique but most often universal. In the past, diabetes education classes were offered during clinic hours in the clinic setting. Patients had difficulty arriving at these meetings due to work, etc. This class was designed to meet the request of our patients by offering the classes in the evening the last Thursday of the month from 5:00 p.m. - 7:00 p.m. in the Yawkey Demo Kitchen.

Since the program started five months ago, patients have been receptive to the education program and the team has plans to increase the frequency of the group to further patient engagement around diabetes education.

“When I first got diagnosed two years ago, I literally was lost. I was nervous and afraid. I was trying to figure out what to do. When my doctor told me that I had to prick myself three times a day, I was doing more than that to figure out where I’m at.”

This program has taught me to recognize the symptoms and be more active. I continue to come to the classes because I get to meet different people that have the same condition as me so that way I don’t feel alone dealing with this. I could learn from other people, solving some of their problems but also it helps me to apply it to what I’m doing at home.

I think the class is great. They should be doing this more often. It’s been very helpful to me.” —Jose, Diabetes patient



Complex Care Management: A Patient Story

In March 2018, Boston Medical Center Health System (BMCHS) became part of a Medicaid Accountable Care Organization (ACO) and began a transformational journey to redesign care delivery and improve health outcomes for some of the state's most vulnerable patients. BMCHS is now two years into the ACO work and has achieved some remarkable outcomes, on both the system and individual level, thanks in large part to the work of an innovative and committed group of nurses.

Complex Care registered nurses are the leaders of the multidisciplinary Complex Care Management (CCM) team. Their work is focused on the highest-risk, highest-cost ACO patients, many of whom are living with addiction, mental illness, and homelessness. Complex Care nurses strive to meet patients where they are at and empower patients to achieve their goals, using a nursing framework that is trauma-informed, holistic, and patient-led. In partnership with patients, CCM nurses look beyond the traditional medical model to take on many barriers to wellness. To date, CCM nurses across the state have partnered with hundreds of patients. One of these patients, Mr. T, graciously agreed to share his CCM story.

When Mr. T first met Megan, his CCM nurse, he felt he was at rock bottom. He had recently experienced a near-fatal opioid overdose. His access to treatment was complicated by homelessness and multiple serious medical problems, including heart failure and diabetes. He was admitted to the hospital on five occasions followed by long rehabilitation stays. His life experiences had put strain on relationships with his friends and family, and it was difficult to find support in the community.

Despite all these challenges, Mr. T had a clear vision for his needs and his future and agreed to enroll in CCM. After a comprehensive intake with his multidisciplinary team, which includes a Community Health Worker and a Pharmacist, it became clear that Mr. T's biggest goal was achieving permanent housing.

Using a strengths-based approach, the CCM team began the journey with Mr. T. He connected with a Housing Specialist and undertook the long process of preparing a viable public housing application. He was able to achieve some early wins, such as obtaining transportation to medical appointments, applying for supplemental security income (SSI) and building understanding of his

medical conditions and medication regimen. Over his months in CCM, Mr. T formed an authentic caring relationship with his team. The strength of this relationship with his team sustained their bond through numerous setbacks, including relapses and hospitalizations. Through the ups and downs of the journey, Mr. T never lost sight of his goals.

Today, Mr. T lives in his own studio apartment in Boston. He has achieved recovery from his substance use disorder and is focused on giving back to his community by leading recovery groups at BMC. Mr. T's medical conditions remain serious, but he has the tools and supports to manage them and rarely requires hospitalization. He has reconciled with his family and enjoys spending time with his sister and his children. Recently, his CCM nurse has started a conversation about graduation from the program, so the next patient may have the opportunity to begin the CCM journey.



When asked about what CCM has meant to him, Mr. T said, “it took everybody collectively to get this journey done. Megan and Sonya started off helping because I had so many health problems. I couldn’t remember my appointments. They would call a couple of days before my appointment and remind me. They came in and assisted with my medication, if I didn’t know how to take it, they would send someone out to come visit me. If it wasn’t for this program, I wouldn’t know really where I’d be. That’s the honest truth. I needed that support. It took a hospital and my family to get me on track because I couldn’t do it alone. I’ve been clean and sober for three years now.”

“I recommend this program for people because this is what other people will probably need in their life if they have care management. Especially ones who are still out there, sick and suffering, from a drug or disease addiction. They need teams like care management because that would make their process a little bit easier. I’m a prime example. I’m standing strong now. I can stand on my own. I ain’t got to hide behind a door. I can come in and out freely in my own apartment. I could go to that bathroom any time I want to, take my medication, my water pill whenever I want to. That’s all because of care management and everything, my whole team, my family being supportive. It’s beautiful.”



MOVE

MOUNTAINS



BMC Primary Care Nurses Aim to Reduce Low Acuity Emergency Room Visits

Boston Medical Center's Ambulatory Nurses in the Primary Care locations of Pediatrics, Family Medicine and General Internal Medicine are leading efforts to decrease unnecessary and costly emergency room visits. The organization committed to a multi-prong approach to reduce unnecessary visits by 5% in 2020. The Primary Care Nurses are helping to achieve this goal by providing patients with timely access to clinical advice through improved telephone triage systems. Using evidenced-based telephone protocols, nurses are supporting our patients by triaging all symptom-based calls in order to determine the most appropriate level of care in a timely manner.

As part of the Boston Accountable Care Organization (BACO), Boston Medical Center is focusing efforts on the quality-of-care delivery while reducing health care costs. An interdisciplinary team was formed to conduct a comprehensive review of the data and current services offered to patients of BMC. After evaluating the Emergency Room usage claims data for 2018-2019, a subset of emergency room visit diagnoses was identified as being diagnoses manageable in Primary Care and Urgent Care locations. These visits were further defined and named as, "Low Acuity" (LAED) diagnoses. Further evaluation showed ten diagnoses, such as upper respiratory infection, sore throat, headaches, conjunctivitis, rash, musculoskeletal, low back pain, gastroenteritis, and urinary tract infections that made up 83% of all LAED visits.

In late 2018, the Primary Care Nurses conducted routine emergency room visit follow up calls and obtained additional visit information from our patients in order to understand the patient's perspective and identify any unmet needs. Information obtained from our patients revealed common trends. Most patients did not call their Primary Care Provider (PCP) prior to seeking services in the emergency

room. Reasons for seeking evaluation in the emergency room included the lack of knowledge of the role of their PCP office in the management of sick visits and potential emergencies as well as being uninformed of the hours of operation of their PCP office. Patients also revealed the lack of available appointments and inconvenient appointment times as reasons for seeking care from an emergency department. Delays in the ability to speak with a clinician in order to determine the severity of their symptoms were identified and considered barriers to obtaining the reassurance patients often needed. This delay resulted in inappropriate use of the emergency room. The LAED team determined that a multi-prong strategy and approach was necessary to reduce the overall LAED visits, and efforts began focusing on Education, Outreach, Access, and Nurse Telephone Triage.

Primary care nurses manage an average of more than 2000 calls per month. Not all calls are identified as triage when routed to the nurse pool, but they all have the potential for triage, which is identified as symptom-based and time sensitive. "Telephone triage is an interactive process between a nurse and client that occurs over the telephone and involves identifying the nature and urgency of the client health care needs and determining appropriate disposition" according to Carol Rutenberg, MSc, RN-BC, C-TNP, a nationally recognized expert on telephone triage and a consultant in this project. Telephone triage relies on nurses' skills at listening, motivational interviewing, critical thinking, pattern recognition, and the use of the nursing process. Nursing protocols are tools used to support this process.

Nurse telephone triage was determined to be a vital component of the goal to reduce unnecessary LAED visits. Ambulatory Nurse Leaders, Tami Chase and Sherry Brink, conducted an assessment of the current telephone triage practices through data

and manual chart review. This revealed opportunities in operations, technology, and nurse triage practices such as assessments, interventions, use of evidence-based care advice and/or documentation of the call.

Compelled by improving our patient's experience, staff nurses across the ambulatory primary care sites committed to setting best practice benchmarks by enhancing the access of nurses over the telephone for callers verbalizing concerns or illness. The patient feedback information helped to define the duration of time a patient should await a call back from their PCP office. The Primary Care Staff Nurses define "timely access to speak with a nurse" to be within one hour for a Pediatric focused call and two hours for an Adult focused call also giving the call centers the ability to escalate real time triage as needed.

Operational changes were put in place to facilitate return calls in the defined timeframe. All "symptom-based calls" were rerouted from the call center to the Nurses in Primary Care. To facilitate efficient and timely responses, messages sent in the Epic system were streamlined to one pool designated for symptom-based calls and the nurses were given direct access to easily schedule appointments for same day sick visits. These operational changes provided the foundation for the nurses to work more efficiently and set them up for the ability to successfully meet their new benchmarks.

In search of a framework to support nurse triage, Lois Howry, Ambulatory Informatics Manager, assisted with identifying an Epic resource, Marnie Woyat. Marnie had previous experience with incorporating Thompson and Baxter's Nurse Protocols into the EHR. A presentation of the project was developed and shared with all concerned parties. In late Fall of 2019, BMC approved a project to purchase the electronic version of the Nurse Telephone protocols and



integrate them into the Epic system further supporting the evidenced-based practice of Nurse Telephone triage. When the project is completed, electronic protocols will be used as checklists to support the nurses' critical thinking and determine the most appropriate level of care for patients. The triage protocols will improve the standards of care that includes documentation in real time, prevention of reworking and decrease the chance of overlooking important information, essential documentation, assessment, diagnosis, collaborative planning, intervention, evaluation, and clear documentation of pertinent negatives.

These protocols will facilitate the use of evidenced-based practice for home care recommendations, optimal documentation and use of dispositions to capture data and measure outcomes. To date, much of this information has not been retrievable. Nurse Telephone triage dashboards will be built for the tracking of data in the system, practice and individual nurse level. The dashboard will provide the nurses with the ability to select and prioritize calls and tasks as well as the ability to quantify work for future staffing models. The protocols will support nurses by providing a framework for Nurse Telephone Triage thus supporting our patients' needs.

Preliminary data indicates that our efforts made an impact in reducing LAED visits using interventions focused on Outreach, Access and Nurse Telephone Triage. Total ED visit data is dependent upon claims data and lags at least three months behind. Based on triage call data collected in the first quarter of the following year on calls made Monday through Thursday between 8:00 a.m. and 5:00 p.m., Pediatrics and Adolescent Medicine has a median call back time of 52 minutes, Family Medicine 3 hours and 32 minutes, and General Internal Medicine 5 hours and 26 minutes. Factors influencing achievement of the timely access measure may include call volume, acuity mix of calls, and staffing capacity.

Primary Care Staff Nurses at Boston Medical Center are making improvements in Nurse Telephone triage to help reduce the use of the emergency room for low acuity diagnoses manageable in Primary Care clinics and urgent care locations. The Ambulatory staff nurses have set benchmarks to deliver timely nurse triage for all symptom-based calls and assist patients in determining the most appropriate level of care based on their symptoms. With the adoption of industry standard protocols and the implementation

of integrating these computer-based protocols, nurses will have an evidenced-based framework to efficiently triage and document appropriately. Data will be available to help measure this nursing practice. Nurse Telephone triage is one intervention of a bundled approach to reducing unnecessary emergency room visits thereby reducing the total cost of care. Nurses across ambulatory primary care demonstrate leadership, collaboration, teamwork and the commitment to improving patient experiences and outcomes in alignment with the overall mission of Boston Medical Center.

photo by Yael Bermudez

Emergency Department: Quality Care, Throughput and Efficiencies

Boston Medical Center's Emergency Department is ranked the 8th busiest emergency room in the United States with 139,577 annual visits in 2019, according to Becker's Hospital Review. Operating and caring for patients in such a busy environment, while undergoing continual construction phases, requires having the right team, a spirit of innovation, collaborative skills to create efficiencies with our peers in practically all areas of the hospital, and most importantly, the concern to provide the highest level of quality care without exception. Here are a few highlights:

Throughput and Efficiencies

While annual visits have increased at BMC, so has the number and length of stay of patients with an inpatient admission status—patients who stay in the ED for extended periods of time (greater than 2 hours). When patients stay in the ED for long periods of time, it creates concern on the impact of the quality of care being treated within the care areas, as well as for those waiting to be brought back to an available space for evaluation and treatment. Thus, the ED team continually works to assure that patients are seen by a provider in a timely manner as possible. “Reducing the time patients remain in the Emergency Department can improve access to treatment and increase quality of care” (Pierce & Gormley, JEN, November 2016, (42)6).

Consequently, the ED team has been able to successfully manage the high volume of patients who arrive to the BMC ED through several different strategies. The team utilizes concepts in creating and utilizing vertical treatment spaces, results pending areas—maximizing every space within the ED.

Vertical treatment spaces require the identification of patients who can be assessed and treated in alternative spaces that do not require a stretcher or bed. This may be patients who are in hallways or waiting rooms who may have been assessed and had their care started and finished while sitting in a chair.

Results pending areas are areas within the ED such as the Adult ED and Fast Track. This strategy is employed by the team on patients who may initially need a more private area for assessment and initial treatment, but then complete their care and wait in an area in a chair, freeing up a bed for the next patient. Patients in results pending areas may be waiting for lab results to return or may be waiting to have an X-ray completed and reviewed. These patients have typically been identified as those who will be discharged to home. These tactics all aim at having the ability to have treatment space for our sickest patients who require a stretcher or bed.

Quality of Care

In the past five years, the BMC HazMat Team has grown from a single digit team of willing participants to the largest HazMat response team within the Boston city hospitals.

Presently comprised of 64 members from all disciplines—RNs, MDs, Unit Coordinators, Public Safety Officers, Techs, all have completed an 8-hour off site annual training. It was decided over a year ago that working with our own equipment within our own space is the best way to build muscle memory and empower our team. With the generous collaboration of BMC's Emergency Management Leadership, this is exactly what has happened. This collaboration has provided extensive education and training for our team which will soon include monthly education and training. Also, the collaboration has formed a group of super users that will oversee and lead the team.

Almost all our Hazmat team members are part of the BMC ED Staff. Our Super Users have participated in a weeklong national training with other HazMat teams from across the country and are crossed train to work with, and on our Special Pathogens Unit. A paging system with active members has been established and we now have a team that is confident and competent to handle a hazardous incident—a long way from willing participants to confident team members!



A New Organizational Model for Patient Flow

The Off-Shift Nursing Management (OSNM) team is a dynamic group of nurse leaders who are responsible for nursing operations in the off-shift and as well as the shared responsibility of driving patient placement. 2019 presented many exciting opportunities for the Off-Shift Nurse Manager team to adopt new practices and align themselves with the needs of the organization post campus consolidation. Not only did the team grow in size with the introduction of new team members over the last year, but the evolving needs of the organization ultimately widened the scope of the role.

There was a concentrated effort and commitment to each other to cross train team members to both the traditional nursing supervisor aspects of the role as well as in the bed control aspects. This created a more flexible and dynamic team that was able to provide extended evening bed control coverage to drive patient placement through the Emergency department and the Integrated Procedural Platform while facilitating transfers of patients requiring tertiary level of care from the community.

This allowed other members of the team to focus their time and energy on supporting the bedside nurses and patients through rounding on the units, assessing clinical and staffing needs, and partnering with charge nurses to employ problem solving strategies.

The team spent much of the year redesigning their core workflows and implementing new technologies to drive their work. Together they implemented standard work including daily multidisciplinary bed huddles, a standardized hand off process, and standardized rounding. The team also adopted the use of Epic's Transfer Center Module to allow for electronic documentation and tracking of direct admissions and transfers from outside facilities, a process that up until last year remained on paper. They became accustomed to analyzing real-time supply and demand data and other operational metrics using newly installed electronic capacity management dashboards.

Together, with the newly formed Central Flow Unit and the admitting team, the off-shift nurse managers executed standardized

algorithms to drive patient placement for more than 25,000 inpatient admissions in 2019. This work also laid the foundation for the evolving care team regionalization initiatives. Partnering with physician and nursing leadership, the OSNM team drives patient placement of surgical patients to the extended stay PACU program as well as observation patients to the D- pod program. These programs have increased BMC's capacity and ability to admit patients by 16 additional beds.

The new team model has enhanced collaboration and teamwork, streamlined the work to reduce inefficiencies and duplications, and merged the clinical and operational needs of the organization so that each patient is receiving the right care, at the right time, in the right bed. The standardization of their work coupled with the updates to the electronic health record has empowered the OSNM to make better informed decisions and more accurate throughput and capacity projections.



Integrated Procedural Platform

When the decision was made to merge the two hospital campus surgical suites as well as combine the integrated procedural areas such as interventional radiology, neuro interventional radiology, and cardiac cath lab into one Integrated Procedural Platform (IPP), it was not known how mutually beneficial it would turn out to be for patients and IPP team members.

Patients receiving care in this new Integrated Procedural Platform begin and end their experience by being cared for by the skilled and dedicated nurses of the pre-operative holding room and post anesthesia care unit. These nurses have worked hard to make each patient feel well taken care of before their procedures, which now take place on the same floor and in the same IPP space. Nurses in each area can reach out to each other for aid, education, or peer support whenever needed.

The development over the last few years of High-Performance Teams has seen a wonderful opportunity for all staff—nurses, surgical technicians, anesthesia staff, and surgeons to form collaborative and productive teams and produce changes related to patient safety, operating room efficiency, and knowledge sharing between specialties. The cardiac and vascular teams have spent considerable time working in our new hybrid room perfecting how to treat patients requiring both surgical and endovascular interventions. Medical diagnoses which once required massive operations can now be addressed through the use of specialized radiographic technology and small vascular puncture sites. The nurses working in these areas have built a solid relationship with their counterparts working in interventional radiology to care for these patients successfully. The close exposure of these units has also given nurses insight into the work of their peers in other specialty areas and a new understanding for the capabilities of BMC in caring for our patients.

Saving a Co-Worker's Life

There have been several highly acute patient care scenarios where interdisciplinary staff support “moved mountains” with rapid transfer or conversion of cases from strictly surgical or procedural to a combined procedure to give patients the best chance of having a positive outcome.

Nurses in both areas have commented that they are supported by knowing that “help is never far” and they can simply look to the right or left for skilled help whenever necessary. Little did we know that the first real test would be a race to save the life of one of our own. Not long after the inauguration of the new IPP, a staff member's life was saved due to the quick thinking and cooperation of her IPP teammates.

It was around 7:15 on a Thursday morning in January. Andrea knew she wasn't feeling well but thought she could get through her scheduled 8-hour shift in the operating room. After huddle, she went into the locker room and started to feel weak, diaphoretic and had some vague chest pain. One of the night surgical techs saw her and approached the nurse manager at the desk. A group of staff went to the locker room and knew she needed to get to the emergency room quickly.

Her colleagues pushed her by wheelchair to the emergency room and the ED nurse manager and trauma team greeted them. By this time, Andrea couldn't feel her left side and her left leg was mottled. She was now in the trauma bay surrounded by physicians and nurses and there was a lot of urgency.

Her colleagues knew she was in great hands so they went back to the OR to start the day. They received a call within minutes from surgery asking to get the hybrid room ready for a repair of an aortic dissection and possible fasciotomy of left leg. It was their colleague who was fighting for her life!

Andrea was in the OR at 9:05 with the cardiac and vascular team. The general surgery team scrubbed in later to assist as well. She remained in surgery until 6:49 pm. It was a tough day for all the staff. Knowing the severity of Andrea's condition, the team remained calm under tremendous pressure. Andrea was transferred directly to the SICU where she remained for several weeks. She received dialysis and she said that the nurses and staff were kind and caring during a very challenging time. She felt supported.

The journey was far from over, she had several more IR procedures and returned to the operating room. The IPP teams received her with a smile. She was progressing well and was ready for Spaulding rehab to gain her strength and learn how to walk again. Unfortunately, she was transferred back to BMC for a r/o DVT after having pain and vomiting. She was again cared for the step-down unit where she received exceptional care and was discharged back to Spaulding. Andrea remained there until mid-February and was discharged home. The team is happy to report that Andrea is working full-time in the operating room. Colleagues spoke often about that day—the day when many units at BMC worked together to save the life of one of their own.

After six months, the NPDs have made a significant impact on new graduates and nursing staff.

They surveyed staff and found fellows to be:

"VERY ACCESSIBLE, AVAILABLE AND APPROACHABLE"

"A VALUABLE ADDITION TO THE NURSING WORKFORCE"

"EVERY DAY, YOU COME HERE, AND I LEARN SOMETHING NEW."

THEY ASK, "DO YOU HAVE ANYTHING NEW FOR ME TODAY?"

OR "I'VE BEEN WAITING TO ASK YOU THIS QUESTION..."

Nursing Professional Development Fellows

In 2019, in response to the feedback of some of our most experienced nurses, Boston Medical Center created an innovative nursing professional development (NPD) fellowship program to assist new graduate nurses transitioning into practice. This program paved the way for four grant-funded fellowships—two in critical care and two in medical-surgical services, working with new graduates for six months on nights (where most new grads were working.)

Nursing Professional Development Fellows are the bridge between new nurses and the complexities of healthcare systems. They promote organizational standards, cultivate critical thinking skills, provide education and conduct in-services and audits when procedures and changes are rolled out at the hospital, review policies and provide staff with various support.

"During rounds, it's not unusual for a fellow to be seen assisting a nurse with a central line, offering support with Epic documentation during a rapid response or guiding a new nurse with a blood transfusion. Finding policies on the HUB can pose various challenges, therefore, we teach nurses how to access and save policies, even to troubleshoot Epic," said Celia Hill, Nursing Professional Development Fellow.

Why was this program developed?

With the impending nursing shortage, more new graduate nurses have been transitioning into practice, especially in specialized areas as critical care. The Institute of Medicine in its landmark paper *The Future of Nursing* emphasized that patients' needs and care environments have become more complex. Nurses need to attain competencies to deliver high quality care. The literature also states that new graduate nurses are thrust into roles that they maybe inadequately prepared for. A skill that typically needs to be developed in new graduates is that of critical thinking. Well known educator Christine Tanner—coined the phrase "think like a nurse", but how do we foster more critical thinking/ judgement in new graduates and continue this journey of critical thinking.

Senior nursing staff expressed a strong desire for the continuation of the program. NPD fellows, Jo Foley, Corey Leaver, Joanne Rosato, Krisztina Nichols, Celia Hill, and Maureen McCarthy expressed that "one of the best things about this job is working with such great staff."

The role of the NPD Fellow and other creative supportive roles will continue to be essential to the hospital. They ensure consistency and progress on night shifts—addressing new nurses' transition into practice, providing education support and promoting critical thinking that ultimately impacts patient outcomes. Together with staff, they promote BMC's mission and create a healthy environment for new nurses and staff to thrive and develop into excellent caregivers.



Improving Patient Safety by Implementation of Human Milk Bar Code Scanning

Human milk is an important option for babies who are unable to breastfeed. It is associated with improved outcomes for some infants. Human milk is routinely administered by clinical nurses in mother baby units at Boston Medical Center. This includes the neonatal intensive care unit (NICU), the pediatric intensive care unit (PICU), maternity and pediatrics units. Documentation of administration was a manual workflow with two nurses reading the medical record number and name on the human milk label. This posed an increased risk for human error during administration and the potential for infants to receive the wrong human milk which could impact the child's potential exposure to maternal bacteria and viruses as well as maternal medications. In September and October of 2018, there was one administration error and several near misses.

As a result, a nurse committee was formed to review literature of human milk administration standards and best practices. National safety and industry standards recommend utilization of a barcode scanning process when human milk is collected, stored and administered in a patient care setting. Staff nurses identified several key points during human milk administration and presented to nursing senior leadership for approval.

A multidisciplinary group of nurses and IT analysts met weekly to identify the current workflow and transition into a new electronic workflow. From January to May of 2019, the work group met weekly to review all aspects of the proposed workflow and make decisions about the process. Testing was done to validate the proposed scanning process and training was conducted via eLearning. Initial support was provided by IT and nursing superusers for each unit for one week and thereafter, was transitioned to the nursing superusers who were resources to their colleagues.

After implementation of this workflow change, nurse human milk scanning compliance has consistently been over 98%. Anecdotally, nurse feedback has been positive, and staff feel the transition to scanning patients and human milk has improved patient safety.

Critical Care Resource Nurses Implements Early Warning System (EWS) Tool

The Critical Care Resource Nurses (CCRN) is an established clinical team at BMC. They are comprised of nurses with strong critical care ICU backgrounds and work closely with staff nurses and physician teams throughout the hospital. Critical Care Resource Nurses prevent failure to rescue, and support patients requiring ICU level of care outside the critical care area.

In 2019, the CCRN team collaborating with the Quality Improvement group developed an Early Warning System (EWS) predictive tool. EWS uses specific parameters documented by the team to monitor changes in a patient's condition and trigger if certain criteria are met. Failure to act and evaluate these changes can lead to diminished patient outcomes, and these triggers allowed the CCRN to respond quickly to these changes.

Using this tool, an EWS response team, consisting of a certified nursing assistant, the patient's primary nurse, CCRN, and physician, will assess, review and develop a comprehensive plan to support the patient. Once the plan of care is developed, the CCRN uses a note template developed by their team in response to the EWS score of 6 or higher, triggering the best practice alert (BPA) so that team members are alerted to changes in the patient condition. The note also documents the treatment plan.

Implementation of EWS has improved recognition and response to non-ICU patients who are deteriorating. Due to the teamwork, the CCRN team and the physician teams were able to decrease mortality by almost 50% in one year—a significant achievement in improving patient outcomes.

	Control Group	Intervention Group	
Time to resuscitative effort	1.69 hrs	1.22 hrs	Difference in mean = 28 min ; p<0.0001
Time to ICU Transfer	9.82 hrs	7.99 hrs	Difference in mean = 110 min ; p=0.0034
Length of stay; mean	14.1 days	11.59 days	Difference in mean = -2.53 days ; p=0.0015
Mortality	14.5%	8.61%	OR 0.73 (0.57 – 0.94); p < 0.0001



Nursing Supports for Prenatal Patients with Substance Use Disorder

Each year, BMC's RESPECT (Recovery, Empowerment, Social Services, Prenatal Care, Education, Community and Treatment) Program cares for over 120 women who are struggling with addiction in pregnancy. This unique interdisciplinary team works closely to tailor to the individual needs of each patient in a shared decision-making model. Clinical nurses create a caring culture of non-judgment and compassion that informs every aspect of nursing practice.

Patients struggling with addiction are often met with stigma, however the RESPECT team has worked vigorously to break down barriers to earn the trust of their patients and the reputation of a safe space for all women no matter where they are in their journey to recovery. The RESPECT program core values are a steadfast parallel to that of Boston Medical Center by practicing empathy, innovation, advocacy and compassion for our most vulnerable patients every day.

Nursing care from the prenatal period through post-delivery is framed around a philosophy which respects, supports and empowers mothers while considering the safety of their babies. Upon first contact with pregnant patients experiencing a substance use disorder (SUD), nurses provide information about the program, and collaborate with these patients throughout pregnancy to support recovery efforts and

promote both the expectant mother and growing baby's emotional and physical well-being in a non-judgmental manner. BMC nurses take the journey with the patient; establishing care contracts as an agreement by the patient to hold themselves accountable, empowers a therapeutic relationship while supporting and collaborating with the patient to provide a safe environment from antepartum to post-delivery.

The nurses work with the mother and partner or family to provide a very unique type of care which places the mother as healer. The nurses focus support on keeping the infant with the mother and/or partner as much as possible to provide the much needed non-pharmaceutical treatment to reduce withdrawal symptoms. The nurses teach the mother how to calm and soothe her baby, how to feed her baby and most importantly, the nurses practice with an authentic presence of caring.

This year, nursing supports were implemented to bridge the often complex care management of patients transitioning from inpatient to outpatient services. This unique entity offers immediate support to women during the period of highest risk of relapse yet often where they find the most motivation to begin and continue recovery. Our nurses frequently meet with delivering moms during their hospital stay to proactively ensure they have stable housing,

proper medication regimen, appointments and support services such as social work and psychiatry already aligned for the very next day, post-discharge. This process allows for patients to foster a trusting relationship with the care team even before their first outpatient visit and diminishes many of the anticipated risks of relapse. The team is able to offer a myriad of treatment options including Subutex, Vivitrol and outside methadone clinic coordination depending on the needs of the patient.

Nursing works closely with moms who are involved with DCF to support their recovery by creating a unique summary for the patient which represents a detailed account of their relapse prevention efforts, making DCF involvement less scary and better understood. Routinely, patients attend clinic visits up until approximately 6 weeks postpartum, however the RESPECT team is well equipped to support patients for six months and beyond. Keri-Lyn Schob, the newest nursing member of the team recalls a recent event informing a patient of a positive urine screen, "I explained to the patient that this is not punitive and that I needed to know that she was safe, and that I am here to support her. This is the core of nursing, the reason that we do what we do." Keri's office can often be found cluttered with thank you cards, many exclaiming moving sentiments such as "Thank you for believing in me."

Frontline Staff Moving Mountains through the Nursing Informatics Council

The Nursing Informatics Council (NIC) and its forty plus clinical nurses are Moving Mountains by collaborating with other disciplines to improve information technology (IT) tools and nursing informatics workflows. This committee has representatives from all clinical areas including inpatient, critical care, emergency department, perioperative and procedural areas. There is also an ambulatory subcommittee that focuses on the unique workflows of the outpatient clinics. The council meets monthly to review current and proposed IT nursing processes, to identify areas for improvement and to offer solutions to solve issues reported by their colleagues. The staff council is supported by nursing informatics specialists, trainers and analysts providing guidance and helping to drive decisions.

In the afternoon, there are specialty breakout sessions where the inpatient, perioperative/procedural, emergency room, perinatal and ambulatory areas gather separately and focus on their specific needs. During these sessions, council members provide feedback and approve content for the monthly Epic newsletters. They assist in the on-going process to create and revise tip sheets. Members are then charged to utilize these tools to communicate system changes, workflow improvements and best practices to their peers.

The Nursing Informatics Council encourages nurse leaders from all areas to attend a meeting to review workflows that need improvement. Quality improvement tools are used to guide changes and support activation plans. Physicians, ancillary leaders, and quality and compliance specialists have all attended NIC to obtain clinical nurses' feedback on their proposed

system or workflow changes when there is an impact to nursing practice. This type of collaboration is critical to implementing on-line tools that have the voice of the clinical nurse as a key driver for change.

Here are several examples of the work that the council helped drive in 2019:

- A safer way to administer blood
- Improved documentation tool focused in reducing CAUTI rates
- Revisions to the After Visit Summary (AVS)
- Retooling the influenza screening process
- Implementation of bar-coding scanning for milk products and surgical implements
- Activating the Avatar to drive LDA improvements
- Execution of therapy plans for reoccurring medication delivered in the ambulatory clinics

NIC offers a forum for front line staff to make a difference and act as a change agent. Their involvement positively influences the overall acceptance of new features and tools. They are super users. They participate in pilots where they evaluate new features, approve changes, participate in end user acceptance testing and contribute to creating training materials. During implementations, members provide At-the-Elbow (ATE) support to others to assist with adoption of new Epic tools. Council members also lead classroom training for new hires. Having a colleague train a new nurse on how to use Epic in their practice with real life examples is a tremendous benefit.

Members share that they enjoy “having a voice in practice”, “representing their peers” and “being the key communicator of needs and changes”. They work hard to be experts in the online systems, “break down silos”, and appreciate that they “have the voice of the clinical nurse in all the decisions”. When surveyed to ask why they value being a member of NIC here is what they shared:

- “I like being asked my opinion and feel I can give feedback on proposed items to ensure changes reflect current practices. My feedback matters.”
- “Participating in the council has improved my overall knowledge of Epic so I can be an expert user for my co-workers.”
- “I enjoy sharing what I have learned in NIC with my peers.”
- “I get the ‘why’ behind what changes are happening.”

Members of the Nursing Informatics Council presented details about the council, its charge and its accomplishments at national and local conferences in both poster and formal presentations. Members have also contributed to quality projects that were highlighted in poster presentations at Epic’s annual user group, the Institute of Healthcare Improvement annual conference and during BMC’s Quality Week.

In its fifth year, NIC continues to drive system and workflow improvements by engaging clinical nurses to impact overall efficiency and adoption. Staff reported that “I feel empowered by being a member of NIC and the collective energy at the monthly meeting reflects everyone’s drive to improve Epic and improve patient care.” NIC members are a priceless resource for their peers when it comes to all things IT.

Advanced Practice Provider Council Members

MARY ELLEN KILLION, NP, CHAIR
PEDIATRICS

DOUGLAS GRUNSEICH, CRNA
ANESTHESIA

JENNA MEADE, NP
FAMILY MEDICINE

DENISE ECKSTROM, NP
MEDICINE - CARDIOLOGY

FRANCES BLEVINS, PA-C
MEDICINE - HEMATOLOGY ONCOLOGY

ANTONIETA CAMARA, NP
MEDICINE - INTERNAL MEDICINE

MELISSA JACOBS, NP
MEDICINE - INTERNAL MEDICINE

CHERRISSE CARLO, NP
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LAUREN CIPRIANI, PA-C
ORTHOPEDICS

DANIELLE WALKER, NP
PSYCHIATRY

LAUREN HARTNETT, PA-C
SURGERY

New Advanced Practice Provider Council at Boston Medical Center!

It's an exciting time at Boston Medical Center for Advanced Practice Providers (APPs). The newly created APP Council will help promote, develop and support APPs including Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA) who work at BMC. This Council was modeled after advanced practice councils across the nation at major academic medical centers. The Council will function as a centralized resource for systems of care, scope of practice and programs related to APP practice.

Advanced Practice Registered Nurses such as Nurse Practitioners, Certified Registered Nurse Anesthetists, Certified Nurse Midwives, Psychiatric Clinical Nurse Specialists as well as Physician Assistants are represented on the APP Council.

The Council's dynamic and diverse members allow a full perspective of APP practice across all departments, divisions and services at Boston Medical Center.

The APP Council will advise Boston Medical Center and Boston University Medical Group senior leaders on matters pertaining to systems of care, scope of practice, and campus-wide resources and programs.

The APP Council will report to Boston Medical Center's Chief Nursing Officer, Nancy Gaden, DNP, RN NEA-BC; Chief Medical Officer, Ravin Davidoff, MBBCh and Boston University Medical Group Chief Executive Officer, William Creevy, MD, MS.

The Council will also have ex-officio members who will provide a broad view of patient care, education and research perspectives across the medical campus. These members are BMC Associate CNO Diane Hanley, RN-BC; BMC CMO designee Chris Mannaseh, MD; Chair of Graduate Medical Education Jeff Schneider, MD; Boston University PA Program Director designee Angela Reffell PA-C and Boston University School of Medicine Associate Dean of Faculty Affairs, Hee-Young Park, MD.

APP Council members meet monthly to discuss and deliberate action items. Please contact any member or contact the APP council at APPcouncil@bmc.org to discuss ideas to promote, develop and support APPs at BMC.

Town Hall meetings for the general APP campus population will be held quarterly. Please look for invites and plan to attend to hear Council updates.





Nurses Improving Care for Healthsystem Elders (NICHE) Council Update

The implementation of the NICHE program has been well received and supported at BMC. In 2017, the organization supported the development of a NICHE leadership team, which consists of physicians, nurse leadership and inpatient staff nurses. That group has met or exceeded most of the goals set one year ago, with continued work in those goals.

The NICHE staff nurses have embraced the opportunity to advance their practice. Many nurses, including the charge nurse and the nurse manager on 6 West have become Geriatric Resources Nurses (GRN) over the few years. Throughout the organization, there have been several more staff nurses who have advanced their practice by becoming GRNs.

In support of the continued commitment to NICHE, a conference was hosted by the NICHE committee. The conference titled “State of the Science in Geriatric Nursing” was a day-long professional development conference held on September 12, 2019. Sessions throughout the day focused on the four M’s of evidence-based geriatric care (mobility, mentation, medications, and what matters). Guest speakers Pat Noga VP of the Massachusetts Hospital Association and Arlene Stoller from the NICHE organization provided cutting edge information on the new dementia guidelines for nursing care and the importance of having the discussion with patients to determine what matters most to them. BMC is so proud of the work done by all of our NICHE experts.

Substance Use Disorder Council

The Substance Use Disorder (SUD) Council’s charter is to provide evidence-based training and support to the nurses at BMC, with the Council’s three priorities being policy development, education, and development of clinical champions, advocates, and leaders. There are currently over 35 members from inpatient and outpatient clinical nursing that have met monthly since April 2019 utilizing a shared governance model that empowers clinical nurses to share, learn, and lead.

The nurses on the SUD Council have brought forward challenges that are faced in the clinical environment, ranging from disruptive patient behaviors, lack of specialty knowledge, moral and ethical dilemmas, and the confrontation of stigma.

They have worked with BMC’s Legal Department to develop the inpatient absence agreement, a document that is reviewed with newly admitted patients to encourage harm reduction and participation in their care during hospitalization. Nurses want to establish a trusting relationship with patients while simultaneously encouraging safety and autonomy, and the inpatient absence agreement was created by the council with feedback from colleagues in mind. They have also created an online SUD educational resource on the Nursing website.

Council members have taken on the role as clinical leaders during their shifts to assess the needs of their patients, colleagues, and BMC community. Each month the voice of the nurse is shared and heard and used to inform the direction of the work to ensure progress in what really matters.



Integrative Nursing Council, Focus and Deliveries

“Integrative nursing is a framework for providing whole person/whole system care that is relationship-based and person-centered and focuses on improving the health and wellbeing of caregivers as well as those they serve.” —Mary Jo Kreitzer, Ph.D., R.N., F.A.A.N.

Integrative nursing deals with the mind, body, and spirit. Some of the integrative therapies are: meditation, music, guided imagery, yoga, aromatherapy, deep breathing exercises, resiliency, pet therapy, care channel, caring touches and prayers. All these play a major role in calming and comforting patients and staff. It’s all about a healing and caring relationship.

At BMC, we have an Integrative Nursing council, comprised of nursing staff from different departments. They meet the first Thursday of each month. The goal is to provide education and to empower patients as well as staff with the use of evidence-based practices.

Initially, the Council developed a quarterly newsletter about what we do at BMC. Over time, they have progressed to having their own integrative website which was launched in January 2020. Now staff can view short video clips on deep breathing exercises, watch instructional yoga videos, as well as read articles about self-care and recipes.

Also, Reiki requests are now available on the HUB and ongoing Reiki classes up to Level 3 are now available to all staff.

Last year, integrative nursing notes, aromatherapy, and reiki policies were established. Today, BMC is approved for essential oils like ginger, peppermint, lavender, mandarin, black pepper, frankincense, Bergamot and clary sage. These essential oils were carefully selected to guarantee patient and environmental safety.

Aromatherapy has recorded a huge success in the PACU. They hope to extend services to the mother baby units and other departments as soon as possible.

Last year’s conference at Lombardo’s in Randolph, MA was something to write home about because of the topic of the event: “Empower, Innovate, and Cultivate—Change Starts with You”, and with Rebecca Love as the keynote speaker. The topic of the conference was so captivating with deep professional implications that it attracted many attendees beyond BMC staff.

This year, the 10th Annual Integrative Nursing conference is scheduled to take place on May 8th, 2020 with an exciting topic—“Expressions of Joy” with Nataly Kogen as the keynote speaker.

The council serves as a professional development opportunity platform for nurses at BMC. Their interests grow every day because this platform is innovative, exposing us to deeper knowledge of our professional concerns. The Council hopes to have more outside nurses and clinicians, vendors and staff to be able to reach a greater number of participants for this program.

In conclusion, the noble goal of this council could best be understood in the words of Florence Nightingale, often referred to as the founder of modern nursing, when she stated that “The role of the nurse was to put the patient in the best possible condition so that nature could act and healing occur.”



MANY FACES CREATE OUR GREATNESS



The Complex Roles of the Care Management Team

Hospital management is no longer about utilization review and discharge planning. Hospital care managers are now expected to align their practice activities with medical staff practice, influence clinical costs associated with practice variations, and overcome obstacles to progression-of-care. They promote coordination of care among various caregivers, assimilate more information about economic factors, proactively advocate on behalf of the patient, facilitate seamless hand-offs to community resources and understand the impact of political trends on funding.

In very practical terms, it's a patient-centered approach to working with physicians and the clinical team to ensure the patient gets the right treatment, in the right place at the right time.

The care manager follows a specific number of patients and performs an initial and on-going case management assessment to determine care coordination and discharge planning needs, based on the patient's condition and presentation.

The team's utilization review responsibilities include evaluation of all cases within 24 hours of admission to facilitate care coordination and discharge planning and to determine if social work intervention is required. She/ he applies standardized approved criteria for medical necessity. There is too an on-going concurrent daily medical record review to measure patient progress against anticipated discharge, level of care and length of stay. They ensure that the patient receives the appropriate services and has an appropriate length of stay, as well as assist with obtaining the approval from the insurance provider.

Discharge planning starts on the day of admission. The care manager collaborates with the clinical team and medical providers team to initiate the anticipated discharge plan. The care manager facilitates communication within the healthcare team to coordinate the patient's anticipated discharge plan of care. She/he acts as the patient advocate by negotiating for, and coordinating resources with the payer, agency and vendor systems to expedite care and avoid care delay days and denials of payment.

There are many different programs at BMC, that the care managers are involved with to assist with their discharge planning. One of the programs the care managers have been involved in is the decanter program. This program was created to help transition patients from the hospital to an appropriate post-acute care setting.

The care managers assess the patient's clinical needs and insurance coverage. Many patients at BMC are uninsured or underinsured. These patients are apt not to be discharged to a post-acute facility due to lack of insurance. The care manager will identify these patients and discuss with the interdisciplinary team the level of care the patient requires post-discharge. They will identify the needs of the patient, such as physical therapy/ occupational therapy needs, long term IV antibiotics, wound care, family teaching, etc. Social support is also identified if it is a barrier to care progression or discharge. The three areas the decanter program offers are short-term rehabilitation, long-term care and hospice services.

Another aspect of care management that people may not be aware of is the general inpatient hospice (GIP) program. Nurse care managers can suggest to the physicians and nursing staff that if a patient is imminently dying and too sick to be moved, patients can be converted to general inpatient hospice status for comfort measures. Care management offers the patient and family the benefits of hospice care while here at the hospital. Families also receive up to 13 months of bereavement support.

Established in 2018, the Guardianship Program continues to thrive. This program was developed by a multi-disciplinary group of departmental stakeholders, legal affairs, business strategy, social work, care management, psychiatry and hospital service. They found that using outside counsel and establishing a guardianship oversight group to regularly review the status of patients admitted longer than the hospital's average length of stay was key to the program's success. As one social worker states, "there has been major stress and time lifted off the family. Also, the guardianship process has moved exponentially faster and therefore fewer internal meetings reviewing alternative discharge planning options (even if there were no alternatives)."

In 2019, Care Management established high-risk meetings with legal affairs, patient advocacy, social work, care manager, business strategy, patient finance and appropriate hospital services for high-risk patients with the goal to identify patients "stuck "in the hospital (or at risk) who do not require hospital level of care and be able to intervene as soon as possible. The group discusses and reviews barriers/needs, develops interventions to support a safe discharge, and assist care managers and social workers with planning for the most difficult dispositions. They also mobilize additional resources as appropriate. Overall, having these high-risk meetings with a multidisciplinary group has been beneficial to the organization to creatively problem solve and identify workflows or resources to help patients.

Other niche programs have been established with care management leadership including:

The 4E triad: Nurse managers, nurses, physician and care management leadership conduct meetings with the strategy team to work on unit specific initiatives with the goal to decrease length of stay and improve the patient experience by setting expectations related to joint replacement surgery.

Multi-D collaboration: The pre-procedure team, care management, nursing, surgeons, rehabilitation services and strategy work to operationalize target discharge dates and ensure consistent and accurate information is provided for patients along the continuum of care. Early results showed 16 bed days were saved by the intervention.

"I think patients are better prepared for their surgery and have a better understanding of what to expect post-op after meeting with Sheryl. It helps tremendously when identifying post-hospital resources needed when it is discussed pre-op. I also think the anticipated discharge date helps everyone on the team speaking and thinking the same. The collaboration between pre-and post-op managers has been amazing!" said care manager Maryellen Doucette.

These programs have helped bring change to the hospital's overall length of stay and assisted the care manager and the rest of the healthcare to a discharge plan.



Periop 101

In 2016, the operating rooms (OR) at Boston Medical Center (BMC) were heavily dependent on travel nurses with as many as 17 travelers in one of our OR suites at one time. While travel staff are clinically skilled, levels of expertise vary tremendously, and the limited contract time creates high turnover. High staff turnover creates challenges on several levels including nurse educator time (and other facility resources) for onboarding and orientation of each new traveler, constant precepting by the rest of the staff, and most importantly, inconsistencies in the team dynamics during surgery.

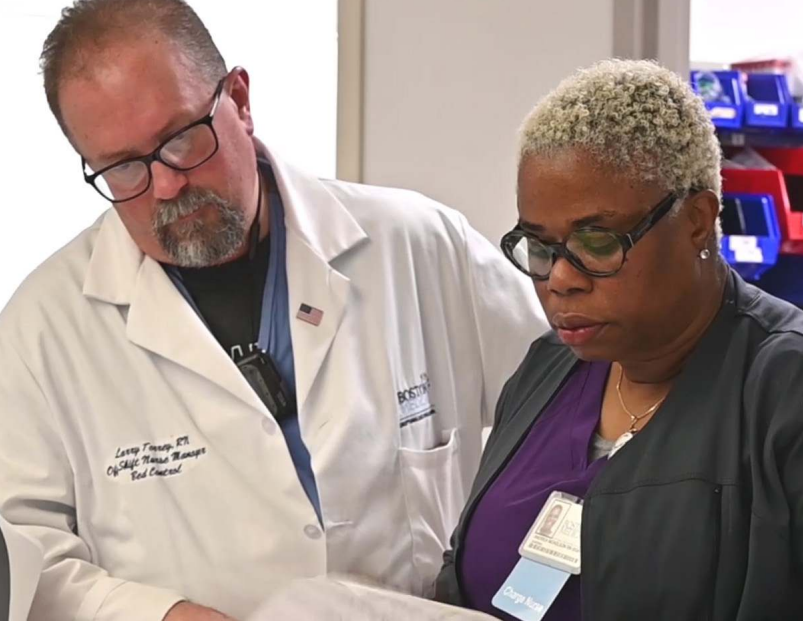
The OR is a highly technical and complicated practice setting requiring a comprehensive, extensive, and expensive orientation while the mean age of OR nurses nationally is continually edging toward the age of retirement. This has created a shortage of experienced OR nurses responding to our recruitment efforts.

To meet our staffing needs and limit our dependence on travelers, BMC has created an innovative collaborative relationship with a local school of nursing for experienced nurses who want to work in the OR. The BMC OR nurse educator developed a program with the college to train nurses to work in the OR using the evidence-based Association of periOperative Nurses' (AORN's) Periop 101 Program in conjunction with other resources.

The didactic classroom preparation is completed at the school of nursing, skills labs are done in the Simulation Lab at BMC, and then the registered nurse interns are placed in the OR at BMC or other local hospitals for a precepted clinical experience. This clinical experience allows the nurse intern to learn hands-on clinical skills from an experienced OR nurse while the OR team interacts with the nurse intern evaluating their learning and potential fit with their team.

BMC has conducted two internal transition programs offering this training paid for by BMC. Interested BMC nurses applied, were interviewed, and offered an opportunity to shadow for a day in the OR to assure the desire to work in this setting. A total of nine internal transition nurses have been trained in this manner through the program. In addition to those internally transferred, the OR has hired 14 additional new OR nurses from this program for a total of 23 new OR nurses.

This program has been a huge success on multiple levels, providing an avenue for BMC and other Massachusetts nurses to build a foundation of perioperative knowledge and skills enabling them to apply for OR jobs, many of whom have been hired directly into their clinical site, and from our own standpoint, building our OR team with hand selected and home grown (trained) OR nurses. We have retained 19 of these nurses to date, decreasing our dependence on traveler OR RNs significantly. Today we have only four nurse travelers across both OR settings.



Medical/Surgical Charge Nurse Development Program

The charge nurse, a clinical nurse leadership position, is the natural role for succession to the nurse manager position. BMC nursing leadership believed that a succession plan should focus on improving communication and developing leadership skills in order for charge nurses to successfully assume the nurse manager role. Charge nurses are involved in decisions that affect patients and the unit; and have an enormous impact on whether an organization meet its goals. As demands for quality outcomes increased, a commitment to decreasing patient harm was adopted; the realization of empowering the charge nurses was recognized as a viable option to provide bench strength to the nurse manager ranks. As future nurse managers, the complexities in healthcare required more than an expert clinician; it involves understanding the importance of communication and leadership.

The succession planning program was comprised of a pre-assessment, followed by three workshops to improve knowledge in professionalism, communication and leading teams, and the business of healthcare. The program concluded with a post-assessment.

The assessment tool and content for the workshops were adopted from the American Organization for Nurse Leaders(AONL), TeamSTEPPS®, and the Comprehensive Unit-Based Safety Program (CUSP).

The program began with participants completing the American Organization of Nurse Leaders (AONL) Nurse Manager pre-assessment, anonymously. Participants identified their current skills using a four-point (novice, advanced beginner, competent, and expert) Likert scale. The assessment was focused in three areas: The Leader Within: Creating the Leader in Yourself; The Art: Leading the People; and, The Science: Managing the Business. The next step in the program was to introduce new knowledge utilizing three workshops, the main focus was the TeamSTEPPS® curriculum. At the end of the workshops, the charge nurses were invited to take the American Organization of Nurse Leaders Nurse Manager post-assessment.

The three workshops were developed and focused on improving the communication skills of the 24 medical-surgical charge nurses to help prepare them to take on the nurse manager role. Each session was presented in an interactive format allowing for the content and materials to be presented, practiced, and discussed.

The TeamSTEPPS® workshop helped the charge nurses learn and practice the skills they needed to communicate effectively with their colleagues. It is an effective strategy that introduces tools to improve patient safety by enhancing leadership skills. TeamSTEPPS offers several solutions to improve patient safety. One of the highlights of its education is communication. Communication is the leading cause of errors in healthcare. TeamSTEPPS® also supported the importance of promoting relationships within the team for improving patient care. Effective communication strategies are crucial in building team trust. TeamSTEPPS® is identified as an evidence-based program that taught the importance of effective communication and the ability to manage conflict within teams. A lack of cohesiveness and mutual understanding leads to conflict that affects patient outcomes. It is crucial that leaders work together to resolve barriers. Implementing this evidence-based workshop facilitated the importance of charge nurses' understanding of their work from three perspectives, professional development, efficient communication, and healthcare business to influence the team and patient outcomes.



Additional workshops on professionalism and the business of healthcare were also presented.

They were conducted by individuals who had experience in the topic. The sessions were presented using video vignettes and case studies. They allowed charge nurses to apply the content learned to current problems. The scenarios were equivalent to situations that occur in the clinical environment. It gave the participants an opportunity to think about professional practice by applying action learning techniques to solve problems. Presenters were asked to use an interactive discussion to engage participants. Questions were encouraged to clarify and promote further discussion.

The professionalism workshop aligned with the AONE's 'leader within' domain. The Role of the Nurse Leader was from the Agency for Healthcare Research and Quality (AHRQ), Comprehensive Unit-Based Safety Program (CUSP). One of the principals of CUSP is the importance of culture owned at the unit level. The content supported learning by clarifying the role and responsibilities of new leaders. It supported professionalism by addressing the leader's position and responsibilities. The CUSP kit included facilitator notes, video vignettes, and

PowerPoint slides to highlight professional development and work alignment. It helped the charge nurses understand their role while engaging in reflective practice.

The business of healthcare workshop was presented using concepts from AONE's Science Domain: Managing the Business. It included an explanation of external policy decisions and how they affected the systems in the medical center. It included reimbursement and challenges with current policy decisions. The participants learned the importance of collaboration, and quality care, through a finance lens. The workshop also identified how the participant's work affected the medical center's bottom line and was key to its success. Nursing consumes a large portion of the medical center's budget and resources. The workshop helped them understand healthcare business from an external and internal perspective. The facilitator helped participants understand the business of healthcare from a unit perspective.

At the conclusion of the 3 workshops, the post-assessment was administered anonymously on paper. The post-assessment results helped to evaluate if there was a perceived change after the workshops; it also provided insight for future charge nurse needs. The post assessment demonstrated great improvement in communication and leadership. 63% of attendees noted positive changes that were greater than fifty percent. The Leader Within domain had 20 questions, 60% had changes that were greater than fifty percent.

Anecdotal discussions revealed the charge nurses wanted to learn more about the business of healthcare and how it influenced their work. The project broadened the knowledge of charge nurses and helped them understand the medical center's decisions and their role in that process. They learned to be confident communicators who had a positive impact on patient care. The project also supported leadership development and clarity of the charge nurse role.



Maternal Child Health (MCH) Preceptor Orientation

A core group of Labor and Delivery expert nurses that frequently precept inexperienced new nurses, identified that these nurses struggled after the end of orientation on Labor and Delivery and at times were overwhelmed by the pace and the acuity of the unit. They had approached the unit manager Michele Schultz and unit educator Lynne Lambert to discuss what they may do as a preceptor group to redesign orientation and add consistency to the program.

The preceptor group met weekly for several months to discuss the pace of orientation and the structure of the didactic learning. The preceptors considered how they could better seek out experiences that aligned with the nursing practice so that the new learner could apply their knowledge at the bedside.

They articulated the importance of starting with the fundamentals of labor and birth. They emphasized the importance of weaving in the art of labor and delivery nursing care and the role in supporting physiologic birth, so the learner makes human-to-human connections with their patients from the beginning of their experience.

They had recommendations for placement of didactic education in the orientation and wanted to bring in various methods of learning from different sources i.e., fetal monitoring eLearnings, fetal monitoring classroom learning, spinning babies (techniques on positioning that supports physiologic birth), AWHONN classroom learnings facilitated by our unit-based educators, and circulating and scrub nurse trainings.

The group discussed when and how to assist the new nurse in gaining skills to care for high-risk maternity patients and the challenges of when the normal patient turns abnormal. Using Benner's model of novice to expert, they articulated and shared experiences of how to bring the new nurse on a 5-6-month journey of skill acquisition. The preceptors thought it was important to use simulation learnings especially for those experiences that need accuracy and timing. In their recommendations, they appreciated and hoped that this type of learning would best prepare the nurse for competent performance in an emergency. Their work has been critical in the design of Labor & Delivery orientation of new staff.



Dedicated Education Unit

The decision to create a Designated Education Unit (DEU) at BMC for the purpose of onboarding new graduate nurses to the medical-surgical division was multifactorial. In 2018, there were a high number of new to practice nurses being onboarded, and Nursing Professional Development Specialists and Nurse Managers were noting the difficulty of providing a comprehensive orientation for these staff. The nursing preceptors at this time were feeling overburdened as new to practice nurses require a great deal of support and guidance through their transition to professional practice. Creating a comprehensive orientation that focuses specifically on the learning styles and social needs is essential to improve the transition from academia to professional nurse.

The decision was made to utilize a certified Nursing Professional Development Specialist (NPDS) in an expanded role to oversee the clinical orientation in combination with a dedicated nursing education unit and nurse manager. This nursing unit was chosen during a large reconfiguration of the nursing units within the hospital. At this time nurses had an opportunity to choose what nursing unit they wanted to work on. The nurses who chose to work on the dedicated education unit were eager to be a part of this new project. To support the onboarding of the new graduate nurses on the unit much of the staff enrolled in a preceptor course/workshop to further hone their skills.

This new DEU model allowed for a standardized onboarding of new graduate nurses in an expanded orientation program ensuring an introduction to the professional role of a nurse, quality care, evidence-based practice and hands-on skill development. The development of this program was based upon the identified need to ease transitions of new nurses into the professional role of

nursing as well as creating a standardized experience for all new nurses. The evidence-based curriculum was based on Benner's novice-to-expert framework and inclusion of Tanner's Model of Clinical Judgement was incorporated into the program to enhance the development of "clinical knowledge through expert guidance and coaching". A successful transition needs an environment that supports the new nurse during this transition (Casey, et al., 2004). Learning objectives were developed based upon evidence-based practice and areas of patient safety identified in the literature and within the institution. The curriculum designed for the DEU and outcome measures are new graduate nurse centered and emphasize the knowledge, skills, and attitudes these nurses should be able to demonstrate upon completion of the DEU orientation.

The DEU model consists of a five-week orientation with direct oversight by a nursing professional development specialist. The orientation occurs on an adult medical nursing unit, 6 East, and is purposeful in the application of hands-on skills, introduction of evidence-based practice, professional development, and delivery of quality care. The NPDS works one-on-one with the new hires, providing guidance to the many aspects of patient care. This includes an introduction to the electronic health record, integration of evidence-based practice guidelines to daily practice, introduction to the environment of quality improvement, standardized measurement data such as the National Database of Nursing Quality Indicators and exposure to HCAHPS, also known as the Hospital Consumer Assessment of Healthcare Providers and Systems. The integration of patient safety and quality care occurs in a classroom setting as well as through daily clinical conferences.

Feedback received from the staff who have oriented through the DEU has been overwhelmingly positive. The end of the first 12 months, 39 new RNs have oriented with a 91.3 percent retention rate. Ongoing support for the new graduate nurses continues for an additional 5 months after DEU orientation with the Nurse Residency Program.

Classroom and simulation-based curriculum incorporates hands-on skills and simulation to provide additional supports for the transition to professional nurse and lifelong learners. "I had a wonderful experience on the DEU", "I am so grateful to have the opportunity to participate in this program", "I love the classes that extend beyond the DEU", and "the simulation allows for me to practice skills I will need in my clinical area", said the new graduate nurses.

Due to the success of this program a second nursing unit has been created to function as a DEU. The model mirrors the original model with a designated nursing professional development specialist who has direct oversight of the new graduate nurses and a designated nurse manager to oversee their onboarding.

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Maternal Child Health (MCH) Teams Training

Two BMC novice Labor and Delivery nurses had a goal of making an impact on the culture of safety on Labor and Delivery. They wanted to improve the collaboration and communication with their NICU colleagues and ultimately decrease serious reportable events. In collaboration with the Medical Director for Quality in the NICU and the Nurse Manager in the NICU, they decided to apply for a safety grant sponsored by the Quality and Patient Safety department.

They hoped to help their NICU colleagues with teams training education and sponsor the roll out to the NICU interdisciplinary team so that they could continue the mission of teams training communication from mother to baby in the NICU.

In collaboration with their NICU colleagues, they developed a budget that incorporated supplies, training sessions, speakers, and staff development that would need to accomplish their tasks. They invited Teams Training experts from BIDMC to speak at a day-long session that would serve to refresh obstetric team members and a core group of NICU teammates to introduce the concepts of teams training for their team.

The obstetric nurses had hoped to reinforce the communication concepts in the newly formed huddles with purposeful integration into obstetric simulation. The NICU teams found various ways to use the information and skills in resuscitative simulations and in daily communication routines planning NICU care.

The project influenced other safety projects on the unit such as “52 weeks of safety” clinical pearls that enhance safety and safety interdisciplinary board rounds. These staff have made a great contribution to Maternal Child Health at BMC.

photo by Ed Collier



Professional Development Activities

Professional Development at BMC

Nursing Professional Development (NPD) is comprised of 21 nursing professional development specialists who represent all the specialties at BMC—medical/surgical, critical care, maternal child health, emergency services, perioperative services, central education including simulation and primary care. They provide both nursing focused and interprofessional targeted programs.

Nursing continuing professional development in the specialty areas include broad topics such as substance use disorder and domestic violence. BMC was the first provider unit that had a Massachusetts Board of Registration in Nursing (BORN) approved Domestic & Sexual Violence Training pursuant to MGL that all LPNs, RNs, and APRNs needed to complete for their license renewal for 2020. This course assists in providing much needed knowledge for our patient population. The patient population of BMC is also impacted by the current substance use epidemic and the provider unit provides multiple programs addressing continuing nursing professional development on this social determinant of health affecting our community.

Other specialty knowledge courses include Trauma Care Everywhere (medical surgical level trauma course), transgender care, chemotherapy simulations, introduction to cancer care, and a SICU hearts and minds course. Additionally, NPD has offered resiliency trainings that included Reiki 1 and 2, Resiliency 1 and 2, Aromatherapy, and the Annual Integrative Nursing Conference.

In 2019, the Nursing Professional Development provided over 296 programs with about half of those targeting interprofessional audiences. Many of the nursing and interprofessional programs utilized simulation based active learning to engage and reinforce knowledge, skills and practice over passive methods of lecture only learning.

BMC has committed to a Magnet journey and supports the continuing professional development and education progression of its nursing staff. The ongoing goal is to provide more offerings in professional development focused on certification and specialty nursing. We continue to meet the needs of the learners determined by a self-assessment and identified needs assessment by key stakeholders as well as by evidence-based trends.

BMC is committed to providing nurses with opportunities for obtaining continuing professional development and contact hours. BMC has its own Provider Unit through American Nurses Association, Massachusetts, and is approved to provide nurses with contact hours for programs. In 2019, the BMC Provider Unit almost doubled the number of programs and contact hours since last year and reached more nurses and other participants than previous years.

By the numbers:

297 PROFESSIONAL DEVELOPMENT PROGRAMS PROVIDED

1,020 CONTACT HOURS PROVIDED

4,018 NURSES ATTENDED

6,372 TOTAL PARTICIPANTS IN OUR PROGRAM OFFERINGS

WE PROVIDED PROFESSIONAL DEVELOPMENT ON ASPECTS OF SUBSTANCE USE DISORDER, DOMESTIC VIOLENCE, INTERPROFESSIONAL TEAM TRAININGS FOR ONCOLOGY CLINICS, EMERGENT EVENTS (BESTT), AND OBSTETRICS (EMERGENT C/S). THERE WERE PROGRAMS ON CARE OF THE PATIENT PERITONEAL DIALYSIS, ARTERIAL LINES, TAVR, OB PATIENT IN STEPDOWN UNIT, PATIENT WITH AGGRESSIVE BEHAVIOR AND TRAUMA CARE EVERYWHERE.

thank you!

CELEBRATIONS & RECOGNITION

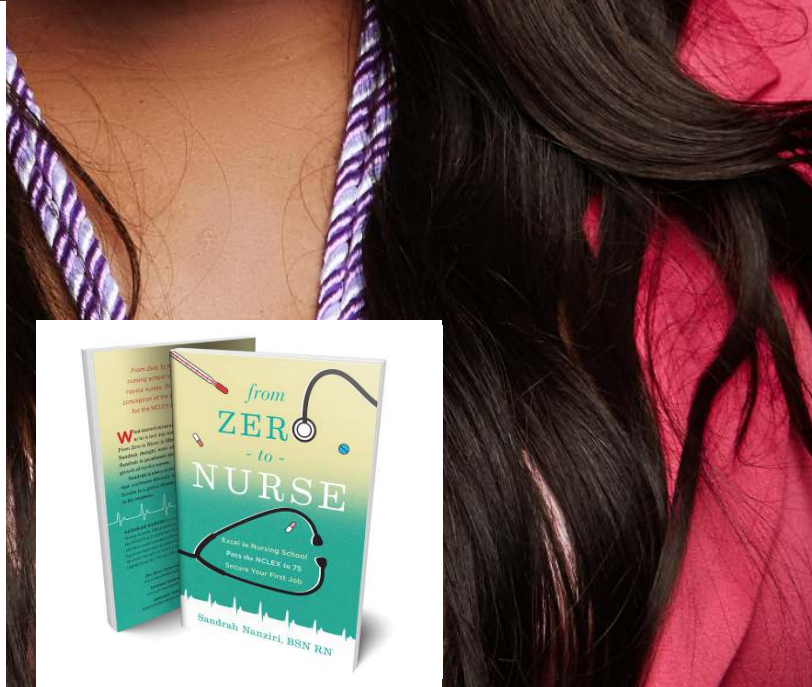




NURSING SPOTLIGHT
SANDRAH NANZIRI, 6 EAST NURSE

“From Zero to Nurse is a resource for aspiring nurses, student nurses and new nurse graduates. While in nursing school, I realized that having the right resources simplified my journey. I wanted the same for other nurses, so I began researching and documenting my journey as a way of paying it forward. Being selected for the new nurse residency at Boston Medical Center was a highlight at the start of my career. This experience enabled me to explore why residency programs are beneficial for new nurses. I am grateful to have started my career at a hospital that mirrors my virtues.

I also wanted to inspire nurses to write more. If we can document, we can author books. Books that can advance the profession as well as inspire young people to join the profession.”



Book illustration by Stewart A. Williams; Photo by Reedy



NERBNA Excellence in Nursing Awards

Five of our outstanding BMC nurses received the New England Regional Black Nurses Association Excellence in Nursing Awards at the 31st Annual NERBNA Award Dinner, held at the Boston Marriott in February 2019. We are proud of our nurses. It is through their excellence in practice and patient advocacy that we achieve Exceptional Care Without Exception. Congratulations!

- Marva Durand, ASN, RN**
- Andrea Nicholson, BSN, RN**
- Mariama Tejan-Seisay, BSN, RN**
- Sharmecka Horton, BSN, RN**
- Narces Norceide, BSN, RN**





20th Annual Nursing Excellence Awards

The Annual Nursing Excellence Awards was held on May 8, 2019. We congratulate all the nominees and award recipients for their compassionate and exceptional care provided to our patients.

Nurse Excellence Awards

Courtney Albano, RN
 Kathleen Honore Byrne, RN
 Emily Dossantos, RN
 Marva Durand, RN
 Donna Guidaboni, RN
 Karitas O'Connell, RN
 Joanne Rosato, RN
 Georgianna Shoemaker, RN
 Deborah Silva, RN
 Rebecca Zappala, RN

Ann G. Hargreaves Award

Jessica Kehoe, RN

Peggy Cenci Memorial Award

Deborah Canavan, RN

Lynn Ronan, RN Celebration of Life Award

Tamzen McKenzie, RN

Friends of Nursing

Michael Hurley
 Joanne Timmons



**NURSE HERO JULIE SWAIN, RN,
RECOGNIZED AT THE BOSTON RED SOX
NURSES NIGHT 2019**

Fondly referred to as the “smother-mother” of her unit, Swain’s nominator calls her “easily the kindest and hardest working RN at Boston Medical Center.” Red Sox super fan Swain received the DAISY award and the Edwin F. Hirsch Award. She was also recognized in the Boston Globe in 2018 for her work with the VIAP Program at BMC, where she builds relationships with trauma patients/victims of violence and provides them home care when insurance doesn’t cover a home visit by a local agency, the VIAP continues care even after discharge.

“She always goes above and beyond, even in the smallest of ways by bringing in personal shampoo/conditioner for patients with extended stays,” her nominator adds. “Julie also loves the Sox and would never expect this!”

Congratulations Julie!





2019 DAISY AWARD RECIPIENTS

DEBORAH CAREY, RN – NICU
KATHY BRADY, RN – MICU B
EVENA CHARLES, RN – 6W MP
ROGER BLANZA, RN – CCRN

This year, we honored four BMC nurses who received the Daisy Award for Extraordinary Nurses for their compassionate care. They exemplify the kind of nurse our patients, families, and staff look to for support. The DAISY Award is an international nursing recognition program that was established in 1999 by the family of Patrick Barnes, who died at the age of 33 from complication of Idiopathic Thrombocytopenia Purpura (ITP). As a way to turn their grief into something positive, the Barnes Family came up with the DAISY Award, an acronym for Diseases Attacking the Immune System. The Barnes family believes nurses are the unsung heroes of our society who deserve far more recognition and honor for the compassionate care they provide to patients every day. BMC honors four nurses a year with this prestigious award.





2019 CNA OF THE YEAR AWARDS
JOCELYNE ALLEYNE, CNA – 5W IMCU
LEAH STUMP, CNA – ADULT ED

At Boston Medical Center, Certified Nursing Assistants work under the direction and supervision of nurses and participate in the delivery of patient care. Their role is essential in providing direct clinical and support services to patients and families across the health care continuum and functions as an effective member of the health care team by contributing to the efficient operation of the unit and accountability for fiscally sound, quality patient/family clinical outcomes.

The CNA of the Year Award is given to CNAs who exemplify dedication, leadership qualities, work ethic, professionalism, commitment to quality for their patients, continued education and how they work in a team within their unit/area and with other departments.



2019 UC OF THE YEAR AWARDS
DENISE CARUTHERS – FLOAT POOL
TERESA TAYLOR – MICU B

Unit Coordinators are responsible for the overall administrative functions of the nursing station/front desk. They work collaboratively with the clinical team and participate in the delivery of patient care by providing a variety of clerical, customer relations, and support services to patients, their families and healthcare team members.

The Unit Coordinator of the Year Award is given to UCs who are exemplary role models, influence the development of others, foster growth, learning, are creative and innovative and exhibit outstanding performance in their areas.





Nurses Week: May 6–12, 2019

Every year, we honor our nurses and the nursing practice at BMC through educational activities and simulation workshops, recognition programs and events such as our nursing craft fair and family day at Fenway Park. We celebrate our nurses and the exceptional care at BMC every chance we have.





A Nurse's Medical Mission Trip to Haiti

Rachel Mays, RN, MICU B clinical nurse at Boston Medical Center (BMC) first became interested in medical mission trips when she was in nursing school. After reading Paul Farmer's book "Mountains Beyond Mountains," and learning how her classmate's family had gone on mission trips, it really caught Rachel's interest. She was inspired to see how her practice as a nurse could extend beyond working in a hospital and give back to those who have limited access to health care.

In December 2018, BMC clinical nurse Rachel traveled with a non-profit organization, Lavi Project, to set up mobile clinics. This was her second 10-day medical mission to Haiti. She was a member of a 28-person team that would pack up a very large truck every day and travel 3 to 4 hours into the rural communities of Haiti outside of Port-au-Prince.

Through local parishes, the team served individuals with the basic necessities such as antibiotics, antihypertensive medications, daily vitamins, and daily oral care. Rachel provided patient teaching focused on health promotion on how to perform daily care and take care of oneself. She completed head to toe assessments, patient education and collaborated with other team members for patient interventions.

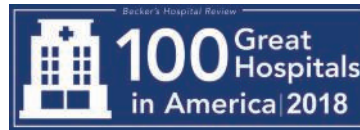
Rachel and the team traveled to four different rural communities, on four different clinic days and served over 930 Haitian people.

Great work Rachel!



Volunteer and Team Building Activities

The SICU team took time out to volunteer at the Greater Boston Food Bank during the holidays.



Boston Medical Center Awards & Recognition

- Boston Medical Center was listed on Becker's Hospital Review's "150 Top Places to Work in Healthcare."
- For the third year in a row, BMC received a Top 25 Environmental Excellence Award from Practice Greenhealth.
- BMC also won three Circles of Excellence awards from Practice Greenhealth, in energy, climate, and green building.
- BMC was designated a LGBTQ Healthcare Equality Leader by the Human Rights Campaign. The status is awarded to healthcare facilities that attained a score of 100 in the Healthcare Equality Index (HEI) 2019.
- BMC was named one of Becker's Hospital Review's "100 Great Hospitals in America." Hospitals are chosen for this award based on their excellence in clinical care, patient outcomes, and staff and physician satisfaction.
- BMC nurses are recipients of the New England Regional Black Nurses Association Excellence in Nursing Awards.
- Over 30 BMC nurses were nominated by patients, families, and colleagues for their dedication and care for their patients in The Boston Globe's 2019 Salute to Nurses.
- Boston Medical Center received an "A" in patient safety from The Leapfrog Group's Fall 2019 Hospital Safety Grade.
- Boston Medical Center Health System was named #1 on a list of the top 100 women-led businesses in Massachusetts by the Globe Magazine and The Commonwealth Institute.





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